THE FORMULATION OF HEALTH AND WELFARE RELATED SOCIAL POLICIES FOR THE PHYSICALLY DISABLED IN ALBERTA AND BRITISH COLUMBIA

by

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ABSTRACT

The purpose of this study was to analyse and compare the development of policies for the physically disabled within the central health and welfare administrations of the Alberta and British Columbia governments from 1945 to 1980. The interaction of policy development with the organizational structuring within which the policies were administered, was analyzed to determine how the policies and their organizational frameworks changed over time.

This study originated from observations made within Alberta's Department of Social Services and Community Health in 1980, concerning the ambiguous nature both of the content of certain policies concerning the physically disabled, and of the organization of the responsible department areas. Within the department, my difficulties in perceiving the client boundaries and program boundaries of particular jurisdictions that purported to administer programs for the physically disabled, were compounded by observing that services of particular programs were duplicated by other jurisdictions. These ambiguities led me to question whether there were underlying principles accounting for the manner in which both had developed.

It was decided to compare the development of all policies affecting the physically disabled within the Alberta departments concerned both with public health and with public welfare from 1945 to 1980. In order to enlarge the amount of

data bearing on the problem, the analogous departments in British Columbia were chosen for comparison. Data were taken from secondary sources, the annual reports of each province's health and welfare related departments. These were analyzed according to the methodology of grounded theory, using the techniques of theoretical sampling, and of the constant comparative method of analysis and coding to classify documentary data originally not created for research purposes. In order to develop a broad range of acceptable indicators that permitted the coding of data into conceptual categories of explanation, a series of guiding questions, developed to suit the purposes of the research, was constructed. Conceptual categories with various properties emerged from the data, and were sufficiently generalized to designate characteristics of the policy development process that occurred in both Alberta and British Columbia. Four conceptual categories accounted for similarities between the two provinces while properties within the categories identified differences. These categories were named boundary decisions, labelling contexts, valuation contexts, and contextual constraints.

The category of boundary decisions elicited and clarified both the type of policies that were taken within the departments according to the conditions that they met, and made explicit the type of policies left outside of their functioning. The categories of labelling contexts and valuation contexts provided an analytical explanation that accounted for the prescribed boundaries while simultaneously legitimizing the

types of policies undertaken. The category of contextual constraints identified the presence of socioeconomic and institutionalized constraints that impacted on the development of policies and on their organizational arrangements within particular jurisdictions. A literature review verified the existence of these conceptual categories as variables intimately involved with policy development issues in general.

The categories and their implications for the development of policies according to the needs of the disabled were related to the wider context of welfare state ideology. Boundary, valuation, and labelling were linked by properties that had a common underpinning of an utilitarian principle. The predominance of this principle underlying the policy making for the disabled was contrasted with other perceptions of the functions of social policy. The proposition was formulated that the economic values of the capitalist system and its institutions dictate social policy making for the physically disabled. The implication of this for the disabled was that policy making and planning for them at a governmental level will continue to lack comprehensiveness and attention paid to certain demonstrated needs as long as these values are predominant. Planning recommendations address the problem of how change could be brought about through the advocacy of groups of the disabled.

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PREAMBLE

Purpose and Definitions

The purpose of this study has been twofold: to describe, analyze, and compare the development of policies for the physically disabled within the central health and welfare administrations of the Alberta and British Columbia governments, from 1945 to 1980; and, in conjunction with this, to analyze the interaction of policy development with the organizational structuring of the frameworks within which these policies were administered.

For purposes of clarification, certain meanings have been ascribed to the notions of framework and policy. Firstly, policy has been defined very generally as the "adoption or maintenance of a course of action" (Crichton 1980, p. 22), in this case, with respect to the physically disabled. Secondly, organizational framework has been defined as the "differentiation of positions, formulation of rules and procedures, and prescriptions of authority" (Ranson, Hinings, & Greenwood 1980, p. 2), of the organizations. It is within this formal organizational design that organizational members operate. Ranson et al (p. 3) have stated that the "framework, rather than being removed from organizational working, is intrinsically involved in the shaping of the actual operation of rules, and the real working of authority, sustaining the distribution and conception of the

division of labour". Hodgett (1960) also linked the courses of action taken by policies with their encompassing organizational framework. He said that "more elusive but equally relevant are the policy implications inherent in work divisions" (p. 135).

It is this interaction or linkage between the policies that were made and the identified organizational frameworks that I described in order to determine how, if at all, the policies and their central organizational administrative mechanisms changed over time. The caveat, 'if at all', recognizes implicitly that "change must not be confused with simple variation ... since variation of forms and structures is ... universal in history ..." (Smith 1976, p. 10).

Problematic Issues of Analysis

Firstly, the process of policy making by individual organizational members was not analyzed since it was impossible to have access to the day to day negotiations that took place long ago.

Secondly, because the problem concerned the planning of central administrative structures to facilitate the operations of policy making and service delivery, it was clearly qualitative in nature. This meant that it was not amenable to measurement and the use of analytic statistical devices for interpretation. A methodology suitable for the purposes of qualitative research had to be selected. This was the data collection and analytic strategies of Grounded Theory. Briefly, the stages employed in this technique were: 1. entering the field work phase without a hypothesis 2. describing or recording what happened 3.

formulating explanations as to why it happened on the basis of observation (recorded) (Bailey 1978, p. 46).

For purposes of introduction it is important to note that Glaser and Strauss (1967, pp. 251-257), the describers of Grounded Theory, have distinguished between the research process itself - i.e. the comprehensive strategy for research - and the process of obtaining the "insights" that direct and guide the research. The origins of these 'ideas' or 'models' come from sources other than the data under examination, usually from personal experiences either before the research question is developed or later as the observer reflects on his or her experiences during the course of the actual research.

An explanation of the source of these insights is demanded in order to make clear the following: how my observations were influenced by my move through different perspectives concerning how the physically disabled obtained services within either the health or welfare framework; how the grounding of these perspectives in empirical observation provided the rationale for the research question; and how these perspectives operated to define the boundaries of the research in terms both of data collection and the establishment of an accepted historical and ideological context. The discussion of the source of ideas, the elaboration of the theoretical research perspective and of the grounded theory research process combined to produce the frame of reference within which analysis proceeded.

Organization of the Study

The study has been organized into three parts. Part I

includes: the construction of a personal frame of reference as an explanation for the source of ideas; an elaboration of the ideological-historical context that bounded the analysis of the data at the beginning of the time period in question; and an explanation of the grounded theory method of research and materials selected for analysis.

Part 2 is built around the construction of a central integrated theoretical framework. The evidence for verification of this framework is presented, first, for British Columbia and Alberta from 1945 to 1972, and then for 1972 to 1980. Included in these chapters is a literature review for comparison and contrast.

Part 3 includes concluding remarks and planning recommendations for future policy making for the physically disabled.

CHAPTER ONE

THE CONSTRUCTION OF A PERSONAL FRAME OF REFERENCE:

Introduction

Crichton (1980, p. 279) has outlined the following eight levels at which policy-making can occur: the levels of social philosophy and ideology that act to clarify the grounds of choice to be made by a society, and that become expressed as value preferences either explicitly or implicitly; the government policy planning level that shapes the broad ideological goals into priorities and legislation based upon a consideration of the people's will; the administrative planning level that after considering in detail issues of legitimacy, feasibility, and support determines the resource allocations to be made; the program planning level that is directed to specific issues; the service delivery level where services are rationed; and the client or consumer level which may or may not participate in policy making. The latter five levels encompass the actual structures and processes of government policy making.

I had the opportunity to work at the governmental level in Alberta's Department of Social Services and Community Health, while as a student clerk, preparing a discussion paper for their Rehabilitative Programs. During my research there it occurred to me that the organizational design for allocation of rehabilitation

services for the physically disabled within programs, branches and divisions in the department affected their ultimate accessibility to a physically disabled person. I wondered whether British Columbia's system of health and of welfare (from which province I had come) presented similar problems of access for their physically disabled. Out of these speculations emerged the following general research question; what can be learned by comparing the evolution of the design of the central administration structures for rehabilitation services to the physically disabled in British Columbia and Alberta?

In due course I returned to the university setting to ponder how to develop this initial general question. I realized that my observations at the governmental policy-making level were quite different from the way in which I had viewed patient services when I was working as a physiotherapist at the delivery level, a scant one year beforehand. Then, my role as a student involved in critically examining issues of ideology and philosophy began to affect how I reflected on my Alberta experiences.

In retrospect, it was clear that as I moved from one policy-making level to another, my knowledge and consequently my assumptions, and the perspectives from which I made my observations, had evolved and 'raised my consciousness' from one level to another.

At this point it is necessary to pay some attention to what is meant by 'perspective' and why this concept is important to consider in planning situations.

Perspectives

Mannheim (1936) defined perspective as that which "signifies the manner in which one views an object, what one perceives in it, and how one construes it in his thinking ... Even in the formulation of concepts, the angle of vision is guided by the observer's interest" and "the model that is implicitly in the mind of a person when he proceeds to reflect about an object" (pp. 272-275). Upon entering each new policy-making level, the knowledge and perspectives that I had arrived with changed in two ways. Firstly, I made a transition from a state of relative unawareness to one of relative awareness of the influence of government structure on policy making and its implementation for the physically disabled. Secondly, after I had entered the delivery and governmental levels, I eventually found myself moving away from a state of initial confusion and lack of understanding about my surroundings to one where my reflections became inextricably bound up with the accepted standard operating procedures of each level. I became aware of this alteration in how I perceived the 'reality' of my environment during my clerkship in Alberta, so it was with some effort that I endeavoured to remain a critical observer.

These difficulties in remaining an 'observer' have been explained by Holzner and Marx (1979) when they said, "this certitude of reality as unitarily, objectively there - and certainly not merely subjectively imagined or socially constructed - provides a firm framework for the manner in which we perceive any particular thing. It is extremely difficult to sum up this

attitude by observing it across many diverse situations and then reflect on it" (p. 83). They stressed that it is necessary to specify the observer's position and point of view if only to make clear what that person's knowledge is based upon. As Myrdal[1] 'so succinctly phrased it, "things look differently, depending upon 'where you stand'. Prior to answers there must be questions. And there can be no view except from a viewpoint. In the questions raised and the viewpoint applied valuations are implied". Understanding that knowledge depends upon the perspective or perspectives held by organizational participants is a relevant concept for planners or decision-makers-at-large to consider since it is from their position at the 'top' that they must orient themselves in order to meet the needs of those at the 'bottom'. Gould and White (1974, p. 174) have commented that because they reflect the biases and values of their holders, the mental maps of the decision makers are crucial.

In order to expose these 'mental maps' of the observer, planner or decision-maker, Holzner and Marz (1979) advocated the construction of a frame of reference. They defined it as a structure that is used to "point to those elements that an inquirer takes as established, as anchor points, and the standards to which his/her inquiries are related. These form the context and the enabling ground within which inquiry proceeds" (p. 101). The frame is a mechanism to define the relation of the observer to what he or she knows and represents in terms of their taken-for-granted assumptions about what is important to know, epistemological and methodological assumptions, and the analytical devices within which the observer's inquiry proceeds, especially the tests

through which the inquirer guarantees or validates the knowledge that results from the inquiry.

The frame of reference that dominated the emergence of the specific research question and the selection of methodology is described as a composite of three sub frames of reference - that of the physiotherapist at the delivery level, that of the student clerk at the governmental level, and that of the student critiquing the ideology and philosophy levels of policy-making. Each frame represents the 'fruit' of my observations at one level as they were before moving into another. Implicit in each are shifts in values and biases. The total frame of reference, described in this and the ensuing two chapters, represents the insights that dominated my formulation of the research question before developing any preconceived hypotheses, explains how the research question was bounded, identifies the historical-ideological context which I have taken as given, and by explaining the particular theoretical assumptions that underpinned the frame of reference, provides a rationale for the selection of grounded theory as the methodology.

Observations of a Physiotherapist

One of the most basic characteristics of my work as a physiotherapist in a rehabilitation facility, and that of my co-workers, was that patients arrived, almost magically as it were, for treatment in our department. A medical history was always obtained from them at the outset, but we were divorced from considering the path that the patient had to take to get to us. In our role as clinicians we never had to account for the

accessibility of our facility to other needy victims of disability. Problems concerning admittance to our and other treatment-oriented services rarely emerged. The exceptions were, that when the time came to discharge a patient from active treatment, the complexities of fitting him or her into a system of home care, long term care, vocational training-retraining, or social support began to emerge.

Rarely, if ever, at these times were our client categorization problems linked to the umbrella policies and programs developed at the centralized governmental level. As a clinical person working within and for a particular facility, as well as in a profession, I tended to consider myself and my clients in isolation from the influence of government's centralized administration. The therapist approached the patient from the clinical point of view, that is, the patient was seen to have one or more physical problems ... how best could they be solved? The clinician became a trouble shooter with little horizon beyond the immediate patient. Knowledge about other levels of influence such as government policies was meagre.

This individualistic orientation was reinforced by the clients' own perception of themselves. In the early aftermath of recovery from major trauma or disease when a person was facing a life long battle with permanent disability, there was first and foremost, concern with individual problems of coping. The disabled did not become organized at that time in any effort to identify collective needs. They came to belong to a group of similarly handicapped persons only as they derived mutual support from others during their 'rehabilitation' period.

This singular approach to service delivery which I had as a physiotherapist changed when I became immersed in a government department that developed and administered services to the physically disabled.

Observations of a Student Clerk

Over the course of my student placement in Alberta's Department of Social Services and Community Health, I prepared a "Discussion Paper on the Role of 'Rehabilitative Programs' for the Physically Disabled in the Community". During the research for it I became more interested in the problems of the physically disabled as a group.

Some comment is necessary at this point to specify who I included in the latter group for this study and why. I defined the physically disabled as those who suffered from some self-limiting or progressive anatomical or physiological abnormality that resulted in significant impairment of function. Because my own experience had been with clients who suffered from a primary physical problem, those who suffered from primary impairments of the senses (without accompanying problems of a physical nature) were automatically excluded in order to bound the collection of data. In addition, as Topliss (1979, p. 48) has noted, the blind and the deaf are the two groups most often selected to benefit from the rehabilitation programmes. She suggested that perhaps the person handicapped by sensory defect, but retaining mobility and manual dexterity was the most easily recognized as able, given training and suitable job placement, to make a contribution to the economic life of the community. This has appeared to have

occurred in Canada with the early development of the Canadian National Institute for the Blind (CNIB).

During the clerkship, two major organizational characteristics of the department became a focus for my attention and concern. The first was based on initial impressions of the Department which came to be confirmed after further investigation into services for the physically disabled, and the second upon an increasing knowledge of the Department's organization.

(i) First Impressions

I perceived the organization of the services administered by the Department to be very confusing due to their apparent duplication and fragmentation. For example, home care support services for the physically disabled provided within the Coordinated Home Care Programme (CHCP) of the Community Health Services Branch were also available as community programs funded by the Preventive Social Services Program (PSS) (it has since been renamed) of the Community Social Services Branch. Both branches belonged in the same Division within the Department. However as I tried to familiarize myself with the arrangement of programs for the physically disabled within Social Services and Community Health, I was still, as Silverman (1971) has pointed out, "an untutored outsider unable, without further knowledge of the commonplace assumptions being used, to comprehend the implications of the behaviour" (p. 129) that I was observing. For example, the intake criteria for both of the above programs was also defined differently as follows: 1. Entrance into the CHCP was based on eligibility criteria that required the physically disabled person

to have a medical need. If the client did not require nursing, physiotherapy, occupational therapy or speech therapy services, he or she was not eligible for the home support services offered by the program. The claim tended to be made that homemaker, handyman, meals on wheels services were easily available through PSS 2. A physically disabled client could obtain home support services from PSS without having to meet any specific criteria, by simply contacting the community organization responsible for operating the program. Problems arose in obtaining the services of the latter program, because its distribution was not uniform across Alberta since each community had the autonomy to decide what kind of program it would like to fund. More importantly, PSS projects were officially oriented towards primary and secondary prevention. The latter was defined by PSS (Alberta, Department of Social Services and Community Health, 1970) as "early diagnosis or identifying and treating the first symptoms of personal and community need ... where a minimum of early help precludes the need for crisis intervention at a later date" (p. 17). Rehabilitation was recognized by PSS as an area where intensive, long term help could be necessary to restore a situation towards less-dependent or non-dependent circumstances. They acknowledged it as the function of other agencies which were already engaged in the field.

The decision about who to take into a given program became a rationing decision. It was dependent upon the intake policies generated at and by the governmental and administrative levels. And although new policies created new structures, it appeared that the choice of jurisdiction under which policies

were housed had important consequences for their further development, interpretation, and implementation. Thus the allocation of work to different positions of the organizational chart seemed to influence the actual development of policies for the physically disabled.

The observations tended to be substantiated by the interviews that I conducted with a number of voluntary organizations for the physically disabled (citizen and/or patient member) during the clerkship period. Representatives expressed views concerning their perception of gaps in the provision of rehabilitation services in the community, the need for medically oriented and non-medically oriented services, and their knowledge of particular government sponsored programs. In general, these groups felt that the government did not provide a physically disabled person with the appropriate intake routes into the treatment and treatment related services ostensibly provided for them. Titmuss (1971), who analyzed Britain's National Blood Transfusion Service, stressed that its operating principles, of providing services on the basis of common human needs without allocating resources only to those who could pay, were essential in preventing the creation of a sense of separateness between people. He said that "it is the explicit or implicit institutionalization of separateness, ... rather than the recognition of the similarities between people and their needs which causes most of the world's suffering" (p. 228), and had commented in an earlier essay that, "as the social services become more complex, more specialized and subject to a finer division of labour they become less intelligible to the lay councillor or public representative",

(1963, p. 27).

The lack of a clear system of intake at the government planning level and the administrative level for various programs co-existed with the lack of a clear system of intake at the service delivery level, where the day to day rationing occurred. The intake system that existed, seemed to determine in an ambiguous fashion how the services were defined and thus how the clients became categorized.

(ii) Second Impressions

Blaxter (1976) has suggested that definitions in use in the various relevant systems of society are likely to be crucial to an individual's pathway through the services designed to help him or her. In addition to these types of definitions, those employed in the labelling of organizational components such as divisions, branches, or programs may also be responsible for creating a particular impression of services offered within an organizational structure. As Ranson, et al (1980, p. 3) have suggested, structural frameworks are constructed to reflect and facilitate certain meanings.

Within Social Services and Community Health, however, these meanings were difficult to ascertain, since there appeared to be substantial internal confusion on the part of administrators/ politicians as to how their department should be structured relative to broad goals and objectives and definitions. Program mandates were not clearly specified in several cases. Difficulties in perceiving the client boundaries and program boundaries of a particular structure within the Department were illustrated

by the organization of services for the physically disabled into three divisions. Rehabilitative Programs, consisting of CHCP, Aids to Daily Living, Speech Therapy, and the Handicapped Registry, were located in the Health Services Division, separate and distinct from the Rehabilitative Services Division. The latter Division was responsible primarily for vocational rehabilitation services, children's programs for the developmentally delayed, retarded and behavioural problem child, along with residential services for the mentally retarded and some physically disabled. In addition to these two divisions, up until the summer of my clerkship, Handicapped Children's Services had been located in the Social Services Division under the Child Welfare Branch. This program assisted the parents of handicapped children (mentally, emotionally or physically) to maintain care for them in their own homes or approved facilities by providing them with financial assistance.

This separation of planning for one particular clientele into three different jurisdictions made it difficult, if not impossible, to ascertain who had the overall responsibility for providing services to the physically disabled. The three appeared to operate as virtually distinct stratified systems. This evidence of fragmented planning for the physically disabled reflected Titmuss's (1971, p. 225) assertion that it is the ways in which a society has organized and structured its social institutions, particularly its health and welfare systems, that can foster the integration or alienation of the population that they were designed to serve.

Suggestions, Weick (1976), March and Olsen (1976), that

the interrelationship of problems, solutions, participants, and issues often seem to be arbitrary and to make little structural sense, reflected my impression that a reasonably comprehensive policy for the physically disabled could not be adequately developed, given the arbitrariness of the Department's jurisdictional organization into ambiguous divisions, branches, and programs. It seemed to me to be necessary to determine whether there was indeed any stability inherent in policy development and its interaction with organizational frameworks. An analysis was required that could provide a more detached abstraction and systemization of events in order to reveal underlying regularities and connections in policy making of which an organizational actor would be unaware.

Observations of a Student

Bounding the Research Question

When I left Alberta, I thought that I possessed a fairly complete 'mental map' of the government services provided to the physically disabled. In fact although my perspective on service delivery had broadened considerably, I had only addressed the problems of the physically disabled within the boundaries of Alberta's health and social services. During my sojourn there, little if any remark, was ever made concerning the involvement of other departments such as those concerned with education, labour or housing in the provision of services for the physically disabled. As I reflected upon this, I became concerned that a knowledge of these other jurisdictional spheres of action would

certainly be necessary for policy makers to have if they were to plan comprehensively for the physically disabled clientele. Straus (1965) noted that a tendency towards certain forms of fragmentation and compartmentalization characterized not only scientific investigation but, as well, the approach to dealing with human problems during the first half of the twentieth century. However he identified a change in this approach with what he felt was an increasing awareness of the tendency for various types of pathology to occur in clusters and, as studies of social pathology had demonstrated, the clustering of such problems as poverty, unemployment, undereducation, inadequate housing, delinquency and crime, mental illness and poor health, marital incompatibility, divorce and alcoholism. He said that "an identification of the clustering tendency of almost all forms of human pathology is important in considering the concept of rehabilitation ... a growing recognition of the clustering principle by those responsible for formulating public policy, designing programs of social welfare, and implementing different kinds of rehabilitation can have a significant impact on the nature of rehabilitation programs and their response to conditions of social change" (p. 2).

These statements may certainly be true when understood from a theoretical perspective that has looked at change over many decades, but it has not been clear how much of the theory has been translated into practice. Leonard Marsh (1975) in his "Report on Social Security for Canada 1943" identified the need to recognize this principle. He said that "for fully effective social security planning, it is necessary to do more than

visualize the categories which have here been outlined. It is necessary to be aware of associated and comparable contingencies; to appreciate, for example, the similarities and transition between disability and old age, or between unemployment and certain forms of sickness so far as they involve absence from work. When all this has been done it is finally necessary to recognize the essential unities of social security - to fit together, in other words, all the branches of social insurance and social provision in such a way that they support each other, and work together as a coherent administration" (p. 28).

In Canada, policies for the physically disabled began to cut across the jurisdictional boundaries of other government departments as specific departments took on differing responsibilities.

The education of the handicapped (physically disabled or not) has varied from province to province, and has been most prevalent in the city administered systems of the provincial departments of education. A variety of local systems have operated special schools or classes for disabled children.

The federal Vocational Rehabilitation of Disabled Persons Act was passed in 1961 to facilitate trades training for the handicapped. At that time it was administered by the federal Department of Labour, and now by the newer Department of Manpower and Immigration. The provinces (with the exception of Quebec) received fifty per cent of the funding required, from the federal government, to provide training directly in their community colleges and trade schools or indirectly through services purchased from the private sector or voluntary agencies.

Housing for the disabled has been within the jurisdiction of the federal Ministry of State for Urban Affairs. It has co-operated with the provinces and municipalities in providing housing for people with low and or fixed incomes. The emphasis has been on non profit housing for the disabled that usually has been provincially or municipally owned but provided and operated by non profit organizations.

However it appears that what has gone on within and as a result of one system has been ignored by the others. Each system has been appraised, criticized, or applauded as independent entities abstracted from their environmental context. Wessen (1965, p. 153) has suggested that the lack of an organizational pattern for rehabilitation, such as education, typified by the school, and for the practice of medicine by the hospital, has hindered the analysis of the organizations responsible for dispensing rehabilitative services. Indeed the fact that rehabilitation services (in whatever guise they appear) have been administered by departments of health, welfare, education, housing, labour, etc. has indicated that such a task would indeed be mammoth.

Although this fragmentation of effort along a number of categorical axes would have seemed to be an undesirable start for a comprehensive organization of services, I too considered only one of those axes in my analysis. Thus the research question was bounded by limiting the explanation to how and why policies for the physically disabled evolved, in the manner that they did, to the health and/or welfare departments of British Columbia and Alberta. Policies included not only specific so-called

'rehabilitation' policies, but all other courses of action adopted for or concerning that group in those departments. Although these limits were placed on the types of government departments that were included in the analysis, another dimension was considered.

Since my shift in awareness included an appreciation of the demands and needs of the physically disabled as a group, I felt that it was fruitful to consider not only how the organizational frameworks interacted with the development of policies for the physically disabled but also to describe how organizations developed by or for physically disabled clients (used in the generic sense) had contributed to the development or underdevelopment of the provincial policies. The Royal Commission on Health Services (Hastings and Mosley, 1964) noted that,

> the growth of voluntary agencies of all types has been an important factor in the provision of health services. The particular services provided are affected by existing official health and welfare programmes; a voluntary program is begun to fill gaps, to stimulate new programmes, or to provide personal health needs which are not available under legislation. (p. 8)

I have just described how my movement through three hierarchically ordered policy making levels combined to alter my assumptions about the influences that affected the ultimate impact of a policy on a physically disabled client.

Similarly, Bloom (1963) explicated, diagrammatically, his awareness of the hierarchically-arranged systems that provided the framework within which the doctor-patient relationship occurs and is modified. I have adapted his representation of the doctor-patient relationship as a social system, to illustrate those

levels through which my own perceptions were transformed. (Figures 1a and 1b).

In order to complete the bounding of the research question, it was necessary to distinguish from what period in the history of the development of Canadian health and social services that the analysis of data should proceed. Since I was not able to examine data that described the daily ongoing negotiation and involvement of organizational actors in policy making and delivery, I had to lock my analysis into a temporal mode. This allowed the analysis to be focused on the historical development of policies within the organizational frameworks of the departments of health and of welfare. An historical-ideological context was established in order to make clear that these substantive organizations were located within a broader social structure that would certainly have constrained the forms and policies they developed. This last level of influence has been diagrammed in Figure 1c.

Perceptions of a Physiotherapist

Figure 1a) The Clinical Delivery Level

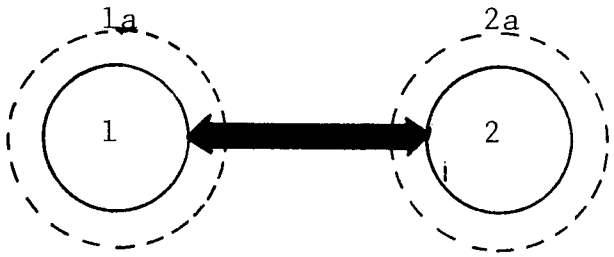
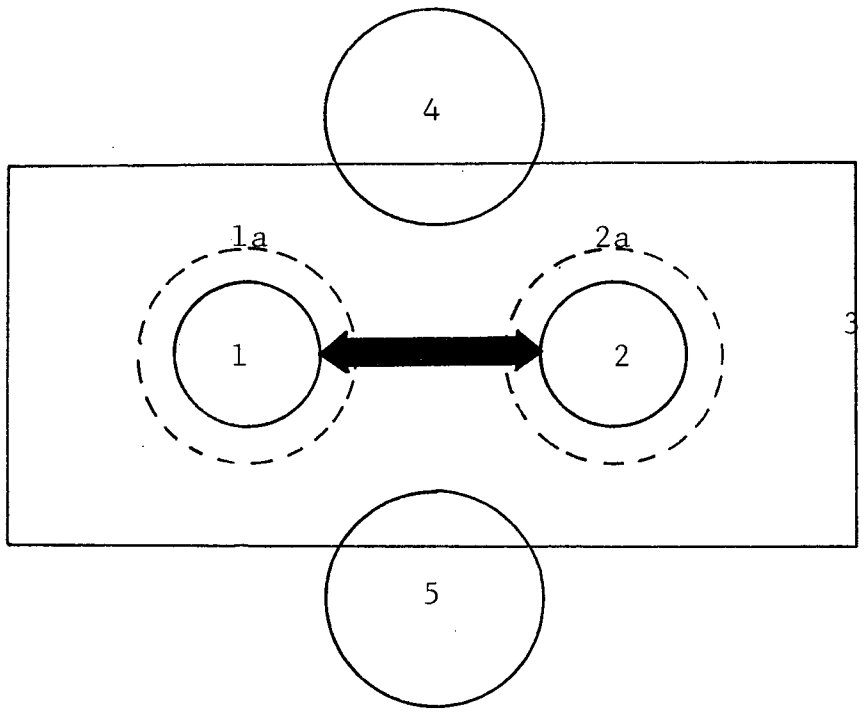


Figure 1b) Movement Through to the Administrative Level



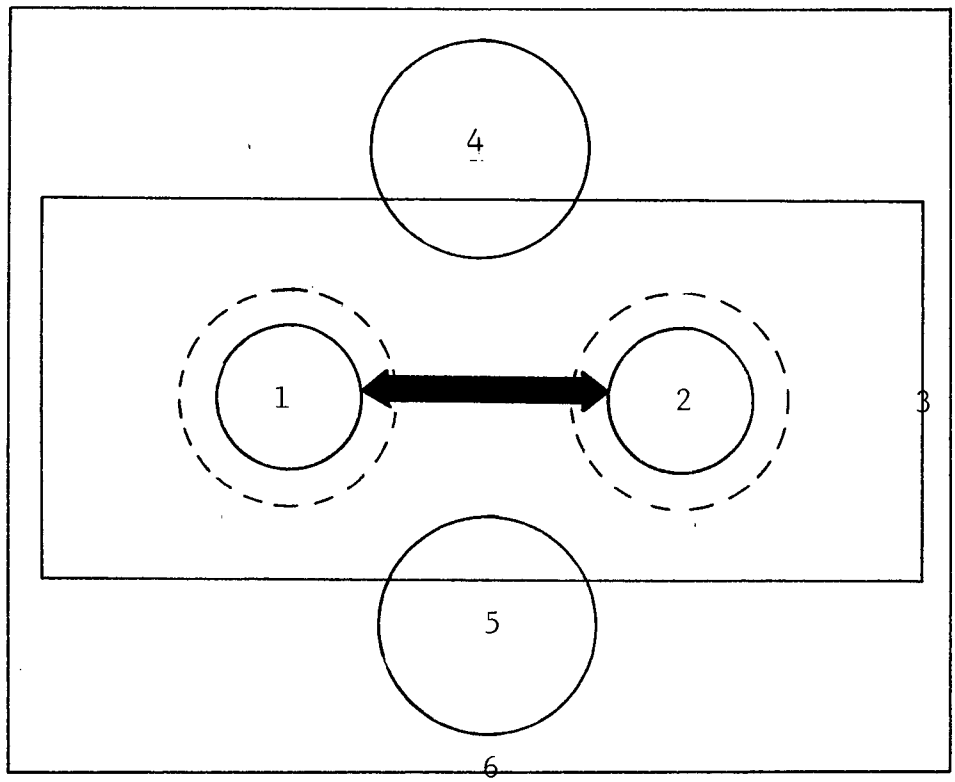


Figure 1c) Movement Through to the Ideological Level

Key:
1. Physiotherapist
1a. Physiotherapy Profession
2. Patient (physically disabled)
2b. Physically Disabled Group
3. Specific Governmental Administrative Policy-Making Level (Health)
4. Other Government Departments
5. Voluntary Agencies
6. Dominant Historical-Ideological Context

Notes to Chapter 1

[1]Myrdal, G. 1976. Race and class in the welfare state. Introductory lecture to a symposium in a series entitled, "The National Purpose Reconsidered: 1776-1976," Columbia University, October 28, quoted in Howards, I., Brehm, H.P., and Nagi, S.Z. 1980. Disability: from social problem to federal program. New York: Praeger p. 7.

CHAPTER TWO

THE IDEOLOGICAL-HISTORICAL CONTEXT OF POLICY DEVELOPMENT FOR THE PHYSICALLY DISABLED

Introduction

Mannheim (1963) and Bailey (1975) both raised the point that ideology influences the way in which individuals observe and reflect. Not only that, but the influence of different ideological systems must also be accounted for in any analyses of organizations. Titmuss (1971) said,

> ... looked at as a whole, different social and political structures and value systems strongly influence the typology distributions ... These differences cannot be explained simply in terms of administrative and organization structures ... and patterns of ... services. The causal factors are more fundamental than that, ultimately, explanations ... have to be sought in the history, the values and political ideals of each society. (p. 173)

More specifically he pointed out that attitudes towards, and relationships with organizational structures can only be understood within the context of the origins, development, and values of the health service of that country.

With respect to these statements, it has been useful to distinguish between what Christian and Campbell (1974) have called two kinds of ideology operating in any political community (p. 5). They described one as the type of ideology which

expresses itself in the operation of actual institutions. The second type was expressed by them as

> ... an abstract principle, or set of related abstract principles, which has been independently premeditated. It supplies in advance of the activity of attending to the arrangements of society a formulated end to be pursued and in so doing provides a means of distinguishing between those desires which ought to be encouraged and those which ought to be suppressed or redirected.(ibid p. 5)

The ideological precepts of the Welfare State concept that emerged in Canada around the end of the depression and the Second World War provided the latter kind of over-arching ideology that subsequently influenced the development of federal and provincial health and social services. The input of the different operational ideologies of British Columbia and Alberta was derived from documentation of the actual operation of their departments of health and of welfare which was analyzed using the method of grounded theory. Prior to doing this analysis, it was recognized that the ideologies of particular political parties in office, also provided a political ideological context that would have influenced policy development.

Combined, these two kinds of ideology formed the historical-ideological context within which policies for the physically disabled were developed in British Columbia and Alberta. In order to distinguish between them, I have briefly described, the introduction of the Welfare State concept into the federal-provincial public policy-making arena; and the parochial political ideologies of the governments of British Columbia and Alberta that existed up until 1971, by which time the Welfare State concept was grounded into the operations of the federal government with

the implementation of national systems of health insurance and social security.

The Intrusion of the Welfare State Ideology into Federal-Provincial Relations

The collectivist ideology of the welfare state concept has maintained that institutionalization of social measures to provide security against the exigencies of an urban-industrial society is a necessity. The devastating unemployment of the 'Dirty Thirties' was the catalyst that activated recognition of the need for institutionalized systems of social security to replace the traditional reliance on either the family or the market place for the provision of relief. In 1867 Canada's British North America (B.N.A.) Act established that social welfare was the responsibility of the provinces and their respective municipalities. By the end of the depression years however, neither the provincial or municipal governments were in a position to finance social services, that had become more costly, adequately from their existing sources of taxation. The provinces were also unwilling to surrender any of their legislative jurisdiction, as it had been established by the B.N.A. Act, to the federal government. The latter, itself, was not prepared to assume any new obligations without the assent of the provinces. To seek advice concerning this jurisdictional dilemma the federal government announced a royal commission to enquire into all aspects of dominion-provincial relations especially on financial matters. Recommendations concerning how a more equitable division of jurisdictional responsibility between the two levels of government

could be effected were desired. The Royal Commission (Rowell-Sirois) on Dominion-Provincial Relations was established with this intent in 1937.

Throughout its deliberations, the Commission held that while some federal powers had to be widened, the autonomy of the provinces was to be maintained and strengthened. This principle underpinned their recommendation to the federal government that it was best equipped administratively to develop equitable systems of unemployment insurance and assistance for the able-bodied unemployed, as well as old age insurance. Apart from these two major exceptions, the balance of the social services - provision for the unemployable, widows' pensions, mothers' allowances, child welfare, public health insurance, workmen's compensation, and education were designated as provincial responsibilities. In addition the Commission favoured the taking of some form of national action by the federal government with respect to establishing health insurance protection. This attitude was tempered, however, by their recognition that, even though the B.N.A. Act had not explicitly allocated the jurisdiction of public health services to one of the two levels of government, it had made the provincial governments responsible for hospitals, asylums, charities, and eleemosynary institutions leaving only marine hospitals and quarantines to the federal government. Consequently, the Commission deemed the provinces to have control over all health matters of local concern. To allow the provinces to meet these responsibilities, it recommended making a National Adjustment Grant (calculated on the basis of fiscal need) available to replace all other conditional or

unconditional federal grants to the provinces. In return for this grant, the provinces would vacate the fields of personal income tax, corporation, and inheritance tax to the federal government.

The Commission's recommendations were discussed at the dominion-provincial conference held in January, 1941. In conjunction with the National Adjustment Grant proposal, the federal government calculated that only Ontario, Alberta, and British Columbia would not receive the benefit of a grant in its initial period. On the basis of this aspect of the proposal, the premiers of those three provinces opposed proceeding with the conference. They claimed that the commission's proposals "were matters to be considered in peacetime, and hasty action, prompted by the war emergency should be avoided" (Guest 1980, p. 134). Consequently the recommendations of the Commission were not acted upon.

Notwithstanding these delays however, out of the work done by the Commission came the first surveys to take a comprehensive and detailed look at the provision of social services in Canada. The effort had begun to place them on some more logical and integrated plan. This thrust towards planning for comprehensive health and welfare services was taken up towards the end of the war by other Dominion initiatives. However, the conclusions that the Commission reached, with respect to federal-provincial jurisdiction over these matters, ultimately effected the manner in which the provinces responded to later policy initiatives. As Bliss[1] (1975) noted,

> Canada has only become a modern welfare state since the end of the 1930's, a development which has barely begun to be appreciated

> as a major event in the society's history. No one can minimize the importance of our transition from a society in which provision for destitution was largely an individual responsibility to one in which a variety of programs guarantees a level of social and economic security to all citizens.

Cassidy (1945) observed that social security became a real issue in Canada in 1943. He said that

> ... spokesmen for all three of the leading political parties, Liberal, Conservatives and the Cooperative Commonwealth Federation, reiterated and amplified earlier statements in favour of broad measures of social security ... however differently the various parties might propose to implement the principles. (p. 1)

After the insecurities and uncertainties that were generated first by the depression and then by World War II, it became clear to countries on both sides of the Atlantic that organized provision had to be made in the post-war world for the risks and contingencies of family life that were beyond the capacity of most to finance adequately from their own resources. Two major studies were undertaken in 1943 by the federal government in this effort to evolve a planned approach to long range policy and program development based on a careful definition of national needs. These were, the "Report on Social Security for Canada" (the Marsh Report), and the "Report of the Advisory Committee on Health Insurance" (the Heagerty Report). The former has been called a "pivotal document in the development of war and post-war social security programs, the equivalent in Canada of the Beveridge Report in Great Britain" (Bliss, 1975).[2] In his report, Marsh (1975) felt that the advent of the Unemployment Insurance Act (1940) for the employed and health insurance still

left a large amount of territory in which a good deal of rationalization was called for. In order to identify the main contingencies that required provision, Marsh developed a six part need classification. Disability was singled out as one of those categories of risk. The others were unemployment, sickness and medical care, old age and retirement, premature death, and family needs. He wrote,

> ... at some points the line between sickness and disability may be hard to draw. But clearly there are certain categories of disability where the cause or results for both are such that special provision is called for. As a category of social need, the burden on the family may be the need for support of disabled member; or it may be interruption or impairment of earning power on the part of one of the bread-winners. (p. 25)

Up until then, the coverage of disability had been fullest in fields of industry covered by provincial systems of Workmen's Compensation. Aside from that, a few pieces of legislation recognized the existence of disability as requiring some kind of provision. Pensions could be secured by the blind, subject to limitations that applied to old age pensions. In a few provinces, permanent incapacity which prevented a husband from working was recognized as a situation requiring assistance on a similar basis to that of mother's allowances. These were in contrast to the generous provision made for veterans of the second war, which provided them with a wide range of rehabilitation measures from vocational to physical.

Marsh stressed that these widely varying standards of treatment as between different classes of the population would demand attention after the war, as well as if, after the insti-

tution of comprehensive health insurance, medical needs were brought prominently into view without any provision for disablement and the crippling diseases.

As Wessen (1965) has said, "rehabilitation, as a social movement, has developed out of the needs of special groups (e.g. children and war casualties) which aroused widespread public feelings and demands for action. Only later has the rehabilitation facility been extended to wider population groups" (p. 125).

The Marsh plan for a two part social insurance scheme included coverage for the unemployment risks of the normal gainfully employed as well as for all employees, and the universal risks for all the insurable population and all gainfully occupied and adult dependents, (the latter including health insurance and medical services). For a variety of reasons its recommendations were ignored by the government after presentation to the Parliamentary Committee on Social Security for their information. The only immediate result of the Marsh report was the passage, in 1944, of the Family Allowance Act. It provided for the payment by the Federal government of monthly allowances for every child under 16 years of age.

Heagerty's specific proposals for health insurance and Dominion aid towards general public health and other health services were abandoned at the 1945 Dominion-Provincial Conference on Reconstruction, as well as the federal government's proposals to the provinces to assume full responsibility for old age pensions, to share in the cost of two public assistance schemes. The concept of a national comprehensive, integrated, and coordinated program of social security was set aside as the

proposals became part of the larger proposals of the federal government relating to fiscal matters on which there was not provincial consensus. Only Ontario and Quebec were unwilling to sign an agreement with the federal government that permitted it to have control of the fields of personal income tax, corporation taxes, and succession duties for a trial period of three years in exchange for the federal fiscal offer of unconditional subsidies. However, as Meilicke and Storch (1980) noted while the federal and provincial governments then felt impelled to independently seek ways in which to influence health (social security) policies, the extensive investigations and discussions associated with the conference had established political and social pressures for action which were not to be denied. "A new era was about to begin" (p. 7).

After the conference's lack of success, the first step towards initiating a collectively-oriented program of comprehensive health insurance for all of Canada was taken by the federal government in 1948. A national health grants programme was established which allocated annual grants for improving the health systems of each province. A health survey grant of $645,180 was provided and matching hospital construction grants of $13,000,000. The other grants were non-matching but proposals for each specific grant had to be submitted to Ottawa each year before the expenditure of funds would be approved. These grants were: general public health, $4,395,000; veneral disease control, $275,000; mental health, $4,000,000; tuberculosis control, $3,000,000; cancer control, $3,500,000; crippled children, $500,000; professional training, $500,000; and public health

research starting at $100,000.

Priorities were established by the federal government to which the provincial governments had to respond since the grants were a welcome source of new funds for their health departments. As can be seen from the allocations, only one specific group of the physically disabled-crippled children - was favoured by a grant. Compared to the others, the grant was not large but indicated that the disabled who were not veterans, did not have workers' compensation or were not special polio cases, were beginning to be acknowledged as a group that had special needs. The health surveys conducted by both British Columbia and Alberta paid special attention to the problem of disability.

Alberta (Alberta Health Survey Committee 1950) focussed its concern on the problem of crippled children in its Health Survey of 1948. The survey noted that, statistically speaking, there was indeed a treatment problem with respect to what was needed by the estimated 2,300 crippled children in the province. The need for an effective program for the prevention of a wide variety of crippling conditions was stressed. In order to gauge more effectively the actual scope of the problem and the location of those children needing assistance, the initiation of a crippled children's register was recommended. The survey also recommended that the Crippled Children's Grant was too small (it was $34,372.00) if it was to be used for treatment purposes, and that the definition of a crippled child used by the federal government should also be expanded to include all types of crippling. At that time only poliomyelitis patients were provided with free hospital and medical care, after the infectious stage

of the illness had passed, and with rehabilitation assistance for vocational training. Otherwise financial assistance for medical and hospital care was available from voluntary philanthropic organizations such as the Shriners and from the Division of Arthritis in the Department of Public Welfare. A variety of agencies functioned in the detection of crippling conditions such as infant and preschool clinics, school health programs and two hospital outpatient clinics. A few hospitals provided treatment services to crippled children. One of the main problems that the survey addressed was the lack of trained personnel such as physiotherapists, orthopedic surgeons and nurses, needed to provide the necessary care.

Indeed, the survey did not at all address the problem of the crippled adult who was not a veteran or covered by some kind of compensation, but stressed that, "if ... given the chance" the crippled child "is often capable of making as great a contribution to society as is the unhandicapped individual". It was also a "good investment", since the child who was successfully rehabilitated would be "a contributor rather than a burden to the community" (p. 82).

British Columbia's (Elliot 1952) health survey addressed not the problem of a specific class of the disabled but the problem of rehabilitation. The province felt that successful rehabilitation meant that a handicapped person was "able to accept and continue in remunerative employment" (p. 49). In order to accomplish this, however, the process could not be limited to either physical rehabilitation or vocational training but would require a range of services. The survey recommended, however,

that only the best risks should be rehabilitated, so that funds would not be wasted and to make best use of scarce trained personnel in rehabilitation. The target group that was suggested was the sixteen to thirty-five year old age group. The utilization of training facilities currently existing was felt to be appropriate as long as counselling services were made available in the hospital so that the rehabilitation process would be continuous. Placement and employment were identified as a major weakness in many rehabilitation programmes. The survey indicated that the National Employment Service would be the logical agency for developing this service. The survey recommended that a newly set up Planning and Advisory Committee should have responsibility for: conducting surveys of the number of handicapped persons in the province, and of the screening, training and placement facilities available in the province; establishing the amount of funds that should be made available to private agencies that operated rehabilitation programmes; exerting pressure on employers to co-operate in a rehabilitation programme; and ensuring that the employment agencies were indeed functioning as they should. In general British Columbia felt that a rehabilitation programme would initially have to be restricted to the group that had the greatest potential capacity for wage-earning, but that all disability groups should be included in it, as the financial and personnel resources of the province allowed.

The health surveys indicated to me that two markedly different perspectives existed between the two provinces concerning the problem of the physically disabled in the late forties. This necessitated drawing a distinction between each province's

response to the incentive of the National Health Grants that would be established in the analysis of the data, and the reality of their political ideologies. The latter differed substantially from the collectivist orientation of the welfare state concept.

Provincial Political Ideological Contexts

Guest (1980) has stated that "the depression also gave birth to parties of protest" (p. 94). The Social Credit party that emerged on the prairies transformed Alberta into a one-party province with its coming into power in 1935 (until 1971). In addition, it was instrumental in transplanting the Social Credit party into power in British Columbia, when that party won the 1952 provincial election. The Liberal-Conservative government coalition had dissolved in 1951.

The influence of the frontier was described by Engelmann and Schwartz (1967) as another factor that was instrumental in promoting the growth of the Social Credit as a third party. They stated that, "life on the frontier both attracts and promotes attitudes of enterprise, experimentation, but correlatively, a suspicion of outsiders, and a concern with the morality of traditional government" (p. 52).

Social Credit began in Alberta as a party of principle. According to Engelmann and Schwartz (1975, p. 245) it lured Alberta populists from the co-operative notions of the UFA - United Farmers of Alberta to an utopian economic scheme that would redress the economic subordination that the province felt it suffered under eastern financial domination. The original social credit doctrine was based on principles that included, delegate

democracy, the mass principle of organization, individualism and private enterprise, in conjunction with, the distribution throughout the community of unearned income by monetary devices such as credit. To the social creditor the "enemy was not capitalism, it was finance, ..., the control of credit by an irresponsible oligarchy" (MacPherson 1953, p. 94). Capitalist enterprise, profits, and private enterprise were all retained in a social credit economic policy that was designed to restore the control of credit to the people. Social credit was a belief in the capacity of the community to deliver the goods and services as long as there was enough financial credit to permit full productive capacity to be attained. Socialism was anaethema to the social credit doctrine because it stood for the further centralization of economic and political power.

Principles, however, gave way in both provinces to social credit governments that were more oriented to electoral success, and that avoided restrictive ideological commitments.

In British Columbia, the Social Credit party, which Engelmann and Schwartz (1975) have maintained "never had an ideological stage" (p. 312) quickly moved to internalize achievement-growth values within their governmental operations. For the next two decades, Social Credit successfully presented itself as the main torchbearer of the values of individual achievement and economic growth previously upheld by the Liberal and Conservative parties" (Galbraith 1976, p. 73).

In Alberta, the oil boom of 1945 enabled the Social Credit government, there, to make the transformation from a party of fading principle to one that claimed credit for the province's

new found prosperity.

Both provincial governments shied away from a commitment to abstract principles preferring to take a pragmatic position in policy matters. The political ideology of social credit remained dominant in both provinces until the beginning of the 70's decade when a major realignment occurred in both governments. In order to separate the effect of a shift in political ideological context from its effect on the development of policies for the physically disabled in the '70's, the analysis of the data from 1972 to 1980 was considered separately. The political ideologies of these new parties have been briefly described below.

Changes in the Political Context

In 1971, the Conservatives ousted the Social Credit from office in Alberta, remaining there as the party in power during the seventies. In 1972, the New Democratic Party (NDP) came to power in British Columbia for a short term of three years, after which the Social Credit again resumed and retained office.

In contrast to the B.C. Social Credit party's pragmatic nature, the NDP have maintained an ideological appeal with their emphasis on the distribution of existing wealth and social egalitarianism. The NDP generally has found its centre of gravity among trade unionists, and blue-collar workers.

Galbraith (1976) has suggested that "the Liberal, Conservative, and Social Credit movements have always had more the character of rival political cliques within a larger, rather vague and inchoate political party" (p. 70). Warham (1974) has also suggested that the Conservative party's "commitment to capitalism

and the concomitant values of the market" (p. 40) resemble those of the Social Credit. The tendency of the Conservative doctrine has been to ascribe a minimal role to government as a social institution, taking innovative action only as an unavoidable response to changing conditions. Traditionally, the Conservatives have supported the status quo and established privilege. Implicit in this has been the acceptance of existing inequalities between classes of people.

This distinction, between the changes that occurred in the political ideologies of Alberta and British Columbia from 1945 to 1980, was drawn in order to establish the contexts within which the analysis of the data must be considered. The results of the analysis from 1945 to 1972, during which time both provinces' ideologies had not undergone any change (with the exception of B.C. in the first three years) are presented first, then for 1972, when political changes occurred, until 1980.

Notes to Chapter 2

[1]Bliss, M. 1975. quoted in Marsh, L. 1975. Report on Social Security for Canada 1943. Toronto and Buffalo: University Press, p. ix.

[2]Ibid., p. ix.

CHAPTER THREE

THE RESEARCH PROCESS

Working Within an Interpretive Paradigm

Goode and Hatt (1952) have stated that "all facts collected, all the analysis of these facts, even the perception of the data are ordered within some sort of theoretical framework" (p. 31). This framework or paradigm underwrites the frame of reference and methodology of any investigator, since, to be located within a certain paradigm is to view the world in a particular way according to certain basic meta-theoretical assumptions. The latter influences the methodological choices made.

The theoretical paradigm that identifies grounded theory as the methodology of choice is interpretive in nature. It operates from the point of view that the world can only be understood from the subjective experiences or points of view of the actors involved in a particular situation. Thus explanations are sought from within the frame of reference of the participant(s). Although the interpretive framework sanctions genuine understanding of direct face-to-face interactions and exchanges, these were not possible to obtain for this study. The methodology of grounded theory has allowed an alternative to the latter approach, by lending itself very well to the interpretation of real life through the recorded experiences of others. Thus it becomes

possible to resort to a process of conceptualization for the explanation of actions recorded in the annual reports of the provinces. Even though, in the strictest sense, the interpretive paradigm has rejected the utility of analyzing structures since they have been defined by it as not existing independently from the minds of people, this was compensated for by examining the structural frameworks of the British Columbia and Alberta health and welfare departments (as they related to the delivery of policies for the physically disabled), only as they emerged from the documentation of organizational participants. Thus an attempt was made to see how control was maintained over avenues of government endeavour by analyzing what was assumed to be subjectively created accounts of reality.

Bailey (1975) has said that "we must 'build up' from everyday life rather than 'predict down' from abstractions which are reflections of our own concerns more than of the reality of the behaviour we are examining" (p. 24). Similarly, Berger according to Silverman (1971, p. 138) has noted that analysis from the viewpoint of the authorities is primarily concerned with the problems involved in the management of social systems. Certainly, what is a problem to one actor, may be a more or less efficient means to an end from the point of view of another. In order to circumvent this problem of perspective, Silverman has suggested that the examination of a situation from the vantage point of competing systems of interpretation can provide important clues as to how it arose, why it continues in its present form, and what circumstances may make it change. Indeed it was Mannheim who believed that, while ideologizing influences could not be

eradicated completely, they could be mitigated by the systematic analysis of as many as possible varying socially grounded positions. In other words, the object of thought could become progressively clearer with the accumulation of different perspectives on it (Berger and Luckmann 1966, p. 10) (Mannheim 1936, p. 103).

It is for these reasons then - to build up from everyday life and to mitigate the influence of ideological perspective that grounded theory was selected as the methodology of choice to analyze more than one socially grounded position. It provided a comprehensive strategy for qualitative research that was based upon the following basic principles.

Although grounded theory is the discovery of theory from data, emphasis is placed on the prior step of discovering what concepts and hypotheses are relevant for the area that one wishes to study. Before either formal theory, developed for a conceptual area of inquiry and flowing out of the data, or even deductive theory based upon a priori assumptions, can be generated, a comprehensive knowledge of the particular substantive or empirical area of inquiry must first be acquired. From this knowledge outstanding ideas can be identified.

In this study, the substantive area was the provincial health and welfare public administrative frameworks that organized policies for the physically disabled. The research question was designed to discover or develop a set of concepts that could help to explain how these public organizational frameworks had interacted with the development of policies for the physically disabled. As was noted beforehand, a general focus or question/

problem predicates the research but not to the extent that a preconceived theory dictates the selection of relevant concepts and hypotheses from the data.

The Methodology

(i) Preamble

The purpose of grounded theory is the generation of theory (either substantive or formal) that is capable of accounting for much of the relevant behaviour in the problem (study) area, through the generation of general categories and properties that emerge from the data. Specific procedures have been developed for the generation of theory via the qualitative handling of data. My research purpose was not the development of theory but the generation of substantive conceptual categories and their properties that would allow the organization of many events that might have otherwise seemed disconnected or paradoxical. The task was to identify whether or not there were discernible patterns of interaction between the policies for the physically disabled that were developed and the structural frameworks of the provincial health and welfare organizations where these policies became located.

Since I limited myself to developing an analytical explanation, not theory, I modified of necessity some of the demands of the grounded theory method and incorporated some of the techniques of other researchers for the qualitative handling of data. Before describing the modified approach that was taken, a discussion of the general strategy of grounded theory is necessary in order to clarify certain of the terminology and the

rationale for the method.

(ii) Grounded Theory

(a) Introduction

The general purpose of grounded theory is the generation of analytical explanations that emerge from the data collected in the problem area under study. The data collection is based upon the systematic choice and study of several comparison groups that belong to the problem area. Most of the conceptual categories used to develop the explanation come from the data and are worked out in relation to the data during the course of the research and collection of data. The latter process whereby data are jointly collected, coded and analyzed is called theoretical sampling. The tool that is used to construct the explanatory categories is an explicit analysis and coding technique called the constant comparative method of analysis and coding.

(b) The Place of Conceptual Categories, Properties and Hypotheses in Grounded Theory

Before discussing the data collection and analytic procedures an explanation of the outcome of the analysis - the conceptual category, its properties and the hypothesis - is necessary. Developing a conceptual scheme is a tool by which the relevant phenomenon in the annual reports were systematized, classified and interrelated. The categories were discovered by intensive examination of the data. They stood by themselves as conceptual elements of the explanation for the problem under consideration. The properties were conceptual aspects of the categories. However, the formulation of an explanation did not stand upon the individual fact(s) taken from the annual reports,

but upon the conceptual category or the conceptual property of a category that was generated from the fact(s). A concept began by being generated from one fact. This fact then became only one of a host of many possible diverse indicators for, and data on, the category. The coding process took full advantage of the inter-changeability of indicators, and developed, as it proceeded, a broad range of acceptable indicators for categories and properties. The concept was used to symbolize the empirical relationships and phenomena which were stated by the fact. Thus the actual evidence upon which a category was based may have changed depending on circumstances, but could still be representative of the same concept that was represented by the category.

The concepts that emerged were designed to be analytic in nature, i.e. sufficiently generalized so that they designated characteristics of the empirical entities. Conceptualization allowed the organization and isolation of many properties of these organizational entities. Since I was not developing theory, hypotheses were not developed out of the categories. However as the facts began to be summarized into empirical generalizations as properties, and into higher level generalizations as categories, inter-relationships between the properties developed, followed by inter-relationships between the categories. These formed the basis of a central conceptual framework called the integrated central theoretical framework.

The evidence itself was used to provide illustrations of a concept or property. Factual examples stated in detail what the latter stated in general terms and could only be used once.

(c) The Selection of Comparison Groups for Analysis

Glaser and Strauss(1967) have stressed that groups rather than singular data should be selected for comparisons in order to make the content of the data more theoretically relevant. In other words, a wide range of groups is chosen for comparison, irrespective of any similarities or differences between them, to help generate as many properties of the categories as possible, and to help relate categories to each other and to their properties. In this study, the use of comparison groups enabled the explanation to be sufficiently general so that it was applicable to a range of diverse historical experiences within the substantive area, and not to just one specific type of situation. Theoretically, social units of any size may have been selected for comparison, from individuals and their roles, to cities, regions, and nations or small to large organizational units.

Comparison groups were also used to provide control over two scales of generality, those of conceptual level and of population scope. The conceptual level was controlled by choosing a substantive level of analysis to pursue, i.e. the empirical entities of health and of welfare departments, rather than selecting dissimilar substantive groups from a larger class of organizations to generate a more formal theoretical explanation.

Population scope was controlled by choosing only two types of substantive organizations for comparison. Thus the explanation that I developed would be applicable only to these organizations. This made the explanation more generalizable than if I had chosen only one group for analysis. Furthermore, the generalizability of the conceptual explanation was increased by

comparing these two different types of government departments between two different provinces.

Comparison groups also provided simultaneous maximization or minimization of both the differences and similarities bearing on the categories studied. This control over similarities and differences was important for discovering categories, and for developing and relating their theoretical properties. Thus groups were also chosen for their similarities and differences to the problem area under consideration.

Establishing similarities among or between comparison groups allowed the collection of similar data that established and verified the existence of a category. Basic properties were brought out by similarities and by the few important differences that were found when minimizing group differences. Minimizing differences among comparison groups also helped to establish that a category existed according to a certain condition or as a particular type. When different groups were compared (i.e. the maximization of differences), different data was collected on a group while strategic similarities were also found between them. The similarities that occurred provided the most general uniformities of scope within the explanation. The differences among the groups helped to generate more properties.

(iii) The Method of Analysis

(a) Levels of Analysis

The conceptual level was substantive as the analysis was drawn from the substantive accounts of the provincial public health and welfare organizations that developed policies for the

physically disabled.

The scope of the analysis was widened by comparing these organizations between two different provinces, those of British Columbia and Alberta.

(b) Selection of Groups

Glaser and Strauss applied the term 'theoretical sampling' to the process of data collection, whereby data are jointly collected, coded and analyzed. They suggested that the initial collection of data from a group be based on a sociological perspective, subject or problem area, without the benefit of a preconceived theoretical framework. Further groups for analysis are supposed to be selected as the emerging conceptual scheme pointed to emerging gaps in the scheme, and by research questions suggested by previous answers. Theoretically, then, I would not have selected a preplanned and prescribed set of groups for comparison. These should have emerged as I went about trying to find situations under which the differences in policy making for the physically disabled could be either maximized or minimized. However since I was not concerned to develop theory about a large area of substantive enquiry, but to develop a conceptual explanation of the research problem at an empirical level, this method was modified by selecting the comparison groups before the data was studied.

It was possible to minimize differences in the first groups selected for analysis in order to enable the establishment of basic categories and their properties. This was done by first comparing the departments concerned with health and with welfare

in Alberta. The maximization of differences was accomplished by changing the scope of the research and including British Columbia in the analysis. Thus research questions were not formulated to direct the further collection of data since the scope and conceptual level of the analysis were already delimited.

(iv) Data Collection Decisions

(a) The Use of Local Concepts

Qualitative coding has been defined by Goode and Hatt (1952) as "one set of techniques for locating and specifying the order" (p. 32) which exists in previously unordered materials. In the initial stages of data collection the coding process was guided by the development of local concepts or general notions that designated a few principal features of the structures and processes found in the substantive area under study. They did not, however, become part of the core explanatory categories.

The framework of local concepts that I developed to outline my substantive area of inquiry flowed out of my experiences in Alberta's governmental policy-making level within the Department of Social Services and Community Health. I have described two perspectives upon which an analysis of government policy for the physically disabled may be based. These were the organizational or top-down perspective and the client or bottom-up perspective. These polar ends of the policy implementation continuum possessed, however, three similar characteristics which formed the basic format for the data collection - orientation, time, and place. There were derived from the observations that government organizations had changed their orientation towards the physically disabled over a period of time and that the delivery of services

from both groups appeared to have been more effective in urban rather than rural areas.

(1) Changes at the Government Level

For example, even within the decade of the seventies, the orientation of Social Services and Community Health (previously the Department of Health and Social Development from 1971 to 1975), towards the physically disabled became increasingly focused. In 1969 with the acceptance of recommendations made by the Blair Report on "Mental Health in Alberta", the province had begun to develop specialized, non-institutionalized programs for the mentally retarded (especially children) and the mentally ill. In contrast, until 1977 with the implementation of Rehabilitative Programs for the physically disabled, the Department had focused on reducing the physically disabled person's reliance on social allowance by creating an Employment Opportunities Program and vocational training programs. Even though there was a provincial Coordinated Home Care Programme and an Aids to Daily Living Program available to the physically disabled after 1977, there was still an urban-rural disparity in their delivery.

In order to make valid comparisons between the provinces, I felt that data to explain the orientation of British Columbia's and Alberta's departments of health and/or welfare towards policy making for the physically disabled, would have to be collected over a much longer time period if changes within one decade were not be abstracted from their historical context. The decision was made to collect data from their annual reports beginning from the mid-forties, with the advent of the 'Welfare State' concept, and

proceeding year by year up until 1980.

(2) Changes among the Voluntary Organizations

A similar approach could have been employed to trace the changing input and orientation of the voluntary organizations into policy-making for the physically disabled. This would have provided an important contribution to the analysis of the under-development of government policy since as Govan (1966, p. 25) has said, "the (national) policy of all the patient-member and most of the citizen-member ones which pay for services under other auspices, is that such services are to be financed by the organ-ization if they are not available elsewhere from public and private funds". Thus gaps in the medical care and rehabilitation services of the public programmes could be gleaned from annual reports of these organizations including evidence of changes in the public provision of rehabilitation services.

The contribution of these voluntary organizations to providing services for the physically disabled has also depended upon the basic orientation of their objectives. The orientation of these groups which has evolved since the first voluntary organization, the Red Cross, was formed in 1896, must also be considered as an input into policy-making.

Before the Second World War, the first voluntary health organizations were broad-based philanthropic groups organized generally by, and consisting of, concerned citizens for the benefit of others. Up until then, the only association to be organized for the provision of services to a specific set of disabled people was the CNIB. It was developed as the result of

the work of a war-blinded veteran and was the first organization to include on its staff and boards those who suffered from a particular disability.

After 1918 there was little new organizational activity until the Canadian Cancer Society was formed in 1938, followed by a slate of new disease-oriented voluntary organizations in the immediate post-war period. Some were conceived in the philanthropic mode, but a new trend towards the development of associations for mutual aid purposes was emerging. Govan has suggested that sufferers of a disease or disability were motivated to seek the company of fellow sufferers in the face of no cure, or even prejudice on the part of non-disabled persons.

At this point, an explanation of the differences between the specific disease-oriented mutual aid groups formed during the '40's and '50's and the new category of patient-member disabled groups formed during the '60's and '70's, is warranted.

Nagi (1965) has explained that there are different categories of people who may require special rehabilitation services and that by differentiating "the phenomena basic to rehabilitation, that is, disability, from other health conditions around which different systems of care are organized", (p. 103) a fundamental distinction can be made between rehabilitation and other fields of practice. He proceeded by making a distinction between active pathology or disease, and disability. The former was defined as the onset of disease involving the interruption of normal processes and the simultaneous efforts of the organism to restore itself to a normal state of existence. Chronic diseases of long or continued duration were included in this category.

It was made clear, however, that disease processes could also have involved impairments or the presence of anatomical and/or physiological abnormalities.

In contrast, disability was defined as a pattern of behaviour that evolved in situations of long term or continued impairments that were associated with functional limitations set on the individual's ability to perform the tasks and obligations of his usual roles and normal daily activities. Disability did not, however, have to be associated with illness, although it could, since in many cases losses or abnormalities of a residual nature remained after the active stage of pathology was arrested or eliminated. Keeping this in mind, Govan (1966) noted that some organizations were not involved in rehabilitation since the disease entities with which they were concerned may be progressive and medical knowledge insufficient to alter their course or because the disease, if controlled, did not require of the patient a radical readjustment in living and, if not controlled, offered little hope of rehabilitation. The muscular dystrophy, multiple sclerosis, cystic fibrosis, and myasthenia gravis societies were included in the former category, and cancer, diabetes, and heart in the latter.

Whereas these groups focused on disease, patient member groups for any of the disabled, called consumer groups, began to gain the attention of the government during the late sixties and especially in the seventies. These groups are run by the disabled for the disabled and function as advocates for changes in government policy towards the physically disabled.

The roles and objectives of voluntary agencies

associated with the physically disabled over the time period in question, have been summarized in Appendix A, and classified according to their orientation.

(3) Sources of Data

Theoretical sampling can be done on previously collected data. Grounded theory has advocated using a range of data collection techniques and different kinds of data, i.e. slices of data. Both of the latter provide different vantage points from which a category may be understood and its properties developed. This is a prerequisite for yielding more information on categories in terms of the differing contexts from which each type of data has been derived.

The different slices of data that I analyzed were derived from secondary sources including the annual reports for both government departments, and pertinent government policy statements.

(4) The Constant Comparative Method of Joint Coding and Analysis

This was a systematic approach that used explicit coding and analytic procedures. The groups to be studied were selected out of the initial data collection decisions that were made. Alberta's Department of Public Welfare was studied first to discover some basic categories and a few of their properties. Initially, incidents were coded into as many categories of analysis as possible as the categories emerged or as data emerged to fit the existing categories. During the coding of an incident for a category it was compared with previous incidents that had

already been coded. When incidents began to be collected from different groups they were compared to the previous incidents. This constant comparison of incidents helped to consolidate categories that were strong and let preconceptions or irrelevant conceptions fall. It also helped to generate a few of the properties of a category, so that the conditions under which a category was pronounced or minimized, either to a particular degree or type, were determined. Once an incident had been coded for several categories, it was used as an illustration only once, for the most important among the many properties of diverse categories that it indicated.

As coding continued, the constant comparison units changed from the comparison of incident with incident to the comparison of the new incident with the properties of the category that resulted from initial comparison of incidents. As constant comparisons were made the accumulated knowledge that pertained to a property of a category became more integrated, as well as the different properties themselves and the different categories. Thus as the incidents developed into properties and the properties into categories, the interrelationships between them also grew.

The next group selected for coding was the Public Health department of Alberta, as it was in one form or another. In terms of ideological context this group was similar enough to that of Public Welfare that any differences that existed in the motivations and predispositions towards policy making for the physically disabled in either department were minimized. The comparison of these two similar groups helped to verify the existence of a category.

Then in order to obtain different data bearing on a category, dissimilar groups were chosen for comparison. These, of course, were the health and social welfare organizations of the British Columbia government. Maximizing the variety of data bearing on a category helped to develop its properties and as well helped to find similarities among the different health and welfare departments in the two provinces.

Description of the Comparison Units

The units of comparison that were selected for analysis were designated at the outset as the health and welfare organizations that developed policies for the physically disabled within the governments of British Columbia and Alberta. Throughout 1945 to 1980, however, the nomenclature of these organizations changed many times. For purposes of clarification the titles of these organizations have been described in chronological order to indicate precisely which organizations were analyzed.

Alberta

From 1945 to 1971, Alberta's Social Credit government organized separate departments of public health and public welfare. Public Welfare became the Department of Social Development in 1969, after Public Health became the Department of Health in 1967. In 1971, the two departments were amalgamated to become the Department of Health and Social Development. This name was retained by the Conservatives when they took office in 1971, until 1975 when it became the Department of Social Services and Community Health. During that same year the Department of Hospitals and

Medical Care was established. It took responsibility from the Hospital Services Commission previously under the jurisdiction of the Department of Health and Social Development. All of the above were included in the analysis with the exception of the Department of Hospitals and Medical Care.

British Columbia

In 1945, British Columbia organized its own separate Health and Social Welfare Branches within a Department of Health and Welfare. In 1948, the Government passed the Hospital Insurance Act and a third branch of the Department, the British Columbia Hospital Insurance Branch was set up. These arrangements were retained when the Social Credit took office in 1952. The latter branch was not included in the analysis since at that time, the insurance program only provided coverage for acute care in approved general hospitals for those who wished to participate and pay. Changes in the branch's policies were described in the annual reports of the other two branches if they had an impact on their own particular policies.

In 1959, the Department of Social Welfare Act was proclaimed and a separate Department of Social Welfare was created. During that year, the Hospital Insurance Branch was amalgamated and the Department of Health Services and Hospital Insurance was created. However since the reorganization did not cause any changes within the Health Branch, the analysis continued to consider it separately. This arrangement continued until 1973 when the department's name was changed to the Department of Health. In 1971, the Department of Social Welfare had become the

Department of Rehabilitation and Social Improvement. After the new Democratic Party captured office in August 1972, the latter was renamed the Department of Human Resources in 1973. In 1976, this was changed to the Ministry of Human Resources by the Social Credit who had resumed office late in 1975.

Part two of this study presents the analysis of the policy development for the physically disabled in Alberta and British Columbia, and its interaction with the actual operation of these institutions of health and welfare.

CHAPTER FOUR

THE FORMULATION OF AN INTEGRATED CENTRAL THEORETICAL FRAMEWORK

Introduction

I began the research process by asking myself how the organizational frameworks of the departments of health and of welfare had interacted with the development of those policies designed for the physically disabled. From this, I proceeded to examine the data from both British Columbia's and Alberta's annual reports. Over the time period in question, 1945 to 1980, I was confronted with the development, within different organizational frameworks, of an increasingly greater complex of seemingly unrelated policies for the physically disabled, whose intra- and inter-relationships combined to become increasingly complicated. Both the policies themselves and the organizational frameworks within which they were located, underwent many variations during this thirty-five year time span. Hence, it was necessary to forge a link between these apparently unordered observations and the formulation of adequately demonstrated generalizations that would be sufficiently analytic in nature in order to offer an explanation for the problem under study.

Given the extent of the variability of data within the annual reports, this appeared to be a singularly difficult task.

The method of grounded theory, however, provided the following strategy to overcome this contingency.

Since both categories and properties are concepts that have been indicated by the data (and are not the data itself), once a category or property has been conceptualized, any change in the evidence that indicated it, does not necessarily alter, clarify, or destroy it. Glaser and Strauss(1967) have said that

> it takes much more evidence - usually from different substantive areas as well as the creation of a better category to achieve such changes in the original category. In short, conceptual categories and properties have a life apart from the evidence that gave rise to them. (p. 36).

Although the evidence that I examined changed its form many times, the effect of this was negated by the conceptualization principle that underpinned the emergence of categories and their properties.

In order to develop a broad range of acceptable indicators that permitted the coding of data into conceptual categories of explanation, a series of "guiding questions" (Dalton 1964, p. 63) was constructed. They were developed to suit the purposes of the total research question and were organized around two inter-related themes, as follows.

Warham (1974, p. 52) pointed out that social policies are distinguishable, not so much by their intended specific benefits but more so by their understated primary purposes. Furthermore, Blau (1974, p. 28) has added that the latter objectives are reflected in the regularities of those social structures that have been established by the governments of a society to achieve them. He said that the regularities, themselves, reflect the deliberate design of the government.

Since I was concerned to identify discernible patterns in both the development of policies for the physically disabled and their interaction with the structural frameworks where they became located, the following set of guiding questions was asked to facilitate the exposure of both the regularities hidden within the design of the organizational frameworks, and, the primary purposes of those policies developed for the physically disabled. (1) What types of policies for the physically disabled were developed within the functioning of the Departments of Public Health and Public Welfare in Alberta, and the Health Branch and Social Welfare Branch of British Columbia? (2) What types of concerns related to the physically disabled were left outside of the functioning of those departments? (3) What kinds of classification schemes had been applied to the physically disabled by the provincial policy making departments, and what were the principles that underpinned those choices? (4) What were the original impetuses for the initiation and development of policies for the physically disabled? (5) By what mechanisms were developments in the policies made that concerned the physically disabled produced, sustained, or altered? (6) What relationship, if any, existed between the policies that were developed and the structural frameworks that were designed to carry them out?

Throughout the asking of these, and subsequent questions that emerged as the analysis progressed, I was continually looking for 'cues' that would help me to categorize the data. I looked for facts that were indicators of different kinds of incidents such as recurring processes and events in policy-making, or conversely their anomalies; recurring themes in organizational

framework design; who or what was instrumental in developing policy; motivations and predispositions that underpinned the interaction between policy development and organizational framework; confused or overlapping usages of labels or concepts; the boundaries or limits of the provincial health and welfare organizations; the resources that enabled a policy to be feasible; and any significant changes that occurred during the course of policy-making.

The Integrated Central Theoretical Framework

The Classification of Conceptual Categories

Conceptual categories emerged as the coding and comparison of numerous incidents that had an analytic bearing on the research question took place. Incidents were coded into many different categories in the initial stages of data collection. These ultimately resolved themselves into four inter-related and theoretically saturated conceptual categories that formed the basis of an integrated central theoretical framework.

Classification of the data into conceptual categories required that their own boundaries were clarified. This was effected through the application of 'labels' that identified the domain of each category or property. Initially the concepts that were abstracted from the substantive situation tended to be current labels in use for the actual processes and behaviours to be explained. They were applied to as many categories as possible that were extracted initially from the data. As the comparison of data continued, these lesser categories were amalgamated into the four over-riding categories of the conceptual framework.

The labels that were applied to these, differed from the former, because they became the explanations for the problem under study.

The classification of data into these four categories was an attempt to desegregate and analyze separately competing yet complementary explanations for the development and organization of policies for the physically disabled. The labels that were applied both to the categories and their properties, although having evolved separately and apart from any preconceived theoretical notions, were also found to exist in the jargon of the relevant literature. To achieve brevity of expression, without sacrificing clarity of the label, the literature was used as a resource to help provide refinements of these conceptualizations.

This strategy has been justified by Glaser and Strauss (1967) who admit that

> ... the trick is to line up what one takes as theoretically possible or probable with what one is finding in the field. Such existing sources are to be cultivated, though not at the expense of insights generated by the qualitative research, which is still closer to the data. A combination of both is definitely desirable. (p. 253)

Emerging from the substantive data, yet co-existent with and supported by relevant concepts from the literature, the terms, labelling contexts, boundary decisions, valuation contexts, contextual constraints were selected to identify the categories. These labels defined conceptualizations of the empirical entities that verified each category's existence.

The use of this integrated theoretical framework allowed the organization of many of the problems identified in the annual reports, and of the solutions that were taken by the decision-makers, that the initial examination of the data revealed. It

also provided an analytic tool by which discernible patterns of interaction between policies developed for the physically disabled and the structural frameworks wherein they became located were exposed.

Prior to the presentation of the data for the verification of these categories, the theoretical framework has been described in order to create an awareness of the manner in which these four categories became inter-related, and of the part that each category has played in the provision of an explanation for the research question.

The category of labelling contexts emerged as facts were gathered that were indicators of a recurring theme underpinning the categorisations that were applied to the physically disabled.

Warham (1974) has stated that

> ... social policy is in any case a categorizing process in that it makes, and remakes, distinctions between categories of people and categorizations of need (or merit, or desert), in relation to each other. This process may be regarded as undesirable 'labelling', but it can also be seen as a desegregating influence, and a positive means through which resources are rationally allocated to intended purposes. (p. 71)

The label that has been applied to an individual will often determine whether or not he or she will be channelled into an alternative role apart from his or her own particular ascribed status according to age, sex or ethnic group. The label that has been given the individual also has implications for determining what kind of resources, if any, will be allocated by society for his or her use. A labelling approach is taken to legitimate implicitly actions that are taken as its consequence.

This category has been discussed first because it describes the contexts within which the physically disabled were categorized and recategorized during the time period in question. This context limited at the outset the kinds of approaches that the decision-makers took towards developing policies for the physically disabled, since as Warham pointed out, the means chosen to tackle a social problem reflect the very ways in which the problem has been defined. The labelling contexts within which definitions have been selected for use by decision makers who formulated policy for the physically disabled are crucial because they reflect fundamental conceptual differences to the whole problem of disability. Labelling also has been used to facilitate the legitimization of policies based on political ideology, or political expediency, or a mixture of the two.

Kahn's (1969, p. 152) perception that the customer often thinks of his needs in categories suggested by the manner in which professionals structure their services urged him to call for the rethinking of definitions of function, conceptualizations of services, and of the nature of the intervention units so far created within the social services sector.

The emergence of the conceptual category of boundary decisions met this request by conceptualizing those policies that were taken within the functioning of the four departments, not in terms of standard definitions of intended functions, but in terms of their actual or primary purposes. This conceptual category emerged as uniformities were detected, from among the data, of certain bases or conditions that underpinned the selection of those policies that became the major sub-units or functions of

the policy package for the physically disabled, within the four departments. Or, in other words, what the domain of the departments with respect to administering or delivering policies for the physically disabled was chosen to be. For purposes of clarification, functions have been defined as "the manifest groupings or types of activities within a service system ... as conceptualized with reference to goals of the particular system" (Kahn 1969, p. 145).

The conceptualization of this set of boundary decisions and their properties added further to the explanation of the research question, since certain boundary decisions were taken that structured the organizational framework in such a way as to maintain the departments' choice of their policy domain with respect to the physically disabled. Kaufman (1978) has pointed out that

> ... organizational arrangements are also a means of communicating the government's intentions. They signal people inside the government, people throughout the country, and, indeed, people and governments throughout the world what the government's emphases will be. (p. 222)

Accurate conceptualization of these boundary decisions becomes important to enable an accurate assessment of the priority assigned to the physically disabled by the provincial governments. The boundary decisions that were made reinforced the limited choices of approach that were established by the labelling context of the physically disabled.

The third conceptual category, that of valuation contexts, emerged after facts were coded that were indicators of recurring motivations and predispositions that underpinned the

policies for the disabled. Both the choice of means, and, the choice of labelling contexts within which reality has been structured by the decision makers, are permeated by latent values.

Pfeffer (1981, p. 8) has stated that as well as understanding how organizational benefits and resources get allocated, it is equally important to understand how such allocation patterns become perceived and justified by the organizational participants. Ranson et al (1980) have stated that

> organizational members create provinces of meaning which incorporate interpretive schemes, otherwise known as frames of reference, and intermittently articulated as values and interests, that form the basis of their orientation and strategic purposes within organizations. (p. 4)

Values have been defined as standards that are representative of desired ends or preferences, and that articulate more discrete elements of the interpretive scheme. These values are drawn upon when necessary and made explicit in order to legitimate particular courses of action. It is "value choice, implicit and explicit, which orders the priorities of government and determines the commitment of resources within the public jurisdiction" (Simmons et al 1974, p. 457).

In the introduction to this chapter I noted that from 1945 to 1980 both the discrete policies for the physically disabled and the organizational frameworks within which they were located, (i.e. the boundary arrangements), had undergone many variations in form. The conceptual category of contextual constraints emerged, then, as uniformities were detected among the sequences of events that preceded the transformation through which one set of boundary arrangements gave way to another.

Theoretical attention in this case was shifted from a focus on outcome (as apparent in the conceptual category of boundary decisions) to that of the process through which the boundary arrangements of the departments were produced, sustained, and altered.

Benson's (1977) discussion on the analysis of organizations argued that the entire explanatory effort must not be confined to that "of an abstracted organization ripped from its historical roots and societal context and innocent of its deeper-lying power struggles and negotiations" (p. 11) since "developments within the organization often appear to be intricately related to events occurring in the larger society" (p. 12). Ranson et al (1980) have also noted that the variability of organizational outcomes is often determined by the extent to which organizations accommodate their own particular set of contextual constraints.

During the emergence of the theoretical framework, it became more and more apparent that the contribution of one conceptual category towards explanation could not be considered in isolation from the effects of its companion categories. In order to present the analysis with as much clarity as possible, each category was, however, dealt with separately. The following figure (2) was constructed to facilitate an understanding of the inter-relationships between the properties and their category, and between categories, that emerged and that have been elaborated upon in the following chapters.

Within the ensuing chapters, the existence of the four conceptual categories was verified with the analysis of the data from the annual reports. In order to establish the existence of

Figure 2 - Conceptual Categories and Conceptual Properties

CONCEPTUAL CATEGORY	CONCEPTUAL PROPERTIES				
		B.C. Health	B.C. Soc. Welf.	Alta. Pub. W.	Alta. Pub. H.
Labelling Contexts	type	.....	societal labelling perspective		traditional medical perspective
	structural determinant	availability of service	employment	employment	medical model of pathology
	continuum	none	concentration at unemployable end	unemployable to potentially employable	treatable end of pathology continuum
	consequences	.....	legitimization of boundary decisions	.....	
Boundary Decisions	type	positive allocative, negative selective	residual, ... positive allocative, ... negative selective		positive allocative, negative selective
	condition	economic	economic for positive allocative		economic
	scope (varied in degree)	service, funding	predominantly funding with some individual case-work services		service, funding
Valuation Contexts	type	economic/ humanitarian	economic/ humanitarian	economic	economic
	criteria of worth	ability	ability	ability	treatable
Contextual Constraints	type	socioeconomic	socioeconomic	socioeconomic, ... institutionalized environment	
	consequences	manifest ..... latent			

categories, the similarities between the data for Alberta were compared and analyzed first. This also established a few basic properties of the categories. Once the similarities were determined, it was possible to compare the different data from British Columbia with that of the first group, Alberta. This comparison helped to maximize the data bearing on the categories and to develop other diverse properties.

Referencing the Data

In order to simplify the referencing of approximately 170 annual reports, modifications were made to the style in which quotes taken from the text of the reports have been cited.

With only a few exceptions (and these have been referenced accordingly), all of the quotes in the following seven chapters were extracted from the annual reports of each province's respective departments of health and of welfare. Even though department titles of these reports have altered from 1945 to 1980, I decided that, if the material was to be presented without interruption, an abbreviated form of referencing would have to be employed, to eliminate lengthy, distracting text references.

Thus for the first quote in each section of a chapter concerning a particular department, the full title of the department's annual report has been cited either in the text or as a footnote, depending on its appropriateness. Additional quotes that supported and verified the existence of the category or property were referenced by page number and year. However to avoid re-referencing the author and department title of the annual report, the word "idem" has been used to denote both of the latter.

In order to do this, I assumed that the author of each annual report was either Alberta or British Columbia, and as such, the titles of the annual reports, regardless of department name change, did not warrant identification in the text.

The citations for the annual reports have, however, been listed by year and appropriate department name to facilitate further referencing.

CHAPTER FIVE

LABELLING CONTEXTS FROM 1945 to 1972

Preamble

This chapter is about the particular social reality that decision makers construct within a government bureaucracy and how that reality affects the fortunes of the physically disabled group.

Howards, Brehm and Nagi (1980, p. 4) as well as Handelman (1978, pp. 10,15) have identified how understanding social problem definition is key to assessing social policy and its actual impact. The analysis described in the next four sections establishes that, from 1945 to 1972, the problem of disability was defined differently between the four government departments according to particular labelling contexts of each. The characteristics of each context, although not always similar, were defined by the category's properties.

Thus, four different bureaucratic interpretations of what problems associated with disability were meaningful, emerged from the data. The physically disabled were then categorized according to these interpretations or definitions of the problem. The chapter also illustrates how the types of policies that were taken within the functioning of the four departments were congruent with the definitions or labelling that had been applied

to the disabled.

Two themes common to the data from all of the departments underpin the conceptual category of labelling contexts. The first reflects a subtle contradiction between the labelling context employed and to whom social policies were directed. For example, in three departments, labelling according to societal norms was imposed upon the disabled group, although in policy-making, these conventions were overlooked by an implicit assumption that the individual, and not society's expectations, had to be changed. Thus disability was perceived to be a problem that could only be ameliorated if the individual was somehow changed in his or her capacity for independence. Within these contexts the problems of the disabled were not defined as problems of society in general.

Relating the problem of disability to the individual, and not to the social environment within which a disabled person lives, reflects the perception of government, that, while they are often disabled through no fault of their own (recall that this data excludes work-related disability), society is also not at fault. Consequently, the provincial governments were prepared to carry out a limited set of interventions that tended to be directed towards improving the status of the physically disabled individual as defined by a particular labelling context. These policy interventions have been described and analyzed in the chapter on boundary decisions.

Handelman has stated that "bureaucratic perception and interpretation are closely connected to the existence of social categories and constructs which bind such processes" (p. 8). Thus within two of the departments, the disabled were labelled

within a context that was dominated by the western world's most pervasive characteristic, that of work. The two departments of welfare categorized the disabled according to their ability to work. The provincial departments of health differed. In Alberta, the physically disabled were labelled according to a traditional medical perspective based upon clinically defined pathology. Evenso, those disabled who were considered to be within that Department's functioning were perceived to be treatable with the potential to make a positive economic contribution to the community. The British Columbia Health Branch was the exception. It did not label the disabled according to their problems, but according to the availability of institutions for their care. This major preoccupation with the ability to work or not to work of the departments' clients reflects how fundamental the Protestant work ethic is to the survival of an industrialized nation.

Taken together, these two themes provide an indication of the extent to which both provincial governments were willing to assume an obligation for interventions on behalf of the disabled. In general, the boundaries of policy making for the disabled were established by bureaucratic world views that perceived physical disability to be a problem of the individual, and that subsequently linked social policy to mechanisms whose various aims were often to return the individual to the work place, if that was possible.

It must be stressed however that the labelling contexts within which the problem of disability was interpreted did not necessarily permit an adequate understanding and assessment of

the scope and dimensions of the problem of disability. That the knowledge of decision makers is limited contradicts Weber's (1978) assertions that a bureaucratic administration's exercise of control on the basis of knowledge " ... is the feature which makes it specifically rational ... they (officials) acquire through the conduct of office a special knowledge of facts and have available a store of documentary material peculiar to themselves"[1]. (p. 15) This chapter identifies that the rationality of the decision makers was strongly bounded or curtailed by the lack of other data on the nature and dimensions of the problem of disability and how labelling contexts that were based upon partialized knowledge automatically eschewed the taking of other policy options for the physically disabled.

Establishing Similarities Among the Data from the Department of Public Welfare in Alberta

This conceptual category's properties of type, structural determinants, continuum and consequences, appeared to reflect existing policy intentions, to be identifiable in the actual operation of existing services, and to provide a frame of reference for examining their effects.

The first property emerged when uniformities detected within the factual data indicated that the physically disabled were defined by the Department of Public Welfare within one type of labelling context. This context, identified in the literature as the societal labelling perspective, maintains that labelling occurs as a consequence of certain societal characteristics, structural determinants or contingencies. According to this

theory, an individual, through a process of labelling, achieves a certain status, not by virtue of age, sex, or ethnic group, but according to individual behaviour/performance, and the manner in which it has been evaluated by society. Mercer (1973) has stated that "achieved statuses are acquired by virtue of individual competence or incompetence as judged by others in the system" (p. 121).

The analysis of the data indicated that the employment status of the physically disabled was the societal benchmark against which they were labelled. Accordingly, the physically disabled were placed along an employment continuum and allocated status as either unemployable/unemployed (incompetent) or potentially employable (competent). Ascribing either of these two statuses to the physically disabled fulfilled two consequences. These have been made explicit in the accompanying data on verification.

The following examples first confirmed that labelling the physically disabled as unemployable was well established in 1945 and continued throughout the time frame in question. They were considered as belonging to that general class of disadvantaged persons who required some kind of assistance to meet their basic needs. Consequently this subgroup of the disabled tended to be those who were the most difficult to deal with, such as the unwell physically disabled.

In 1945 (Alberta, Department of Public Welfare, Annual Report), the Director of Public Welfare stated that,

> practically all assistance provided was for those either partially or fully unemployable for reasons of age, ill health, unmarried mothers with young children, or to those with exceptionally large families

of young children and small earning power[2]. (p. 4)

Alberta's reliance on productive employment to uphold its socio-economic infra-structure entrenched the labelling of the physically disabled as unemployable. This was illustrated by the following statements made by the Relief Branch from 1946 and 1947.

> ... Unemployment relief has continued to remain at a low figure throughout the year and this was accounted for by the fact that full employment continued to be available for everyone who was willing to work. The demand for indigent services including hospital and medical attention continues to show an increase and this is largely due to the fact that persons who had previously been classified as employable are now being placed in the indigent category ... the reason being that whereas during the war years even old and crippled persons were readily employed, their places were being filled by ex-service men and women who were younger and more fit.[3]

The allocation of an unemployable status to the physically disabled was repeated in subsequent years as the following examples show.

> Assistance to unemployable sick persons is continuing to show a steady increase, both in the amount and in the number of people being assisted, and this trend is likely to continue as the population and the average age of our people increase"[4] and "the demand for services to non-employable persons, including hospital and medical attention continues to increase, ...[5]

In 1953, the Disabled Persons' Pensions became available for the physically disabled who fit the following criteria of unemployability.

> Assistance is provided to a person who has a chronic disability from which he has suffered for a period of 12 months or longer

> and who is physically unfit for gainful employment. (1954, p. 33).

In 1960, an amendment to the Public Welfare Act created four distinct categories of unemployable persons. It provided for the administration of social allowances to these former public assistance recipients. A social allowance was to "be paid only to or in respect of a person

> (a) who by reason of age, or by reason of physical or mental ill health or physical or mental incapacity that is likely to continue for more than ninety days, is unable to earn an income sufficient to pay for the basic necessities of himself and his dependents, if any ...
>
> (b) Mothers having the custody of and personally caring for their dependent children who are unable to earn an income sufficient to pay for the basic necessities of themselves and their dependents ...
> Transient persons
> Residents of Improvement Districts or Special Areas[6]

In 1961, the Public Assistance Branch stated that the new social allowance program "relieves municipalities of those persons who could generally be classified as unemployable". (p. 11).

Defining the physically disabled in terms of their employment status continued to be reflected by the financial maintenance policies that were carried out for this subgroup of the physically disabled during the sixties.

In 1968, the Public Assistance Branch stated that the

> Social Allowance program has been designed to meet the financial needs of a person who cannot earn sufficient income for his own needs and those of any dependents by reason of age or mental or physical incapacity or ill health, ...[7]

Allocating the physically disabled the status of unemployable within the societal labelling context of employment had two general consequences. It limited the decision-makers' choice of policy options for the physically disabled, while simultaneously legitimizing the pursuit of policies directed solely towards financial maintenance. The conceptual category of boundary decisions emerged to illustrate the relationship between the implicit application of this status to the physically disabled by the decision-makers and the means that were selected for policy implementation.

As early as 1946, however, those physically disabled who fit the classification were also included in that general group of persons who were perceived to be potentially employable. The Bureau of Public Welfare Branch stressed,

> ... the importance of the work done by the same staff in securing employment for numerous heads of families who either through lack of experience, aggression, partial disability, or other reasons failed to obtain same by their own efforts.[8]

The Department's re-establishment and rehabilitation policy was "the means of establishing several hundred unemployed families ..."[9]

In 1954, the physically disabled were singled out as being potentially employable when the signing between Alberta and the Federal Government of the Agreement regarding the Co-ordination of Disabled Persons was completed. A Rehabilitation of Disabled Persons Branch that was set up to carry out the agreement, approved "applications for training received from disabled persons, when such a program" was "likely to lead to gainful

employment ..."[10]

In 1959, the Branch continued to work with "cases for which training was felt desirable to improve the employability of disabled persons".[11]

> Cases that were considered suitable for employment, following assessment by the Rehabilitation Branch, were referred to the proper National Employment Service office for possible placement ... (1959, p. 43)

In 1961, the Department stated that the

> Supervisor for the Rehabilitation Division deals with all cases applying to the Department for vocational rehabilitation services and for which vocational training, and/or selective placement services may be reasonably expected to lead to placement in gainful employment. (p.37)

The perceptions of the physically disabled as potentially employable clients enabled and legitimized the taking of other policy initiatives. These have been presented in the next chapter where the type of boundary decisions taken become linked with the societal employment context within which the physically disabled were defined.

Establishing Similarities among the Data from the Department of Public Health in Alberta

When the data for the Department of Public Health were compared and analyzed, conceptual similarities from them emerged that also verified the existence of the conceptual category of labelling contexts and its properties. Paradoxically, establishing that similar properties existed allowed the emergence of differences that elaborated and extended the range of different data that could be accounted for by each property. These

differences have been described below.

The type of labelling context within which the physically disabled were labelled by the Department of Public Health differed from Public Welfare's in that they were defined within a traditional medical labelling perspective. The traditional perspective's criteria for assessing the status of an individual has not been primarily manifested in behaviour but includes disease manifestations which have biologic and physiologic bases. The existence of a medical model of pathology functioned as the structural determinant that prescribed the type of labelling applied to the physically disabled. Thus labels were chosen for individuals according to the diagnosis that best fit their biological symptoms. The diagnosis that was made relied upon the ability of the medical practitioner to assess properly the patient's symptoms.

The examples taken from the annual reports verified that the reaction of the Department of Public Health towards the disabled was more in keeping with the traditional perspective of labelling according to a medical model, than with the societal labelling perspective implied in the Department of Public Welfare's orientation to the physically disabled.

Furthermore the examples identified that the physically disabled who were considered to be within the purview of the Department were allocated status and thus recognition because they existed at the treatable end of the pathology continuum.

The traditional perspective has also stated that fixing an individual with a particular label legitimizes that person's disability or abnormal condition. This legitimization, in turn,

had implications for determining the kind of resources to be allocated for this group and to what end. The analysis of the data confirmed the existence of two positive consequences for the physically disabled as follows. Labelling the disabled within the traditional perspective provided resources that provided them with the opportunity to be relabelled as coping with the disability, or delabelled as cured.

The following examples illustrated these points. In 1954, the Department of Public Health stated that,

> recognition of the need for specialized care for the cerebral palsied child has only come in the last dozen years. Since classification of this disease as neuro-muscular has removed the child so afflicted from the province of mental care, outstanding success has been gained in rehabilitating victims of cerebral palsy. (Alberta, Department of Public Health. Alberta's Health Services Program 1954, p. 17).

Research conducted by the medical director of the new Cerebral Palsy Clinics in 1950 estimated that there were "very close to 500, if not over 500, cases of cerebral palsy in the province of Alberta ... and that approximately two-thirds of these could very definitely be benefitted by treatment". (Alberta, Department of Public Health, Annual Report 1950, p. 50).[12] This identification and labelling of this group according to distinct medical criteria legitimized their disability in order to facilitate the provision of designated pathways to recovery (or delabelling) or adaptation to the chronic role (relabelling). In addition, the perception that the physically disabled were treatable restricted the selection of policy options towards this end.

The positive relationship between the legitimization

and limiting function of the labelling employed by the Department of Public Health and the boundary decisions made by the Department has been discussed more fully in the relevant section of the chapter on boundary decisions.

Meanwhile, the relationships between the properties of type and structural determinant that characterized the conceptual category of labelling context, and the property of consequence, have been illustrated in the concluding remarks of the previous statement and in ensuing statements made by the Medical Director of the clinic. He stated,

> since we will be able to treat not more than 30 in the Edmonton Clinic, and approximately the same in Calgary at a later date, it would appear that our facilities are very inadequate. However the birth rate in the Province at the present time should remain under 50 new cases per year, and consequently, though we will be unable to cope with them all at the present, I believe that our facilities are probably adequate, and we will certainly not end up with a program too large for our Province in the future.[13]

Then in 1951, he stated that,

> in response to persistent demands from Calgary, in July of this year the Government saw fit to provide Calgary with the necessary employees to commence a clinic there to start the programme functioning ... Since that time they have been collecting cases ... We hope to use this present Calgary programme very much as we used the Edmonton one initially, to collect the cases, to find out how many and what type they are, so that we may better know exactly what we will require in Calgary when the Government intensifies their program with further employees and perhaps a building. (p. 53)

In 1952, the statement was made that "Alberta's cerebral palsy have a new lease on life through the clinics which have been established by the Government of Alberta" (p. 119). Those

cerebral palsied that were taken into the program were also allocated status as 'treatable'. The division stated in 1954 that "it becomes increasingly apparent that the backlog in Cerebral Palsy in the Province of Alberta of treatable cases is much greater than we had anticipated" (p. 135).

Rheumatoid arthritis was also diagnosed as an underlying pathology that predisposed an individual to severe physical disability. From among this group, those who were treatable were also identified. In 1953, the Director of the Division of Arthritis Services stated that "it might be indicated here that approximately fifty per cent of the patients who are referred to the Clinic for consultation by the family physician, turn out to be Rheumatoid Arthritics" (p. 139).

The following example illustrated the positive consequences of acquiring this particular label. In 1969, the Division stated that,

> it is undoubted that the Division of Arthritis Services, with its clinics in Calgary and Edmonton, has rendered a most useful service to those people in the province of Alberta who have had Rheumatoid Arthritis or have had conditions simulating Rheumatoid Arthritis and have required some assistance in diagnosis and treatment. Through the clinics ... many patients have been assisted in learning to live with a very troublesome and, at times, tragic disease. (p. 69)

Two other causes of disability were labelled within the traditional medical perspective. In 1954, the Department stated that,

> this high incidence of poliomyelitis in the past few years has made it the major communicable disease in place of tuberculosis. It had replaced this disease as a cause of death and as a cause of permanent disability and has

> placed a heavy burden on the hospital services under the Poliomyelitis Sufferers' Act. However, for 1954 the falling rate of poliomyelitis has permitted tuberculosis to resume its former position.[14]

Recognition was also given to the existence of rheumatic fever that if not treated could resolve into a potentially disabling condition. When the Rheumatic Fever Prophylaxis Program began in 1958, any child under 18 years of age was eligible for treatment under the program "providing the child's physician" could "demonstrate a history of rheumatic fever" (1960, p. 59). In October, 1963, work was also started in looking after six infants who had been born in Alberta "showing thalidomide type deformities" (p. 61). Later this program was replaced by the Juvenile Amputee Clinic. Any child up to their eighteenth birthday "suffering from amputation, congenital or traumatic," was "seen and any necessary prosthetic limb ... provided" (1964, p. 69).

Following this, the Cystic Fibrosis program was implemented by the Department in 1964. It proved "to be invaluable in bringing to light previously unknown cases of the disease, since the known cases at its outset, numbered 46" (1964, p.69). "Eighty-six children were receiving these drugs during the calendar year 1970" (p.43).

Establishing Similarities and Differences with the Data from the Social Welfare Branch in British Columbia

While comparison of the findings from Alberta's Department of Public Welfare with the new data from the annual reports of B.C.'s Social Welfare Branch established that several

conceptual similarities existed between them, it also allowed particular differences in the development of and organization of policies for the physically disabled to emerge.

Examination of the data verified that the Social Welfare Branch also labelled the physically disabled within a societal labelling perspective, characterized, again, by the structural determinant of employment. Differences between these two departments were accounted for by the property of continuum. While the Alberta department allocated the physically disabled status according to where they fit along the continuum, the Social Welfare Branch tended to label and concentrate their classification of the physically disabled at the unemployable end of the same continuum. Separation of some of the physically disabled into a potentially employable group only occurred under one condition. This was the existence of a marketplace in which there were unlimited opportunities for employment. Given the acceptance of this condition by the decision-makers, their recognition of the reality of an imperfect supply and demand situation for employment, the physically disabled tended to be automatically excluded from participation in the workforce. British Columbia made explicit, more so than did Alberta, the effect of the structural determinant of the employment market on employment opportunities for the disabled.

The acquisition of the unemployable label legitimated the pursuit of certain policies for this subgroup of the unemployable class. These consequences have been illustrated more fully in the chapter on the conceptual category of boundary decisions.

The following examples verified the existence of a societal labelling perspective based upon the determinant of employment. They also established the tendency for the disabled to be labelled at the unemployable end of the continuum, due to the existence of the latter property.

In 1948, the Social Welfare Branch noted that although

> ... the war of 1939 brought an abrupt end to conditions of unemployment, ... the need to provide for physically and mentally incapacitated persons remained. Mindful of the impoverishment of the municipalities, the Provincial Government in 1941 assumed 80% of the costs of direct relief to unemployable persons residing in organized areas, paying 100 per cent of this cost in the vast unorganized territory of the Province.(Department of Health and Welfare, Social Welfare Branch, Annual Report for the Fiscal Year Ending March 31st, 1948, p. 9)

By 1948, the general employment situation was identified as a determinant that tended to force the physically disabled into identification with that group of unemployables who would have to rely on social allowances (i.e. public assistance) for their livelihood.

The Branch's Family Division stated that,

> ... in looking for an explanation of the rise in the number of recipients of social allowances, "it is difficult to find a positive answer ... Another factor no doubt is the general unemployment situation. We have noted the difficulties presented for the older worker in obtaining employment - and the older worker is usually defined as 45 years of age and over. If these groups are finding difficulty in seeking employment, it is a logical conclusion that the physically or mentally handicapped person is experiencing even greater difficulty. Where the handicapped person might have found work in the past, no such opportunities are presented now with so many able-bodied persons available to do the work. These physically or mentally handicapped persons must then perforce be considered unemployable and will be forced to

apply for social allowance if they are in need". (p. 40)15

This poor employment outlook was used by the Branch to legitimate the labelling of the physically disabled as unemployable. The implicit assumption made was that, given the current employment situation, no other solution to the problems of the physically disabled, other than that of providing financial assistance, was feasible. The following statement made by the Social Allowance Section of the Family Division in 1950 illustrated this point.

> Prosperity and high employment will always affect our case-load to some extent, especially in that group whose ability to take employment is affected by their age and by the degree of their handicap and the availability of employment of a type which they can do in the area in which they live. Under good employment conditions they may find employment suitable to their capability, but in any tightening or slackening of employment they are usually the first to suffer, and in the broad interpretation of our criterion of unemployability, it has always been considered that they are eligible for Social Allowance. This is the group that no doubt accounts for any wide variation in the case-load, as there will always be a substantial fixed proportion who are totally and permanently unemployable in circumstances beyond their control, who must seek and receive assistance from public sources. The like comparison is, therefore, that our caseloads increase in times of low employment, but the important difference lies in the fact that in times of rising employment the case-load does not decrease proportionately but remains more or less static. This would seem to point to the conclusion that each year it is becoming increasingly difficult for disabled or partially employable persons to become re-employed.
>
> Another phase of the problem was indicated by a report from a district office which stated that among its case load were a number of persons who were unemployable in their present geographic location where "light" or selective work is scarce or unobtainable. This is a situation which exists to some extent in many parts of the Province. There are persons, however, who belong to a

> particular area or setting and have no wish to move or be uprooted, consequently their hopes of rehabilitation are often limited not only by their handicap and degree of unemployability but by the opportunities for work within their ability in the particular area in which they live ... (pp. 23,24)

The Social Allowance program stated that it intended to serve

> the unemployable person or head of family who must seek financial help by reason of illness or physical or mental handicap, ... For them social assistance represents a protection against the hazards to security which every individual or family faces. (1951, pp. 23,27)

In 1954, the Family Division stated that the physically disabled were marginally employable, at the best of times.

> ... there is always a group of those in receipt of assistance whose employability because of some physical or mental handicap is at best only marginal. (p. 39)

And in 1963,

> It is recognized increasingly that the concepts of the employability and unemployability of the individual are related to employment opportunity as well as to actual physical, mental, or social disability. Given unlimited employment opportunity, severely disabled people are, in fact, employable. On the other hand, where there is a restriction in employment opportunity, people who are mildly handicapped or who are less favoured in knowledge and skills may find themselves less employable ... The social worker can often resolve the problem of insufficient motivation, but it is usually not in his hands to provide employment opportunity. (p. 36)

As one regional administrator for the Social Welfare Branch had put it,

> ... in the employment market there is some elasticity at the margin. In other words, there are always some employment positions which employers have a choice as to whether they need to fill them or not. Obviously this

> elasticity at the margin applies to an even greater extent in self-employed positions. (1963, p. 20)

The impact of the employment situation on the plight of the physically disabled was used to legitimate the provision of social assistance as a "comprehensive provision enabling financial maintenance and supporting services to be available to disabled and unemployed persons and to families lacking a breadwinner" (1963, p. 33).

The Assistant Deputy Minister and Director of the Branch remarked that

> ... the great majority of these people are not equipped by reason of intellectual, physical, and emotional capacities or aptitude to gain or hold continuing employment. They are the last to get hired, the first to get fired. For them, the slightest negative change in the employment market has immediate effects ... (1968, p. 9)

Beginning in the early sixties, an effort was made to change the status of the physically disabled from that of unemployable to employable. Although the physically disabled were still considered to belong in the unemployable category, efforts were made with the implementation of community Rehabilitation Committees to manipulate the work environment into providing jobs for the disabled. In 1962 the general administration for the Branch's regions stated that,

> ... the effort is not only being made with unemployed employable persons, but also with men or women who might be considered unemployable. In this connection the rehabilitation team has worked in conjunction with our social workers and has continued its activities in the Nanaimo and Chilliwack areas and is planning a survey in Prince George and other areas. The team's efforts have been most productive with a return to employment of individuals who have not been self-supporting for a number of years.

> The Department continued to study and explore all methods of rehabilitation and was pleased to co-operate with the officials of the Matsqui District Municipality in a pilot plan established by them through their centennial park project, whereby jobs were made available by the municipality to people who for sometime had been unable to find even summer-time employment. (pp. 10,36)

Although the rehabilitation committees functioned throughout the sixties, the structural determinant of employment was still evident as a major force determining the labelling of the disabled. The following examples verified the existence of this property and its potential and actual effect on rehabilitation policies for the physically disabled.

In 1967, the Department stated that,

> ... contrary to popular opinion, careful surveys here and in other parts of the continent have conclusively shown that the bulk of social assistance recipients are in fact not rehabilitative to employment because of such factors as age, health, need of mothers to care for the children, and serious psychological or social handicaps. Numbers who might otherwise be helped are simply not acceptable to employers and the indications are that this proportion is likely to increase as employers become more selective in keeping with changing technological requirements. This may require reappraisal in future of the appropriate role of welfare programmes and of possible alternative ways of providing for income maintenance. In general it may be said that the rehabilitative services of the Department are relatively efficient in encouraging the bulk of recipients who are reasonably employable back into the stream of employment. (p. 14)

In 1969, a regional administrator stated that,

> ... the rehabilitation committee has continued to function, and several people have been sent for retraining, either through Canada Manpower, Division of Rehabilitation, or ourselves. However with unemployment at its present level, available counselling and training resources

> are soon overutilized and their net effect negated. Unemployment cannot be solved by the provision of social assistance. Retraining schemes are excellent and essential, however, more effort must be taken to keep our employment figures at a manageable level. (p. 59)

Another administrator stated that,

> ... the rehabilitation of financially assisted people has now become complicated by the demands of employers for special skills. The planning which must go into the preparation of the individual and selection of training courses is difficult and time-consuming.[16]

In 1970, the Social Assistance and Rehabilitation Division declared that,

> ... the Department participates with the Department of Manpower and the Health Branch in local rehabilitation committees, the purpose of which is to co-ordinate the rehabilitative services of the three Departments and other agencies on behalf of disabled and handicapped persons. The objective is to assist such persons to achieve the highest level of functioning possible, including self-care and employment placement. Because the process involved is time-consuming, it has not been practical to assist large numbers of persons by this means. (p. 18)

Finally, in 1971, the year in which the Department of Social Welfare was renamed the Department of Rehabilitation and Social Improvement, a regional administrator stated that,

> ... in a labour market in which the numbers seeking employment are far greater, than the jobs available, employers will pick the potentially abler and reject those who have major and possible even minor defects. No matter how strong their motivation for work may be, the physically handicapped, ... , often will be passed over not once but repeatedly. They will be barred from demonstrating, despite their handicap or record, they are capable of performing effectively. Many of them will simply not have a chance.
>
> But when jobs are plentiful it is much easier for the handicapped group to succeed, not only because employers are less critical, but

> because the marginal group realizes that others like them, and some possibly more handicapped, have succeeded in getting a job and performing satisfactorily. (p. 56)

The perception by the Social Welfare Branch that the physically disabled could be labelled as employable only if the market would bear it, had the following consequences. Firstly, it limited the policy options, other than financial maintenance, that were taken to deal with the unexpected consequences of employment in the event that it appeared likely. Secondly, this perception of the immutability of the employment market legitimated the taking of these limited policy options.

The conceptual category of boundary decisions has demonstrated the relationship between this aspect of the labelling context and the policy options that were taken.

Establishing Similarities and Differences with the Data from the Health Branch in British Columbia

Throughout the analysis of these annual reports, facts that indicated whether a certain type of labelling context was used to define the physically disabled did not emerge with the ease with which they had done so for other annual reports. Unlike the other three departments, the Health Branch did not label the physically disabled according to their employment status, nor did the branch label according to pathology. Rather the categorisation of the physically disabled appeared to be based upon the type of 'institution' that was currently available for use by this group. Institution in this sense includes programs and other social structures. It has been mentioned previously

that Blaxter identified the existence of administrative categories into which the disabled are often slotted. Thus even though the conditions under which the physically disabled were categorised were different from other departments, this still occurred within a societal labelling perspective or context, since labelling occurred as a consequence of the availability of social structures or institutions. The property of continuum did not emerge from this data.

Recognition of the needs of the physically disabled and action to meet these needs was contingent on there being an available service. Quotes taken from the annual reports to verify these statements are limited because the institutions themselves have been described in the chapter on boundary decisions. However one example in particular identified the Branch's categorization of candidates for their rehabilitation program according to the availability of services in the community.

For example, in 1956, the Rehabilitation Co-ordinator for the branch stated that,

> the productiveness of a rehabilitation programme is greatly dependent on the proper selection of suitable candidates for subsequent study and attention. However, this statement must be qualified. Proper selection must also be related to the breadth and depth of service available in the community, and as the services broaden, the meaning of proper selection changes. Gradually as services develop, more applicants who present a difficult picture can be considered. A year ago certain applicants would necessarily have been deferred. To-day some are being accepted ... Acceptance of referrals, however, is not decided on the basis of a certainty that a successful closure in terms of gainful employment and financial independence will result, but whether the particular service that the individual needs

> is available.(Department of Health and Welfare, Health Branch, Annual Report, 1956, p. 129)

Categorising the physically disabled according to existent structures, and not according to information concerning their needs, automatically legitimated those boundary decisions that had been taken, and that are described in the following chapter.

Notes to Chapter Five

[1]Weber, M. 1964. The Theory of Social and Economic Organization. edited by Talcott Parsons, and first printed in 1947. New York: The Free Press quoted in Handelman, D. and Leyton, E. 1978. Bureaucracy and World View: Studies in the Logic of Official Interpretation. Memorial University of Newfoundland: Institute of Social and Economic Research.

[2]Alberta, Department of Public Welfare, Annual Report, for the Fiscal Year Ending 31st, March 1946, p. 4; 1947, p. 6; 1948, p. 7; 1950, p. 11; 1951, p. 11; 1952, p. 10; 1953, p. 11.

[3]Idem, 1946, p. 2,6; 1947, p. 2; 1948, p. 7.

[4]Idem, 1948, p. 7; 1949, p. 10; 1950, p. 11; 1953, p. 11.

[5]Idem, 1948, p. 3; 1950, p. 9; 1952, p. 9; 1953, p. 8; 1954, p. 8; 1955, p. 8; 1956, p. 8.

[6]Idem, 1960, p. 10; 1961, p. 11; 1962, pp. 18,19.

[7]Idem, 1968, p. 15; 1969, pp. 14,15.

[8]Idem, 1945, p. 2; 1946, p. 2; 1947, p. 2; 1949, p. 8; 1950, p. 9; 1952, p. 9; 1953, p. 8; 1954, p. 9; 1955, p. 9; 1956, p. 9.

[9]Ibid.

[10]Idem, 1956, p. 48; 1957, p. 49; 1958, p. 47.

[11]Idem, 1959, p. 43; 1960, p. 38.

[12]Alberta, Department of Public Health, Annual Report, 1951, p. 54.

[13]Ibid.

[14]Idem, 1953, p. 17; 1954, p. 16.

[15]Alberta, Department of Health and Welfare, Social Welfare Branch, Annual Report, for the Fiscal Year Ending March 31st, 1950, pp. 23,24.

[16]Idem, 1968, p. 41; 1969, pp. 40,41.

CHAPTER SIX

BOUNDARY DECISIONS FROM 1945 to 1972

Preamble

In the introduction to this study, policy was defined as the adoption or maintenance of a course of action. No attempt was made to locate it within a particular sphere of policy. However, since the established literature on policy must be taken into consideration, several distinctions concerning the terminology that was used have been made.

Typically, policies that are carried out within the jurisdictions of health and of welfare organizations, are referred to as social policies, though often in the literature they are discussed as social welfare policies. Social programs that are identified as being within the realm of social welfare are also identified as social policies. Although there is no agreed upon definition of social welfare (used interchangeably with social policy), perhaps Kamerman and Kahn (1975) have provided the most functional description of basic social programs included within its framework. These have been listed as income maintenance, health, education, housing, employment and personal social services. Macarov (1978, p. 10) has stated that the latter include child care and placement, services for the elderly,

family welfare, services for the disabled, and help to other disadvantaged groups.

This study has partialized social policy by examining only one of its aspects, that of the particular policies that had been developed for the physically disabled. The emergence of the category of boundary decisions indicated the existence of basic concepts that underlaid and affected policy making for the physically disabled within the provincial governments. In order to elaborate on the relevance of this category as an explanation about the factors that determined the priority that was attached to the issue of the physically disabled, it is appropriate at this point to relate it to a wider context. For these purposes, two contextual levels of interest have been contrasted; the level of social philosophy that underpins conceptualizations of the functions of social policy (which are not nation bound); and the substantive development of social policy in Canada.

Titmuss (1963) declared that without more knowledge of both the needs of a changing society and the social services actually provided, a better relationship between the two could not be achieved. He suggested that it is vitally important to question the ends actually attained, in relation to the ends that institutions of policy delivery are intended to attain. The actual ends of a social policy may be linked directly to the particular conceptualization of social policy function that is held by decision makers. In the next section, the main findings from the analysis of the conceptual category of boundary decisions have been summarized and related to different models of

social policy function.

Models of the Function of Social Policy

Three dominant models of the functions of social policy have been described in the literature - the institutional model, the residual model, and the handmaiden model. Each of these are underpinned by different social philosophies.

Pinker (1979) has stated that the institutional model of social welfare policy treats collectivist intervention in the form of social policy as the most desirable end-product of political action. Priorities become ordered and resources allocated by reference to a criteria of need. The latter is based on the welfare ethics of a social market in which the hallmark of good citizenship is the unilateral transfer from one person or group to another.

One of the principal proponents of this model of social policy was Titmuss (1974), who emphasized the redistributive function of social policy. He saw social policy as a "major, integrated institution in society, providing universalist services outside the market on the principle of need" (p. 31). Boulding (1976, pp. 15,16), like Titmuss, made explicit the distinction between this conceptualization of social policy and economic policy. Boulding defined the objective of social policy as that which builds the identity of a person around some community with which he is associated, so that social policy is that which is centered in those institutions that create integration and discourage alienation.

Titmuss (Pinker 1979, p. 50) rejected that the competi-

tive and self-interested values and processes of economic market exchange provided a sufficient or satisfactory basis for social integration. He formulated the notion of social market as that which was governed by a superior morality to that of the economic market; thus needs were to be met by gifts (unilateral transfers), whereas in the economic market needs were met through exchanges or bilateral transfers. Armitage (1975), who is a Canadian, also has adhered to this model of social policy.

The residual welfare model is based on the premise that an individual's needs are most properly met through the private market, mutual aid, or the family. Only when these have broken down should social welfare institutions come into play and then only temporarily. This model also holds that the individualistic forms of self-help are the most morally commendable. Priorities are ordered and resources allocated accorded to the criterion of price and justified by the work ethic of an economic market.

This model views social services as imposing burdens on the productive forces of capitalism. Historically, philanthropy has stepped in to take up where institutions left off. Pinker (1979) has suggested that the basis of this relationship is the economic motivation of those who act out of self-interest, "enlightened though it may be rather than altruism" (p. 33).

Certainly, the basic principles of these two models as well as their modus operandi conflict with each other. However, while Titmuss's model concentrated on policy as a redistributive tool, it did not acknowledge that the enhancement of social welfare depends equally upon the production and distribution of goods.

This complementarity between production and redistribution has been acknowledged in the third perspective on social welfare policy. Titmuss (1974) called this the Industrial Achievement-Performance Model, while others have described it as the Handmaiden model. It incorporates a significant role for social welfare institutions as adjuncts to the economy. Pinker (1979), like Gil (1970), has suggested that the values of the economic market should not be too easily differentiated from the values of the social market. He argued that the social market must be seen to function as an agency of distribution, but that its material scope and normative autonomy would always be prescribed by the nature of the productive forces operating in the economic market. The latter embodies the values of a mixed economy, in contrast to the residual model that is most closely aligned with laissez-faire values, and the institutional model that follows the precepts of a command economy, in which the state intervenes in major decisions concerning resource allocation. At this point, it becomes necessary to relate these theoretical and ideal models to the development in Canada of its own social welfare ideology as well as to the conceptual category of boundary decisions.

Social Policy within the Canadian Context

Although several Canadian writers (Turner 1981, p. 4; Guest 1980, p. 19; and Armitage 1975, p. 205) have recognized the existence of a tension between the values of economic freedom and individual responsibility, and the 'humanitarian' values of the social welfare ideal, they have asserted that Canada has

shifted from the residual approach to social welfare policy (predominant before the Second World War), to committing itself to the institutionalization of the rights of individuals to demand help on the basis of need.

The health related policies of hospital insurance and medical care insurance have been described as meeting a collective need for protection against the risks of illness. The income maintenance policies of the Canada Pension Plan claim to meet a similar need for protection against the hazards of retirement and old age, as well as sudden disability and widowhood.

With the introduction of these plans, in the fifties and sixties, policies that had once taken care of the needs of the physically disabled apart from the general public, were assimilated. Thus the physically disabled were included in the universal coverage of the health plans, and more selectively under the pension plan. These policy events have been mentioned only briefly in the analysis of the data bearing on boundary decisions, for they are more relevant to the conceptual category of contextual constraints.

These three major programs of which the disabled became recipients, appear to be underpinned by the philosophy of the institutionalized concept of welfare. However public assistance policies of a residual nature were also identified in the analysis of the annual reports. Up until the late seventies in Alberta and earlier in British Columbia when guaranteed annual incomes (not pensions) became available to the disabled, income maintenance was provided, first, as a supplement to those who could not live on their disability pension, and then as a safety net for those

who did not meet the requirements of the Canada Pension Plan, according to their need.

Other than these two policy types, a third type called positive allocative was identified as a property of the category of boundary decisions, and reinforced by the categories of labelling and valuation contexts. These three categories were linked together by properties that had a common underpinning of an utilitarian principle. These policies, distinct from those that became institutionalized and those that were residual, were taken within the functioning of the four departments because they met economic criteria. Strong economic values, whose existence is substantiated in the following chapter on valuation contexts, (in British Columbia, a humanitarian value was secondary in importance) underpinned the decisions to take these policies, as did the labelling of the physically disabled within an employment context that was concerned with production and investments in the future. The proposition that has emerged from the inter-relationships of these three categories is that policy making for the disabled has only been considered to be within legitimate boundaries of state intervention if the policies met economic criteria. The Handmaiden model of social policy appears to be congruent with the ends actually intended, and actually achieved for the disabled from 1945 to 1972.

If the institutional model of social policy was adhered to by Canadian decision makers, then surely the needs of the disabled would have been considered a priority since they have many needs that have been described in the literature since 1945. Marsh (1980) has stressed that social policy is concerned with

those services that are provided for no other reason than that of improving or maintaining individual well-being. The examples that have been cited in the analysis identified many instances when policies, such as those for vocational rehabilitation, specific treatments for the pathologically defined disabled, home care, to name a few, were legitimated using criteria based on some future return on investment for the state. Social policy of an institutional nature is also assumed to be centered in those institutions that create integration and discourage alienation. Obviously while the policies may have desired to encourage integration of the physically disabled into the community, they certainly did not create it. A type of boundary decision called negative structural selective was identified by the property of boundary spanning mechanisms that when put into place did not allow comprehensive integration to take place.

Creating integration also carries with it the idea that attention is paid to changing the environment to facilitate true integration. The quotes from the annual reports indicated that effort was directed towards modifying or attempting to correct the individual problems of the disabled instead. For example, while attempts were made to improve the employability of the disabled, attempts were not made to require employers to hire disabled individuals who were sufficiently qualified.

This conceptual category also drew attention to the exclusive as well as the inclusive features of policy making for the disabled, through the type of boundary decision called negative structural selective. These types of policies, that were not considered to meet economic criteria, fell to the

voluntary sector or the philanthropists thus fulfilling the residual conception of social policy function. The data bearing on this category has illustrated how the residual model of social policy was created and reinforced through the operation of institutional practices in the form of boundary spanning mechanisms. In accordance with Perrow's (1972) assertion that "organizations are multipurpose tools for shaping the world as one wishes it to be shaped" (p.13), the particular organizational design of each department provided the means by which the decision makers' particular definition of social policy function was imposed on the policy making process.

Through these mechanisms, issues that had the potential to create observable/manifest conflict between the physically disabled as a group and/or their advocates, and policy makers were kept out of the arena of political debate. Lukes (1974, p. 23) has suggested that the most effective use of power is to prevent this manifest type of conflict from arising in the first place. What may be intimated from the analysis of the data however, is that a contradiction existed between the power that was exercised and the real interests of the physically disabled that were excluded from the functioning of these four departments.

The aim of the ensuing sections has been to verify the existence of this conceptual category and its properties, by presenting the facts that emerged as indicators of them, for the four different provincial departments.

Establishing Similarities among the Data from the Department of Public Welfare in Alberta

Introduction

" ... one dominant strategy for maintaining organizational-environmental relations is the choice of domain; a choice that creates the need for additional strategies to enhance and maintain the legitimacy of the organization's claim to that domain" (Miles 1980, p. 282). This department's choice of domain and strategies to maintain that domain was characterized by the emergence of three different types of boundary decisions.

Each type has been described briefly in order to provide an introduction to the general boundaries within which the Department operated. Following this, the detailed analysis of each type of decision has been presented according to their characteristics as designated by their individual properties.

The first decision took in that group of general assistance policies that was based upon the residual poor law category into which the unemployable physically disabled fit. These policies were concerned with establishing a baseline for equality of condition among the various groups in this residual category using systems of unilateral transfer.

The second type represented those policy decisions that were perceived to be feasible to the decision-makers because they were based upon the use of positive allocative selection mechanisms. Navarro (1976, p. 447) defined these as the type of intervention that was made by the state that regulated and coordinated resources that had already been produced and that

ultimately determined a positive response to overall economic growth.

These two types of boundary decisions were differentiated by recognizing that they took within their functioning, those physically disabled who were allocated status on the employment continuum as either unemployable/unemployed or potentially employable. The positive allocative boundary decisions that were made separated out for attention those of the physically disabled who had the potential ability to make good use of resources to be allocated to them, from the chronically and/or severely permanently disabled clients for whom continuous support but not solution to their problems was feasible.

The former sub-group had certain positive allocative boundary decisions made in their favour, such as the provision of rehabilitative services, whilst the residual sub-group of the physically disabled was relegated to relying upon public assistance measures for their livelihood. The following example confirmed that, within the perspective of the Department of Public Welfare, public assistance was considered to be a legitimate approach to supporting those of the physically disabled identified as problematic.

In 1961, the Public Assistance Branch stated that,

> ... social allowance will be given to those persons who are older or handicapped in a way that will make rehabilitation difficult and in the majority of cases impossible. (Alberta, Department of Public Welfare,Annual Report for the First Year Ending 31st, March, 1961, p. 12)

It was more accepted to make investments in the policies taken within the positive allocative boundary decisions, than

within that category of residual boundary decisions. The distinction that has been made here, between these two types of boundary decisions, has been supported with further evidence from the annual reports.

The last type of boundary decision was taken in order to regulate the boundaries that were established by the former two types. It was based upon the use of negative structural selection mechanisms that operationally excluded from consideration those alternative boundary decisions that were not deemed to be economically viable for the state (Navarro 1976, p. 448).

Residual Boundary Decisions

The Department of Public Welfare took within its functioning those policies that were concerned with the provision of some kind of general public assistance to that residual class of unemployable persons who were unable to obtain the basic necessities of life for themselves.

Although the organizational design of the assistance program varied during the time period in question, the following examples verified the existence of this type of boundary decision and, that it was based upon establishing a minimum of equality of condition for those identified as unemployable. This emerged from the data as a property of this type of boundary decision. The property of scope provided another common thread that linked together the various different factual data taken from the annual reports. The scope of these residual boundary decisions limited those policies that were taken by the Department to the provision of financial assistance, only, for the amelioration of the

problems of the physically disabled that were enhanced by their unemployable status. In the Department of Public Welfare, this was accomplished directly through cash or in-kind programs, excluding direct service provision. The following examples illustrated these points.

In 1945, the Department was responsible for funding a wide array of in-kind and cash programs for the unemployable group, and stated that, "the demand for indigent services including hospital and medical attention continues to show an increase ..." This trend was due to "the desire of the Government to extend its service to better the conditions of people who are actually in need of assistance" (p. 2).[1] At this time, the Minister of the Department of Public Welfare remarked that,

> as far as Direct Relief is concerned, provision has been made to assist those of our population who, owing to reasons beyond their control, are unable to obtain the necessities of life ... Due to employment being available for all physically and mentally fit persons, practically no assistance was required for those in this category. Some help was given to the partially unfit, and in cases of temporary sickness, but the greater part was given to the aged and infirm, who will remain public charges indefinitely. Medical attention and hospitalization was also provided. For those totally unfit to care for themselves, even though financial assistance might have been provided and who had no one to look after them, provision was made for their care in private nursing homes, Salvation Army Hostels, St. Joseph's Hospitals, MacLeod General Hospital and other institutions of a similar nature. (1945, p. 48)[2]

In 1948, the Bureau of Public Welfare that at that time administered the public assistance measures stated that,

> ... help had to be given to the partially unfit and in cases of temporary sickness but the greater part was for the care of the aged and infirm, who due to their various disabilities, had to be provided with the usual necessities, and to those requiring them, medical and hospital services. (p. 7)

On June 1, 1953, these public assistance measures were augmented with the introduction of the Disabled Persons' Pensions by the Government of Alberta. The Pension Board stated that,

> ... to be eligible for this pension a person must be 21 years of age and must have 10 years residence in Alberta immediately preceding the date on which the application for pension is made. No supplementary allowance is paid to pensioners and no provision is made for Hospital and Medical Services. (1956, pp. 36-37)

The provision of aid to that residual category of needy persons, that included the physically disabled, appeared in the following examples. In 1959, the Department stated that "financial assistance is provided to those in need through the various pension programs and public assistance" (p. 7). During 1960, the administration of this financial aid through public assistance and/or pensions underwent a significant change. An amendment made to the Public Welfare Act enabled the provision of a Social Allowance either "in the form of vouchers or cash" to "be paid to or in respect of a resident in an amount sufficient to enable the resident to obtain the basic necessities of himself and his dependents in any ... for the purpose of ensuring that no resident of Alberta lacks such things, goods and services as are essential to this health and well-being, including food, clothing, shelter and essential surgical, medical, optical, dental and other remedial treatment, care and attention ..." These payments were to be provided at a level that was "recognized as a minimum

for the community" (p. 10)[3].

This program came into effect on June 1, 1961. The purpose of assistance was to "provide needy people with financial assistance necessary to ensure a minimum level of health and decency" (1961, p. 7). In the annual reports from 1963 to 1969 one of the main functions of the Public Assistance Branch was described as the provision of "financial aid ... to those persons for whom the Provincial Government has accepted responsibility and who are in need, in order that they may live at a minimum level of health and decency ..." (1963, p. 9)[4].

Positive Allocation Boundary Decisions

The property of condition identified underlying uniformities among the data bearing on this aspect of the conceptual category. Thus it emerged from the data that this type of boundary decision allocated resources to allow the operation of service policies for the physically disabled that fit the condition of providing an economic return. These boundary decisions were conceptually different from the first type in two respects. The residual category of boundary decisions was based upon unilateral transfers whilst the second type operated with the expectation that employment would result and that this in turn would be a return on public money spent. Secondly, the scope of the positive allocative boundary decisions was wider. Not only was financial assistance provided as a means to an economic end, but individual case-work services were offered specifically to the physically disabled group within this boundary. Policies of this nature were subsumed under the broad label of

rehabilitation. The means that were chosen to carry them out become evident in the following examples.

The analysis of the annual reports indicated that as early as 1945, individual members of the Department of Public Welfare assisted in establishing potentially employable persons in jobs other than what could be arranged through the National Employment Office.[5]

In 1938 when the Poliomyelitis Sufferers' Act was passed in Alberta, the Public Assistance Branch gave financial assistance towards the vocational rehabilitation of physically handicapped persons qualifying under this act. Patients were provided with assistance towards vocational training or preparation in academic and secretarial courses.[6]

When the Rehabilitation of Disabled Persons Branch was established in 1954, its service emphasis was directed towards developing and providing employment or vocational training opportunities for the potentially employable disabled. The following examples verified that the orientation of the branch was towards those policies that had the potential to or would eventually evoke a return on public money spent.

In 1956 the Branch stated that "people suffering from a wide variety of disabling conditions have been successfully trained and re-established in gainful employment", (p. 47) and in subsequent years that, "a wide variety of disabled persons from all parts of the province applied to the Co-ordinator's office for assistance in re-establishing themselves in gainful employment following disease or accidental injury".[7]

In 1960, the rehabilitation program was described as

being available to persons sixteen years of age and over who had a

> ... reasonable chance of becoming self-supporting citizens through the services available. It is thus a vocationally-oriented program. It includes however, services to disabled housewives who may be returned to their positions as home-makers, thus relieving the family on public assistance funds of the burden of hiring a housekeeper. (p.37)

The Department of Public Welfare continued to operate a program of vocational rehabilitation specifically for physically or mentally impaired persons until November 1964 when the Rehabilitation Division was merged with the Social Allowance and Social Assistance Divisions. The emphasis changed from providing "vocational rehabilitation to the disabled to a program designed to assist as many families and individuals, physically disabled or not," as "was feasible within the resources of this Department and the potential of the recipients concerned" (1965, p. 8). Although the form of the program was altered, its focus on voc rehab remained firmly entrenched. Throughout 1967 to 1968,

> ... training of rehabilitees under the Rehabilitation Agreement continued to require approval of the provincial Training Selection Committee ... Within the period under review 115 handicapped persons were approved and enrolled for higher education or training, 28 of whom entered or continued in university. (1968, p. 44)

The next type of boundary decision illustrated how the Department maintained control over the process of selecting potentially employable candidates for vocational rehabilitation, whilst simultaneously allowing other government and private

agencies to provide the services and support a great deal of the cost. Although it was clear from the former type of boundary decisions made that policies for the physically disabled, specifically, were given priority only if they promised some economic return, the regulation of departmental boundaries by the following negative structural selection mechanisms allowed even this priority to become somewhat diffuse. Responsibility for the actual provision of vocational rehabilitation workshops or educational facilities for the physically disabled did not become a priority of the Department.

Negative Structural Selection Boundary Decisions

Miles (1980) has said that "the very existence of an organization depends on the regulation of its boundary" (p. 317). The analysis of the data indicated that boundary spanning designs were put into place to meet two conditions that would allow control to be maintained over the residual and positive allocative boundary decisions that were made concerning the physically disabled. These were: (1) to maintain linkages with the department's environment while simultaneously warding off those environmental influences that might otherwise have disrupted the primary purposes of their positive allocative boundary decisions; and (2) to confine the scope of both boundary decisions to the provision of financial assistance, along with limiting service provision to that of individual casework within rehabilitation.

Besides these conditions, the structural mechanisms (i.e. types of boundary spanning designs) that were utilized to

regulate the boundary, emerged as another property of this conceptual category. The following examples have verified the operation of a range of different boundary spanning designs for the Department of Public Welfare - a bargaining model, gate-keeping, co-ordinative devices, and coding of the boundary. The manifest consequence of utilizing these types of negative structural selection mechanisms, also emerged from the data.

Bargaining

As early as 1949, the "so-called bargaining model" (Agranoff 1977, p. 21) was employed by the Department of Public Welfare to achieve an exchange of services between other government departments and the private voluntary sector. This mechanism permitted the delegation of operational responsibility for various aspects of the rehabilitation programme to these external groups. The Public Assistance Branch handled matters pertaining to the granting of assistance with respect to rehabilitation under the Poliomyelitis Sufferers' Act, while the Department of Education actually operated the service. In 1953, the Branch stated that,

> physically handicapped persons qualifying under the Poliomyelitis Sufferers' Act continued to benefit by this scheme. In this particular aspect of our work we were greatly assisted by having many of the people accepted under the Vocational Training Scheme, administered by the Department of Education. (p. 11)

Although the Rehabilitation of Disabled Persons Branch operated within the organization of the Department of Public Welfare, the responsibility, both for carrying out the selection

process and planning rehabilitation services, was not within only the Department's jurisdiction. The Branch described the mechanism that was employed to decentralize authority.

> ... an Interdepartmental Rehabilitation Committee consisting of the Deputy Minister of Public Welfare (Chairman), the Assistant Deputy Minister of Health, and the Regional Director of Canadian Vocational Training, Department of Education ... serves two functions at the present time. The first of these is dealing with applications from persons seeking rehabilitation services under the program. The second function is planning for the provision of adequate rehabilitation services in Alberta.
>
> A training selection Committee ... composed of a Canadian Vocational Training representative, a National Employment Service representative, and the Provincial Co-ordinator of Rehabilitation ... (1955, p. 43)

approved applications for training from disabled persons.

Both the Department of Education and the National Employment Service played a major role in the provision of rehabilitation services to the physically disabled. The Rehabilitation of Disabled Persons Branch stated that,

> excellent co-operation continues to be received from the Canadian Vocational Training Branch of the Department of Education in providing training for disabled persons. Correspondence courses are also provided under the Rehabilitation program. General education courses are provided through the Correspondence School of the Department of Education, with the Department of Welfare buying textbooks in needy cases. Vocational Correspondence courses are provided through Canadian Vocational Training. (1956, p. 47)[8]
>
> The Department of Education pays the cost of tuition in any approved course, and will pay maintenance allowances if the trainee's circumstances so warrants. (1957, p. 48)
>
> Under the Co-ordination Agreement, the National Employment Service accepts the responsibility

> for the placement of cases under the Rehabilitation Program. The Special Placements Section of National Employment offices, where such sections exist, handles the actual cases. (1956, p. 48)[9]

The Branch directed some of its efforts towards bargaining for improved employment placement services in the province's rural areas. In 1958, and mentioned again in 1959, the Rehabilitation Co-ordinator stated that,

> it continues to be obvious that these placement services are almost completely inadequate to meet the demands placed upon them by the rehabilitation program. The service is especially weak in rural and village cases not close to a local office of the Employment Service. The officers detailed to do the Special Placement work are so overloaded that it is impossible for them to service the handicapped in the specialized, individual way that is required to find work. Strong representations from all provinces are continually being made to the Federal Government to improve the National Employment Service, but aside from a staff training program, no progress was noted in the year 1957-58. (p. 48)[10]

In an attempt to enlist the services of the Department of Public Health, "the details of the Rehabilitation Program were ... presented to the Public Health Nurses at their annual convention, in an effort to ensure early case-finding" (1959, p. 49).

The resources of voluntary organizations were also drawn upon by the Department, as the following examples illustrated.

> The Department of Public Welfare assisted in some cases with the cost of supplies and equipment for trainees, and by arranging for the Canadian Foundation for Poliomyelitis to pay for transportation costs for seriously disabled trainees. (1958, p. 47)

More specifically, the Department of Public Welfare identified the voluntary agencies as having complete responsibility for the setting up of and operation of rehabilitation workshops for the disabled. The government offered them some financial support.

> In September, 1955, the Rehabilitation Society of Alberta for the Handicapped was incorporated by provincial charter. This represents the amalgamation of the three branches of the former Alberta Association for the Handicapped and the Edmonton Rehabilitation Society. The Rehabilitation Society of Alberta for the Handicapped now operates rehabilitation workshops for disabled persons in Edmonton and Medicine Hat, and a workshop is under construction in Calgary. Financial support from the Department of Public Welfare was under consideration during the period of this report, on the understanding that this would be provided for assisting in the operation of rehabilitation workshops under the Rehabilitation Society of Alberta for the Handicapped. The Rehabilitation workshops provide a valuable centre for the building up of work tolerance after lengthy hospitalizations, and the restoration of confidence through craft work and mixing with other disabled persons. (1956, p. 48).

In 1957, the Branch announced that the Rehabilitation Society of Alberta for the Handicapped had made great strides in the provision of rehabilitation services.

> Rehabilitation Workshops were opened in Calgary and Lethbridge, chiefly as a result of vigorous support at the local level from service clubs and a Homebuilders' Association. The opening of these two workshops brings to four the number operated by the Society in Alberta. The Edmonton Branch Workshop continued to operate at full capacity most of the year, and the Medicine Hat Workshop moved to new and more suitable quarters provided by the City of Medicine Hat ....
>
> The Workshops carry on varied activities such as craft work, sewing, radio repair, public stenography, custom book-keeping, telephone-

> answering service, and provision of transportation of disabled persons to and from medical treatments or training classes. In addition, a vigorous program for the homebound is carried on in all four centres. This program organizes and markets sewing and knitting projects made by persons too disabled to come to the center. (p. 49)

In 1959, the Branch stated that,

> the Workshops operated by the four Rehabilitation Societies continued to function during the fiscal year, each of them being partially subsidized by the Provincial Government, Department of Public Welfare. The Edmonton facility again proved to be the most useful, from the standpoint of providing work-assessment, work-adjustment, and terminal-employment services. In Calgary, the Calgary Rehabilitation Council met with limited success as a tool to co-ordinate services in that area. Although each of the shops made valuable contributions in providing sheltered and home-bound employment to disabled persons, it was felt that these were still in experimental stages, and it was really too early to evaluate their effectiveness in the total rehabilitation program. The Government, however, still feels they are organizations worthy to support, and an operational grant of $10,000 was again made available, and was distributed to each Society ... (p. 45)

In 1960 to 1961,

> the Provincial Government continued its support to the four Workshops operated by the Rehabilitation Societies of Edmonton, Calgary, Lethbridge and Medicine Hat, to assist them with their programs of work adjustment, and training, and sheltered employment. There was an increase in the total number of persons attending the Workshops, and a corresponding increase in the total grant paid by the Province over the previous fiscal year.[12]

In 1962, "an increasing number of rehabilitation applicants were referred to these workshops" by the Branch "for assessment purposes, vocational adjustment and periods of sheltered employment" (p. 24)[13]. In 1964, the Rehabilitation Division remarked that "there has been a marked expansion in the

sheltered employment area in Edmonton since the Rehabilitation Centre started its Goodwill enterprise" (p. 41). The role of sheltered workshops was made explicit at a meeting held between the Provincial Co-ordinators of Rehabilitation for all provinces in 1965.

> Two points in particular that arose at this meeting were standards and definitions of workshops, and grants to support them. The meeting held that there are essentially two operations which can be performed by sheltered workshops; remunerative sheltered employment and assessment and work training. Referring to the second point it was also agreed that it is the role of Federal and Provincial Governments to establish minimum conditions for grants to sheltered employment, and that the Civilian Rehabilitation Branch should proceed to set up such standards with whatever consultation it sees fit to request. (p. 46)

The implication of this statement was that the department had the power to limit its involvement with the actual operation of rehabilitation workshops, while control was maintained over them by making grants available on the condition that they met certain criteria.

The Department of Public Welfare also attempted to employ the bargaining model in an effort to acquire medical rehabilitation services from the Department of Public Health. Medical rehabilitation was considered to be part of the total rehabilitation process. In 1955, the Rehabilitation of Disabled Persons Branch stated that,

> administration of funds for these purposes would fall under the Department of Health. Up to the present there are no funds available for this phase of the rehabilitation program other than those already available prior to the commencement of the Branch's operations. Funds from the Medical Rehabilitation Grant of the Federal Government have been used for the purchase of rehabilitation equipment for hospitals in the

province. (p. 43)[14]

The provision of medical rehabilitation services continued to be perceived as a responsibility of the Public Health Department. In 1956, the Branch stated that the provision of funds for medical services "continues to be held in the 'Deferred' category of the administration of the Medical Rehabilitation Grant which is under the jurisdiction of the Department of Public Health" but that "the Co-ordinator's office continually receives requests for services in this field. Most of the requests are for artificial limbs and physical medicine procedures such as physiotherapy, hydro-therapy, remedial gymnastics, and others. In some cases the Rehabilitation Branch has been able to interest private clubs and organizations in paying for such services, but has been unable to provide them directly through public funds". (p. 47). By 1958, it was necessary to provide funds for the costs of these medical services, although at the time the department did not accept responsibility for total costs.

> The municipal district in which the applicant resides is first approached to determine whether or not it will share in the cost of a public assistance measure. If the municipality agrees to the proposal, it bears 20% of the cost and the province bears the remaining 80%. In most cases, the municipalities have accepted their share of the costs for specific cases.

The Branch made it clear that "the payment for these services under the Department of Public Welfare is considered an interim measure until the Department of Public Health establishes its planned medical assessment units for the rehabilitation program.[15]

In 1960, the Branch remarked that,

> although funds were appropriated by the Department of Health during the period under review for the

> purpose of establishing Assessment Units for the Rehabilitation program, these Units were not put into operation as had been hoped. The Rehabilitation Branch thus continues to obtain medical examinations and reports, treatment where necessary, and prosthetic appliances continues to be a joint provincial-municipal arrangement under Public Assistance regulations. In some cases service clubs have provided the necessary funds for such appliances. (p. 38)

Clearly, the Department of Public Welfare endeavoured, albeit unsuccessfully, to press the delivery for medical rehabilitation services upon the Department of Public Health. (See the following section for discussion of their own boundary decisions.) When this failed, the resources of the voluntary agencies were tapped.

Gate-Keeping

Another facet of the boundary-spanning design for regulating the Department's boundaries emerged from the analysis of the data for 1959. Once applications for rehabilitation services were filtered through the initial boundary of the Rehabilitation of Disabled Persons Branch, the training selection committee, they were processed further by a person who occupied a gate-keeping role that was designed specifically to increase the selectivity of the intake process for establishing the physically disabled in employment. The following example illustrated this point.

> Due to the relatively low proportion of applicants being placed in employment, serious consideration was given during the period to the detailing of a Rehabilitation Officer to placement duties. However, it was decided instead that strong pressure should be brought to bear on the Minister of Labour to detail a placement officer from National Employment Service, Ottawa, and the Department of Public Welfare concerning

> the improvement of placement services. These talks led to agreement on the appointing of an Employment Liaison Officer of the N.E.S. in Alberta. Through regular case conferences, this officer will have early access to information obtained by the Department of Public Welfare which still will assist in placing the person in employment. In addition, the E.L.O. will formally accept on behalf of N.E.S. all cases which have placement potential. The Local offices of National Employment Service will report once a month to the Employment Liaison Officer the placement action taken by the office on cases referred by the E.L.O. The Rehabilitation Division will be informed of the action each month. It is hoped that these procedures will result in more effective placement services for the handicapped. (p. 38)

In October, 1960, an Employment Liaison Officer was appointed by the N.E.S. to fill the above position. To deal with the referral of cases from the Training Selection Committee "for which vocational training, and/or selective placement services" could "be reasonably expected to lead to placement in gainful employment" (1960, p. 37) the Employment Liaison Committee, comprised of the Employment Liaison Officer and Supervisor of the Rehabilitation Divisions was formed. Thus another level of gate-keeping was added to the selection process for physically disabled clients, who were deemed to be potentially employable.

The Co-ordinator of the Rehabilitation of Disabled Persons Branch also functioned in a gate-keeping role through his co-position as Supervisor of Disabled Persons' Allowances. He ensured "that the applicants for this Allowance or for the Provincial Disabled Persons' Pension" were "screened for possibilities of rehabilitation ... Some of these pensioners" were "trained or placed in direct employment". (1956, p. 48).

Co-ordinating

Another boundary spanning mechanism was developed to

link the Department with its environment. A co-ordinated model was implemented that left the organizational authority for delivering rehabilitation services to the existing departments and agencies while creating a new function to co-ordinate the activities of these groups. Thus in 1956, the Rehabilitation of Disabled Persons Branch stated that,

> all health and welfare agencies in Alberta showed an increasing interest in the rehabilitation program during this fiscal year, and have expressed their approval of the centralization of government services for the disabled through the Rehabilitation Branch. (p. 48)

The Branch recognized that "rehabilitation services in Alberta contain many strong and effective non-government programs, some of long standing. In addition, new societies and agencies are springing up constantly, usually directly towards providing service for a specific disability (1960, p. 39).

The position of Co-ordinator was established to carry out this co-ordinative function. The Branch's mandate to develop co-ordination of the rehabilitation work done by voluntary and other government agencies was carried out by a Provincial Advisory Committee that was chaired by the Co-ordinator. It was formed in 1955 and had as its members all those government and voluntary agencies interested and active in rehabilitation. It was "planned to have this advisory Committee meet periodically to discuss the advancement of the work of the co-ordination in order to minimize or prevent overlapping and duplication of rehabilitative services" (1955, p. 44). In 1959, as a result of discussions held by Alberta's Ministers of Health, Welfare and Education, it was decided "to constitute the Provincial Advisory Committee on Rehabilitation as a formal Government Advisory

Committee, under the name of the Provincial Advisory Council on Rehabilitation. Five members of the Advisory Committee were nominated to work with the Interdepartmental Rehabilitation Committee of the Government to plan for the Improvement of Rehabilitation Services" (p. 45).[16] "The major emphasis in the government program" was "to encourage all rehabilitation work in the voluntary field in Alberta to be channeled through the Rehabilitation Society of Alberta for the Handicapped" (1957, p. 49).

In 1963, the function of the Provincial Co-ordinator of Rehabilitation for co-ordination of services relating to vocational rehabilitation was described as follows.

> (1) To encourage the provision of adequate remedial and educational services for disabled children, and continuity of services on their reaching adolescence, so that in due course they may proceed into programs of vocational rehabilitation ...
>
> (2) A further requirement of co-ordination is "to encourage voluntary agencies to define their role and purpose as it affects the disabled and relates to the overall (rehabilitation) program." The Co-ordinator attended the annual meeting of the Alberta Council for Crippled Children and Adults and other meetings of this organization and The Rehabilitation Council of Alberta for the Handicapped, and the executives of the Edmonton and Calgary Councils of Community Service.
>
> (3) Another area of responsibility of the Co-ordinator is that of Chairman of "a committee of representatives of the Provincial Government concerned with man-power, the health, welfare and education of the people of the province to assure co-ordination of their efforts as they relate to the vocational rehabilitation of disabled persons, viz, the Provincial Department of Labour, Public Health, Public Welfare and Education". (p. 19)[17]

In ensuing years, co-ordination,

centered on extending communication between the

> Department of Public Welfare and other departments of government, voluntary welfare organizations and service clubs, and the four Rehabilitation Societies ..., co-ordination aimed to serve various provincial and national organizations, as well as to assist departmental administrations. Among the latter was the Social Service Division of Glenrose Provincial General Hospital for Multiple Handicapped Children, for whom the Department of Public Welfare has undertaken assistance for the eighteen to twenty-one year-old patients on their being released from Glenrose, and in due course, from Foothills Hospital, Calgary. These young people will receive prosthetic appliances and further vocational training under the provincial rehabilitation program.
>
> On the provincial level the Co-ordinator met with the Boards or Executive Directors of three rehabilitation centres, ..., and assisted each to get grants to expand its facilities and to improve upon its services. Also, these societies and Edmonton Rehabilitation Society, were encouraged to reorganize the Rehabilitation Council of Alberta to resume joint action in areas of mutual concern, viz., methods of referral, guidance and counselling, workshop standards, training, placement and follow-up procedures, fees for service, financing and evaluation of programs.[18]

The implementation of these three different boundary spanning designs had the manifest consequence of reinforcing the department's intentions of shifting the responsibility for the operation of certain services for the physically disabled away from their own boundaries and into the domain of other public agencies, and especially, the private voluntary sector.

This conclusion has been verified by the following statements made by the Public Assistance Branch from 1958 to 1959.

> The Rehabilitation Branch established to aid the physically handicapped ... While its services are basically limited to co-ordinating efforts of voluntary groups working on behalf of disabled persons, it has been able to locate direct employment for many who have sought its help" (1958, p. 12), and
>
> Provision is made under the Public Welfare Act

> whereby disabled persons can be assisted both economically and through vocational training by assisting and co-ordinating rehabilitation projects for them. (1959, p. 10)

Coding

Coding the boundaries with sets of intake criteria was another mechanism employed by the Department to ration the resources allocated to the physically disabled within both sets of boundaries.

Within the residual boundary decisions that were made, different criteria were developed for each specific policy. A number of examples verified this point.

Applications for provincial Disabled Persons' Pensions were coded by the Pension Board according to the circumstances of the individual. These circumstances restricted eligibility to those persons who "attained the age of 21 years" (later lowered to 18 years) and who "resided in Alberta for the 10 years immediately preceding the date on which the application" (1954, p. 33) was made. The Board stated that,

> this pension is paid according to income and the income value of assets. A single person is entitled to a pension providing his income or the income value of his assets does not exceed $720.00. A married person is eligible for an allowance providing the income or the income value of assets does not exceed $1,200.00. (1955, p. 36)

On April 17, 1958, an amendment to the Disabled Persons' Pensions Act was assented to "whereby the person who had not had ten years residence immediately preceding the date of the proposed pension payment ... must have been present in Canada prior to those ten years for an aggregate period equal to twice the

aggregate period of absence from Canada during the ten years" (1958, p. 9). Applications were also rejected if the applicant was in receipt of pensions under the Old Age Assistance Act, Old Age Security Act, Widows' Pension, were older than sixty-five, or were in a public institution.

Evidence from the 1959 annual report, that described the introduction of the Disabled Persons' Act by the Federal Government, indicated the existence of a gate-keeping mechanism that regulated the intake of physically disabled by coding the Act's own boundaries with a certain set of criteria. The Pensions Board stated that,

> to be eligible under the Disabled Persons' Act the allowance must be approved after a recommendation from a Medical Review Board. The applicant must have reached the age of 18 and be permanently and totally disabled. (p. 38)

The income and residence requirements were the same as those for the Provincial Disabled Persons' Pensions, as was that portion of the Act that disqualified severely disabled persons from receiving the allowance who were so disabled that nursing care was a necessity and the pensioner had to be placed in a home or institution. In 1961 however, a recipient of the Allowance, while in institution, could also be paid for the month he/she was admitted and for the month in which release was made.

On the Medical Review Boards's recommendation, a Disabled Persons' Allowance could be approved by the Alberta Pensions' Board.

With the introduction of social allowances for that group of unemployable persons, that included the physically disabled, need was established on "an individual basis by the

deficit budget process". The Public Assistance Branch stated that,

> this will involve examining an applicant's income and expenditure and where it can be demonstrated that he does not have sufficient resources to meet his basic needs his income will be augmented to this extent.[19]

Prior to this means tests had been conducted.

Thus, four different types of boundary spanning mechanisms - bargaining, gate-keeping, co-ordinating, and coding - operated as integral, yet rather intangible, components of the organizational design of the Department of Public Welfare. These mechanisms were intangible in the sense that they could not have been identified from a perusal of the department's organizational chart. The implication of this elusiveness is that they would have been less amenable to change, since their very existence may not have been perceived by the physically disabled or their advocates.

The existence of these mechanisms has provided an illustration of the interaction or complementarity between policy making for the physically disabled and the organizational structure of a government department. In other words, without these boundary spanning mechanisms in place, control over the types of policies for the physically disabled taken within the department's functioning would have been difficult to have maintained. These mechanisms allowed non-decisions to be made according to, as was suggested in the preamble, the particular models of social policy function upon which the perceptions of the decision-makers rested.

Establishing Similarities among the Data from the Department of Public Health in Alberta

The analysis of the annual reports for public health indicated that the conceptual category of boundary decisions also described what types of policies were taken within the department's functioning and what types of issues were left outside of the department's functioning. The difference between these data and those from the Department of Public Welfare was that only two types of boundary decisions were made. These were positive allocative boundary decisions and negative structural selection boundary decisions.

Positive Allocation Boundary Decisions

This boundary decision allocated resources to provide case-finding, diagnosis, and treatment services to those diagnostically defined and treatable groups of the physically disabled that were identified in the chapter on labelling contexts for this department. Treatment was directed, more often than not, to the cure or alleviation of these pathologic conditions that prevented, or had the potential of preventing, children and young adults from entering the workforce. Thus these decisions also met the condition of providing an economic return on investments made. Compared to the positive allocative boundary decisions made by the Department of Public Welfare, the scope of Public Health's decisions was broader. The latter tended to concentrate more of its resources on the actual provision and operation of these treatment services. The following examples supported the case-

finding, diagnosis, and treatment orientation functions of the Department of Public Health's policies.

In 1950, the Department "established the first clinic in the Province for the diagnosis and treatment of cerebral palsy, 111 Dr. F.G. Day, an orthopaedic surgeon with special training in cerebral palsy was appointed director of this service..." (Alberta Department of Public Health, Annual Report, p. 27)[20] Clinics were held every Wednesday morning at which new cases referred by attending physicians, public health nurses, superintendents of schools, etc. from all over the province were examined by the orthopaedic surgeon. The 1951 report clearly stated that the clinic "tried to send non-cerebral palsy cases to the appropriate place for treatment" (p. 53).[21]

By 1956, two out-patient clinics in Edmonton and Calgary were in continuous operation. Both clinics were "complete units providing all the modalities of treatment recognized as being required for the complete therapy in this disease. Diagnostic clinics" were "held at weekly intervals ... to gather new cases and revise treatments in the older patients" (p. 57).

On April 1, 1953, the Division of Arthritis Services was transferred from the Department of Public Welfare to Public Health. This division also administered and delivered treatment and diagnostic services from two clinics, one in Calgary and one in Edmonton.[22] In 1967, the Division stated that it,

> continues to accept patients, ..., who are suffering from Rheumatoid Arthritis, upon referral by the patient's personal physician. Clinics are maintained (Edmonton and Calgary) for the purpose of investigation, diagnosis and recommendations regarding treatment. The patient is returned as quickly as possible to his physician with a detailed report covering the clinic

> visit. Hospitalization, medical care, corrective surgery, laboratory and X-ray examinations, physiotherapy and appliances, and the drugs used in the treatment of Rheumatoid Arthritis are all provided without charge to the patient.

It is recognized that, where an early diagnosis can be made, some of the deformities of this disease may be prevented or limited ... And it is equally true that when some of the financial burden, such as might be caused by expensive drugs, is lifted, earlier help may be sought by the patient (p. 90).[23]

In 1947, under the provision made for free treatment of persons suffering from paralysis due to poliomyelitis, patients were admitted to the University Hospital in Edmonton and the Junior Red Cross Hospital in Calgary.[24]

The Division of Hospital and Medical Services that administered the Poliomyelitis Hospitalization and Treatment Program stated in 1954 that the Poliomyelitis Sufferers' Act and Regulations,

> ... provides to residents of Alberta, stricken with poliomyelitis, a complete program of care. During the acute phase of the disease, isolation hospital care is provided for a period of 14 days, through hospitals that have entered into an agreement with the Province to make such care available, ...
>
> No medical care is provided during the isolation period. Following the 14-day isolation period, the Province provides all necessary hospitalization for those cases that have any residual paralysis or weakness, ... Recommended appliances are paid for directly by the Province". (p. 115)[25]

Later in 1960, it was stated that, " ... out-patient physiotherapy, muscle tests, and radiological examinations and other assessment procedures are available. Out-patient speech therapy and occupational therapy may be provided" (p. 60).

In 1958, another specific disease-oriented program was

launched under the Division of Medical Services. The Rheumatic Fever Prophylactic Program was available to children who had had one attack of rheumatic fever. "Each eligible child, on prescription from his doctor," received "400,000 units of penicillin daily as long as the doctor" considered "it in the best interests of the child to do so ..." (p. 42).[26]

In 1963, the Special Handicapped (Thalidomide Type) Infants' Program was started up, under the Division of Medical Services, to look after the special needs of six infants who had been born in Alberta and who showed thalidomide type deformities.

> All infants required special upper arm prosthesis, which were supplied and fitted at regular intervals during the child's growth. (p. 61)

In 1964, the Division of Medical Services stated that the Juvenile Amputee Clinic,

> replaces the previously named "Special Handicapped (Thalidomide Type) Infants' Program".
>
> As well as continuing to look after the six infants showing thalidomide type deformities, any infants or child suffering from an amputation, congenital or traumatic, may be seen and any necessary prosthetic limb is provided. (p. 69)[27]

In May 1964, the Division of Medical Services stated that a new Cystic Fibrosis Program

> was launched which provides the antibiotic drugs and pancreatic enzymes necessary for the treatment of children suffering from this condition. (p. 69)[28]

The long-standing Division of Tuberculosis Control stated its aims in their 1947 annual report as follows:

1. Efficient treatment of all requiring the same.
2. The discovery of all cases of tuberculosis.
3. The supervision of all known cases of tuberculosis.
4. The information of the general public ... (p. 99)

The Division provided free treatment and free diagnosis

for all sufferers of tuberculosis throughout the time period in question.

Three other policies/programs, although dissimilar in terms of the target population they were directed towards, and lacking strong economic criteria, exhibited a similar orientation to either one of, and/or, case-finding, diagnosis, and treatment.

In 1958, Section 3 of the Hospitalization and Treatment Services Act (Chapter 27) was amended "to include among the persons to whom services may be provided persons receiving an allowance under the Blind Persons' Act, the Disabled Persons' Act and the Disabled Persons' Pensions Act" (p. 7). The treatment services provided under the program included "medical and dental care, optical and special services such as physiotherapy, podiatry, chiropracty, etc. ..." (1959, p. 52).[29] These were provided through the Division of Medical Services. Complete hospital services were provided through the Hospitals Division. Later in 1959, out-patient hospital services were provided without charge to pensioners. Prior to this policy being implemented, the physically disabled who could not pay, obtained these services residually through the Department of Public Welfare as public assistance recipients.

Later, in 1963, the Alberta Medical Plan, administered by the Medical Services Division, began operation. This new plan came under the Treatment Services Act Amendment Act (Chapter 70) (1963, p. 5) (Hospitalization as of 1961 was covered under the Alberta Hospitals Act). Although not universal, it was a "comprehensive" plan "providing one level of medical benefits in a basic standard contract" (p. 61). Physicians' services,

laboratory services and diagnostic aids, in and out of hospital were provided. After a waiting period, maternity benefits, annual check-ups and psychiatric treatment were also available. The plan provided for a waiver of premium payments for a period up to six months in the event of sickness or disability, and provided differential subsidies to those residents who had no taxable income and to those who had taxable income of up to $500. Thus the plan was available to those physically disabled who may not have been eligible for a pension, but who had been receiving medical services through public assistance.

In 1961, the Department announced the implementation of another new policy that concerned the physically disabled.

> Effective April 1, 1959, the Province of Alberta extended the interpretation of active treatment care to include chronic care. On the foregoing data 10 existing auxillary hospitals, with a rated capacity of 665 beds, were approved for operation under the Plan. Due to the shortage of beds in this particular area, the Provincial Governments entered into contracts with the existing nursing homes, which had been approved by the municipalities for the accommodation of chronic patients. Also a number of beds in the general hospitals were used for the accommodation of the chronically ill. (p. 9)

These were temporary measures and were supposed to be discontinued as soon as sufficient chronic beds were built.

Then on April 11, 1960, the Auxiliary Hospitals Act came into force. It authorized the "establishment and operation of chronic treatment hospitals in the Province, as hospitals ancillary to the ordinary treatment hospitals" (1960, p. 3). The Minister was authorized to divide the Province into areas by municipalities and to establish these areas as auxiliary hospital districts. An auxiliary hospital program was to be prepared for the district and submitted to the councils of each of the

included municipalities for approval. The administration of this Act came within the jurisdiction of the Division of Hospital Services (previously the Hospitals Division).

Another policy went into effect on September 1, 1963 that put into motion a case-finding service, not only for the physically disabled, but also for those who suffered from disabling mental or emotional problems.

The Registry for Handicapped Children and Adults began to operate under the Division of Medical Services. It was planned

> to eventually provide a complete register of all handicapped persons in the Province, and in addition, function as a referral, information and research centre. (1963, p. 62)

In 1969, the Registry stated that,

> in addition to continuing to participate in the Federal Congenital Anomalies Surveillance Program, a special study was commenced to investigate congenital reduction deformity of limbs ... A new system of case finding in infants under 1 year of age was instituted during the year with the cooperation of the Deputy Minister, Hospital Services Section. A mimeographed form was mailed to the medical records department of all hospitals in the province, to be filled in duplicate for all children under 1 year. One copy is forwarded to Alberta and one is sent to this Alberta Registry and has been a most useful source of information. (p. 38)

Most of the policies of the Department of Public Health that were geared towards the disabled, were invested in children and young adults. The exceptions to these were the development of a system of auxiliary hospitals for the chronic care of those who were disabled or chronically ill (nursing homes for the elderly had been built by the Department of Public Welfare), and the inclusion of disabled persons who were social service

recipients in the hospital and medical care insurance plans of the province.

The next section describes the types of policies that were excluded from this department's functioning and how this was accomplished.

Negative Structural Selection Boundary Decisions

Introduction

Negative structural selection boundary decisions were also made by the Department of Public Health to regulate the boundaries of their positive allocative decisions. Boundary spanning designs, similar to those developed by the Department of Public Welfare, were put into place to fulfill the two conditions previously identified. Specifically the Department wished to limit the scope of their service provision, to those pathologically defined physically disabled, strictly to that of case-finding, diagnosis, and treatment. The bargaining model, construction of gate-keeping positions, and coding the boundaries with sets of intake criteria, were the structural mechanisms employed by the Department, as the following examples have verified.

Bargaining

As early as 1947, the 'bargaining model' was used to achieve an exchange of services between, chiefly, the Department and the private voluntary sector. The exception to this was the Division of Cerebral Palsy that bargained with the Edmonton Public School Board to include schooling for cerebral palsied

children, where required, under the latter's jurisdiction.

The Division of Tuberculosis, working in concert with the Alberta Tuberculosis Association to achieve the eradication of TB, used this voluntary group in order to accomplish certain of its aims. Although the Division included "the rehabilitation of those requiring same" in its objectives, the Division reported in 1947 that it provided "(a) Free treatment (b) Free diagnosis" and that the Alberta Tuberculosis Association "(a) Assists in diagnosis (b) Engages in rehabilitation" (p. 99).

The ability of the bargaining model to impose the Department's own definition of its domain choice on the voluntary sector was illustrated further in the following examples.

In 1948, the Division reiterated that,

> the rehabilitation work, under Mr. Stan Cameron, has been of real assistance to many patients. In carrying out this work, the Tuberculosis Association relieves the Division of a real responsibility. This Association has made provision to supply the equipment for the new Occupational Therapy Department in the Recreation Building at the Central Alberta Sanatorium. (1948, p. 93)[30]

The Association, in addition to supplying the services of rehabilitation officers in Edmonton and Calgary provided "financial assistance to those ex-patients who are continuing their training"[31] and had "done exceptionally well in educating prospective employers and in placing the ex-sanatorium patients".[32]

The bargaining model was also developed by the Division of Cerebral Palsy Clinics to restrict the scope of their service provision. In 1950, the Division stated,

> we have been greatly assisted by the Cerebral Palsy Association, who had paid the rent on the existing

> quarters and maintained a bus to provide transportation, and by the City Firemen who drive the bus. The South Edmonton Kiwanas Club have assisted us in preliminary equipment and expenses, and are raising funds to build a Recreation Building and Playground adjoining the Government Clinic. The Canadian Travellers Association has given financial assistance wherein they purchased the transportation bus and many other clubs, organizations and individuals, too numerous to mention, have offered financial and moral support for the present and future to allow us to maintain the program and expand the extraneous services as we see fit. (p. 51)

In 1951,

> a start was made in the organization of a Cerebral Palsy Clinic in July, with the cooperation of the Calgary Cerebral Palsy Association and the Red Cross Crippled Children's Hospital ... They are now treating approximately 7 patients a day in quarters provided by the Calgary Cerebral Palsy Association. (pp. 31,53)

The Division's choice of a particular service domain was made explicit in the following statements. In 1952 it was stated,

> thus the training program is completely covered by the Provincial Government which leaves the problem of recreation, transportation and boarding accommodation to voluntary societies. Through these clubs, transportation has been provided so that children may be moved daily from their homes or boarding places in Calgary and Edmonton, to the clinics.
>
> The operation of the clinic by the Province of Alberta and operation of the auxillary services by voluntary societies is an example of co-operation to achieve a good result. (p. 119)[33]

Rehabilitation services were explicitly excluded from the domain of the Division as well. Patients were referred from the Edmonton Cerebral Palsy Clinic to the "Co-ordinator of Disabled Persons and Rehabilitation for assistance in job placement or Canadian Vocational Training" (1954, p. 132). The onus for providing rehabilitation services to their children

after moving through the treatment program was offered by the Division to other agencies. In 1958, the Division stated,

> as well as continuing our treatment of children in the younger age group, which included their education during the time of treatment, we have attempted to spend more time on the rehabilitation of those young adults, who, after benefitting by the governmental program have still found it difficult to find their place in society. We hope, in the not too distant future, that we will have a practical programme for job placement functioning with the assistance of the Edmonton Chamber of Commerce. (p. 75)

Gate-Keeping

The gate-keeping mechanism that was in use in the Department of Public Welfare utilized discrete positions to filter and screen incoming applications from the physically disabled for either or both the financial and rehabilitation programs. A similar, although less structured, mechanism employed by the Department of Public Health coped with information overload by limiting the intake of disabled persons into the case-finding service set up by the Registry for Handicapped Children and Adults. Instead of formalizing a specific gate-keeping position, all professionals who could potentially be in contact with handicapped persons were identified as sources of referral to the Registry. The impact of this type of gate-keeping mechanism was weakened by keeping referral and registration by these professionals on a voluntary basis. Although reliance on information gate-keepers may leave organizational policy makers vulnerable to acting on incomplete information, this appeared to be the intent of this government program, as the following examples illustrated.

In 1967, the Registry stated,

> since our policy continues to be that of voluntary rather than compulsory registration, the case load will not likely represent 100% registration of handicapped people throughout the province. (p. 46).

The Registry's intent to put limits on their registration and referral service was pointed out in 1968.

> ... contact with handicapped persons can always be made by the Registry through the Health Units in which these people reside. Thus an individual or his parents can be apprised that an organization is ready to help him with his problem and it is then his concern whether he wishes to participate or not in the study or program available. This liaison between the handicapped and various charitable and service organizations is one of the functions of the registry which has not, as yet, been developed to its fullest capacity and is perhaps something which should be attempted more vigorously in the future.
>
> We would wish that physicians and local health personnel would acquaint patients of the many facilities available throughout the province to help them with their problems. In this way, service organizations such as the Paraplegic patient in advice and assistance, would be enabled to communicate with those whom they wish to serve. (p. 46)[34]

In 1960, a nursing consultant position in maternal and child health was created in a gate-keeping role. Utilizing this position, "a simple system" was "evolved whereby referral of premature or handicapped infants born at the University of Alberta Hospital" could "be made to various public health agencies through the nursing consultant's office". The system was planned "to extend the service to other city hospitals where such referrals present problems" (p. 36). The effectiveness of this gate-keeping mechanism was also limited by restricting its implementation to a few hospitals. In 1961, the Maternal and Child Health Branch stated that,

> the large city hospitals in a metropolitan area which are served by several health agencies present a very different problem for the adequate referral of patients

> who are returning to the community. At present the office of the nursing consultant functions to a limited degree as a clearing centre for information regarding premature infants who are discharged from hospital. A more direct referral system should be developed to extend the service to more hospitals and health agencies not only for infants but for any patients with continuing handicapping conditions. (p. 32)[35]

Coding

The Department of Public Health, like the Department of Public Welfare, employed different sets of coding criteria to limit their intake of disabled patients into each treatment program. The following examples revealed that, almost without exception, their boundaries were coded to take only children into the specific pathologically defined programs. This mechanism allowed the condition of implementing the positive allocative boundary decisions under the assurance that an economic return in the investment would eventuate, to be met.

For example, in 1950, the medical director of the cerebral palsy clinics noted that two-thirds of the cases "who are under the age of 15" (p. 50) could benefit by treatment.[36]

In 1954, the Division of Arthritis Services stated that sixteen of their patients "have become ineligible for treatment due to having reached their twenty-fifth birthday" (p. 131).[37]

Up until 1958 the poliomyelitis program was restricted to children when a change in the regulations under the Poliomyelitis Sufferers' Act admitted "any individual who is a resident of Alberta and suffering from the effects of poliomyelitis" to be "eligible for treatment under the poliomyelitis program" (1958, p. 45).

The Rheumatic Fever Prophylactic Program stated that "children under 18 years of age, ..., are eligible for prophylactic therapy benefits" (1959, p. 61).

Drugs were also provided to children suffering from cystic fibrosis "without a means test up to their eighteenth birthday" (1964, p. 9).

And lastly, the Juvenile Amputee Clinics "examine and, if necessary, provide a prosthetic device for any infant or child up to the eighteenth birthday who suffers from an amputation, congenital or traumatic" (1966, p. 71).

The tuberculosis program was the exception since it did not code its boundaries with any specific criteria.

The Hospitalization and Treatment Services Program, although not restricted to children, coded its boundaries by ensuring that every applicant possessed a hospital and medical card, issued from the Department of Public Welfare. The following statement by that Department's Pensions Board (although extracted from their annual reports) describes this as follows.

> When an application for Old Age Assistance, Blind Persons Allowance, Disabled Persons Pension, Disabled Persons Allowance, ... is approved the recipient will be provided with a hospital and medical card with his first pension cheque. This will entitle the recipient and his dependents to the services listed on the back of the card and becomes effective the first day of the month following the month for which the pensioner has received the pension. This card must be presented to the Hospital, Doctor, Dentist or Optometrist before any service is provided ... also physiotherapy, chiropody and chiropractic services if approved by the Director of Medical Services Division, Department of Public Health.[38]

This mechanism was retained when the program later evolved into separate medical and hospital insurance programs.

The implementation of this variety of boundary spanning mechanisms had one primary manifest consequence. It shifted the responsibility for planning for the adult physically disabled population who did not require institutionalization into the domain of the Department of Public Welfare.

Establishing Similarities and Differences with the Data from the Social Welfare Branch in British Columbia

Introduction

The data bearing on the verification of the conceptual category of boundary decisions for Alberta's Department of Public Welfare indicated the taking of three distinct types of decisions.

Comparison with the data for the Social Welfare Branch of British Columbia identified the existence of a similar conceptual category with one subtle yet significant difference. Whereas the residual boundary decisions made by the Department of Public Welfare were, conceptually, quite distinct from its positive allocative boundary decisions, the existence of a discontinuity that made a distinction between these two domains was lacking in British Columbia's Social Welfare Branch. For example, the provision of social assistance was considered to consist of those financial measures (including pensions) that were of a residual nature, as well as those policies that positively allocated resources towards those services that would incur an economic return on the investment made. Examination of the data from 1945 indicated that the boundaries between these two types of decisions were blurred at the beginning of the time

frame due to the implementation of a different structural mechanism by the Branch. A 'consolidated' design was created whereby the residual financial assistance programs and the positive allocative programs were merged into a 'single human service' division with planning, administrative service, and service delivery functions.

The existence of this particular structural mechanism was verified in the following description of the Social Assistance Act found in the annual report for 1948.

> This groundwork in establishing competent administrative and professional policies with regard to social assistance and related services was given legal recognition by the passage of the "Social Assistance Act" in February, 1945. The Act itself defined social assistance as financial aid to individuals and families, and financial aid to municipalities and other corporate bodies which extended services to people dependent upon social assistance for their maintenance. Mindful of the rehabilitative philosophy underlying the professional treatment of these recipients, social assistance was also defined as health services and occupational training and retraining. Foster-home or boarding-home care was included in this definition. Of particular significance was the inclusion of "counselling services" in this definitive section of the Act, or services given by social workers to preserve and strengthen family life, whether financial aid was necessary or not. (British Columbia, Department of Health and Welfare, Social Welfare Branch, Annual Report for the Year Ended March 31, 1948, p. 25)

Accordingly, the Social Assistance and Rehabilitative Division was created. Bearing this property in mind, for the purposes of analysis however, the two types of boundary decisions were considered separately. The rationale for utilizing this approach was found in the following statement that was made by the Branch's Family Division in 1948.

> For the permanently disabled no rehabilitation is possible, but our efforts are directed to developing other strengths in the family unit to meet the economic,

physical, and emotional needs of the family.[39]

For those physically disabled who were considered to be permanently unemployable, the residual category of financial assistance measures was used to provide them with support. The acquisition of this label hindered them from acquiring the use of alternate resources, such as rehabilitation. In addition, although the programs were merged into one common division, they tended to be delivered along traditional divisional lines that allowed the two types of boundary decisions to be considered separately.

Residual Boundary Decisions

The Social Welfare Branch took within these boundary decisions, policies, similar to Alberta's, that were concerned with providing some kind of general public assistance to that residual class of unemployable persons. The property of scope identified another similarity between the two departments, since British Columbia's policies were also based upon unilateral cash or in-kind transfers. The following examples illustrated these various points.

In 1948, the Branch stated that,

> the major service of providing social allowances to persons and families unable to support themselves was placed on a firm administrative base, and services related to the needs of recipients of social allowances were augmented ... Medical services were made available to recipients of all forms of social assistance (p. 24), ... With only two basic qualifications for eligibility - namely, unemployability and need as set out in the "Social Assistance Act" - this form of assistance is considered by many to be the most flexible form of social assistance in the Province. (p. 42)

The following statement made by the Family Division on Social Allowances identified specifically what was encompassed within the provision of financial aid to that group of unemployables, including the physically disabled, who could not provide for themselves.

> Effective April 1st, 1947, ... the Province undertook a greater share of certain costs, and agreed to share on an 80-20 basis with the organized areas in the costs of:-
>
> (1) Boarding and nursing care up to $1.50 and $2.50 per day respectively;
> (2) Medical care under existing arrangements;
> (3) Drugs;
> (4) Emergency health aid;
> (5) Tuberculosis Allowances; and
> (6) Municipal inmates in the Provincial Home at Kamloops.
>
> Effective April 1st, 1947, the Social Welfare Branch also undertook to pay hospitals in receipt of statutory grants under the "Hospital Act" the sum of $3 per day for every genuine inpatient who is in receipt of social assistance.
>
> In May, 1947, the provision of comforts allowance at the rate of $3 per month was extended to cover not only social allowance recipients in hospital, but to recipients of social assistance (social allowances, old-age and blind pensions, and mothers' allowances) who might be in nursing or boarding homes. This was to be granted on an 80-20 shareable basis ..." (1948, p. 41)
>
> Effective January 1st, 1949, the British Columbia Hospital Service went into effect, and the Social Welfare Branch accepted responsibility for payment of hospital insurance premiums for all social assistance recipients. On cancellation of social assistance, the Social Welfare Branch pays the premiums for a further temporary period of sic months from cancellation.
>
> The Medical Services Plan became effective March 1st, 1949, covering all recipients of social assistance. The plan need only be mentioned here, as a description of it belongs in the report of the Director of Medical Services ... through arrangements made with the British Columbia College of Physicians and Surgeons, they receive without cost to themselves full medical, surgical and obstetrical care in home,

hospital and office.(1949, pp. 7,20).[40]

"In line with this policy of assistance and with contributions by professions and suppliers in the health field," the Medical Services Division was "able to provide defined services by dentists, pharmacists, optometrists, and prosthetists". They also provided "items including medical appliances, glasses, drugs, and transportation to specialists as a supplement to the financial assistance provided by the Department of Welfare" (1949, p. 64).[41] The latter items, i.e. wheelchairs, braces, prostheses, and self-help devices were not covered by B.C. Hospital Insurance.

The following example illustrated both the confinement of the scope of the residual boundary decisions to funding and the structural consolidation that had occurred between the two types of boundary decisions that were made.

> These are only three examples of special services which are possible within the framework of the Social Allowance programme; there are many others for which these funds may be used, such as housekeeping or homemaking services in homes where the mother is ill or absent, payment for children living with relatives, provision of boarding- or nursing- home care for those who, because of age or chronic illness, are no longer able to look after themselves. The programme of co-operation with the Western Society for Physical Rehabilitation, as reported last year, still continues as well.(1951, pp. 28,29)[42]

On April 1, 1955, the Federal Government's Disabled Persons Act was implemented. The primary purpose of this Act was,

> to provide a measure of income maintenance for those permanently and totally disabled persons for whom rehabilitation or other forms of therapy offer no solution. [This pension was administered to the disabled through to 1972.]
>
> To supplement the allowance the Provincial Government extended the cost-of-living bonus regulations to

> provide payment of a full cost-of-living bonus to any recipient of Disabled Persons' Allowance who had completed three years continuous residence in British Columbia immediately prior to the date of commencement of the allowance.
>
> Health services, also, were extended to include any recipient of the allowance who had completed one year's continuous residence in British Columbia immediately prior to the date of commencement of the allowance.(1956, p. 62).[43]

The provision of social allowances was explicitly identified as a residual welfare program for the unemployable in the following statement made in 1963 by the regional administration for the Branch.

> Social Allowance serves as a residual resource for people who are insufficently cared for through other programmes and provisions. In the year under review, Social Allowance was granted for two main groups - the unemployable individual, or the family in which the father was not able to work, ... The needs of this financially dependent group vary greatly. Personal inadequacies exist, and supplementary services are needed along with financial assistance. Many of these people have long-term disabilities and social problems. (p. 27).

In 1967, the Social Assistance and Rehabilitation Division stated that

> the Division's programme is based on the Social Assistance Act and regulations. This includes provision for (1) income maintenance with supplementary benefits for those whose needs cannot be met in any other way and (2) services of a rehabilitative and preventive nature ... Other additional financial help provided by the Department in situations of serious need includes grants for purchase of clothing, for home repair, for school starting supplies, and for other situations of exceptional need. Where necessary the cost of transportation is provided to enable access to health services or to enable employable persons to take advantage of employment opportunities. (p. 13)[44]

In 1968 there were "2,751 disabled or elderly persons being assisted with the cost of boarding- or nursing- home care"

(p. 15).

The financial scope of the social assistance program was identified in the next example. In 1970, the Social Assistance and Rehabilitation Division stated that,

> social assistance provides a substitute income for those who have no other way of providing for their daily needs. Traditionally these have been mothers with children, the aged, those with social, mental, and physical health problems that prevent employment, and dependent children. (p. 16)

For a number of years another division of the Social Welfare Branch also participated in the delivery of residual policies for children. The Child Welfare Division dealt with the problem of facilities to care for the severely handicapped child. In 1947, this Division stated that,

> treatment facilities for those who may benefit seem fairly adequate, but for the chronically handicapped child there are few resources. An institution is not the answer for all ... Some effort will need to be made to determine the size of the problem throughout the Province and wherever possible to provide help in the family home to enable the child to remain in his own home. This might entail some additional financial aid or the employment of housekeeper services on a part-time basis in order that the mother be relieved of some of the burden. In other instances bedside nursing services, where available, would help greatly ... As they grow older, some may require permanent institutional care, but if their stay in their homes has been made brighter and more comfortable, the later years of separation from family will be less difficult ... A few children, however, with involved and serious physical handicaps have been admitted, for whom we have tried to provide specialist services. One 10-year old boy so badly crippled with arthritis he could not walk and crawled only with difficulty, has been in care a number of months. It was frustrating to learn that this little boy could not be helped medically, but there was at least some satisfaction in knowing that all available advice has been obtained and that these months have afforded some opportunity for his training and for preparing his family to care for him more adequately when he returns to them. (p. 20).

In 1948, the Division reported that it,

> is being asked to plan for some badly crippled children and will try to place them in carefully selected foster-homes. Until such time as suitable institutional care is available, however, the cost of such foster-home care must of necessity be high. (p. 83)

In 1951, the Division described that,

> the permanently physically handicapped children who come to us present a pathetic and perplexing problem in foster-home placement. The physical set-up at the Queen Alexandra Solarium limits the number who can be admitted under present policy to that institution, and it excludes children suffering from certain conditions which require fairly constant individual bedside care. With no other resource available, we have had to place a number of these children in foster homes, ... (pp. 48,49)

In 1952, the Division took in "thirteen boys and girls in care ... who, because of severe crippling conditions," had "known long periods of hospitalization and discomfort in their lives" (p. 42). In 1955, the Division described the permanently physically handicapped children who were not committable to an institution, but whose own families could or would not care for them, as requiring foster home placement.

> These are children in care at parental request. Some of these are in the group of physically or mentally handicapped children. In some instances the child needs treatment not available in the community. (p. 49)[45]

The data has illustrated that throughout the time period in question, a dichotomy between financial assistance policies for those who could not work, including the physically disabled who were defined as unemployable, and employment policies for the potentially employable, including the physically disabled, was maintained. In the annual report for 1971, under the new department name of Rehabilitation and Social Improvement, a

statement made by the Assistance Deputy Minister iterated this point. He said that,

> our priorities have been concerned with helping people get work when they are in any way employable, arrange for a realistic and positive maintenance of income for the seriously disabled and handicapped, and to ensure no one is without the means of acquiring the basic necessities. (p.10)

The next section describes those positive allocative boundary decisions that took in employment related policies either for or concerning the disabled.

Positive Allocative Boundary Decisions

The positive allocative boundary decisions made by the Social Welfare Branch were based on a condition similar to that found underpinning the boundary decisions of the Public Welfare department in Alberta. The former also took within its functioning rehabilitation policies for the physically disabled directed primarily towards facilitating employment with the expectation of an eventual return on public monies spent. If this goal could not be met, it was expected that the rehab programs would facilitate an increase in the disabled person's capacity for self-care and physical independence. This was congruent with the expression of a humanitarian value that has been described in valuation contexts.

The scope of the rehabilitative program was also similar to Alberta's. Rehabilitation services, initially made available through funding, gradually evolved into the provision of some direct casework services for individuals by the social work staff of the regional offices. The Branch's unwillingness to

describe the physically disabled as potentially employable was found in data that described the reluctance of the Branch to become directly involved in job placement for those individuals who did receive rehabilitation services.

In 1949, the Branch described an "experimental step" that was taken in the direction of making rehabilitation available to the physically disabled.

> Arrangements were made for three post-polio patients who were Provincial responsibilities to receive remedial and vocational training through the services of the Western Society for Physical Rehabilitation, whose treatment centre is situated in Vancouver. If the plan progresses successfully, it is hoped to continue with three cases at a time as a tentative measure.(p. 18)

The vocational orientation of this programme became more apparent in the following descriptions of the results achieved by specific individuals from 1950 to 1951.

> Some of these cases merit specific mention, and chief among these are those assisted under the experimental assistance programme to aid in the rehabilitation of the handicapped, ... a ... younger man ... was temporarily assisted to complete the treatment and training he had begun in the treatment centre under private auspices. The public funds used to assist in his care were shared by the Province and responsible municipality. At the time of his discharge he obtained part-time employment, but because of superior education he intends to seek further training to equip himself for full-time employment.(1950, p. 28)[46]

Jack, an epileptic, was described as having

> been helped from the point where he did not think he could take any training, through the steps of vocational guidance, enrolment and training to the point where he managed job placement by himself. He had developed independence of spirit as well as financial independence, in that he is now self-supporting after many years on public assistance. (1951, p. 27).

Tom suffered from a partial paralysis which he had

had since birth.

> As his best subjects were book-keeping and mathematics, and as he expressed a desire for training as a time-keeper, arrangements were made for a vocational course along these lines ... Tom was sent to the Vancouver Vocational Institute. During his attendance there Social Allowance was granted for his needs.(1951, p. 28)[47]

In 1952, Rehabilitation Services stated that,

> not all examples of rehabilitative assistance can be so dramatic or exceptional, but are none the less important. Some grants are made to the non-handicapped or minor-handicapped group in vocational training, such as shorthand and typing, bookkeeping, metal work or mechanics, shoe-mending, or nurse's aide, and usually mean ultimate independence for the person or family. Even small extra grants to cover the cost of special text-books, rental of a typewriter, or purchase of uniforms or equipment for a technical course have been all that was needed to make possible training which restored the person or family to economic independence with no further need of Social Allowance.(p. 27)[48]

In 1953, the Family Division stated that

> effective October, 1952, the quota of patients for whom the Social Welfare Branch will share in the costs of their rehabilitative treatment in the Western Rehabilitation Centre was increased from nine to twelve at any one time. In practice this quota is divided proportionately between arthritic patients and para-plegics, or otherwise orthopaedically handicapped. (p. 32).

Then in 1953,

> some twenty-seven persons received in-patient treatment and training at the Western Rehabilitation Center under the Provincial quota ... in addition, the Province participated in whole or in part in the cost of out-patient treatment for another thirteen patients ... Many received vocational training while in the Centre, while others undertook vocational training after their discharge. (p. 33)

As in the past, the Branch emphasized the employment goal of rehabilitation assistance. Another example described this.

> Mr., D., aged 52, had suffered from an arthritic condition for some years which had necessitated several applications for assistance to maintain himself, wife, and three children for temporary periods of unemployment. He was described as an independent person who had shown resourcefulness in finding casual employment when his condition permitted, but his usual occupation, which was of a manual nature, was proving too difficult for him to continue in view of his physical condition ...
>
> On the occasion of his most recent application for assistance he was helped and encouraged to have extended medical treatment. As his physical condition improved, he himself began to explore alternative possibilities of employment within his capabilities and indicated a desire to learn industrial first aid, which his attending physician agreed was within his physical ability. Supplementary assistance was given with tuition fees, books, and other incidentals and transportation, to enable Mr. D. to take a course in industrial first aid, while Social Allowance continued in pay for him and his family. All costs were shared by the responsible municipality. At the end of the course several opportunities were available to him, and he finally obtained employment in a large local firm where his job was to be first aid and some office duties. (1953, p. 32)

Case-work with the physically disabled was carried on in the regional offices administered by the Branch. In 1954, one regional administrator stated that,

> throughout the year, members of the staff continued to try to rehabilitate as many of their cases as possible. This particular phase of the work is handicapped by the fact that many work opportunities available in other areas are not available in Region IV. The main industries are mining, lumbering, and farming, all of which require workers of high physical standards. However, wherever the possibility of re-establishing anyone on a self-supporting basis existed, either wholly or partially, the effort has been made. (p. 28)

In the same year another region determined what proportion of their social allowance caseload could benefit from rehabilitative efforts directed towards employment. The administrator stated that,

> the staff continued to improve their knowledge and methods of rehabilitation. A meeting of the staff was held ..., and it was more than ever evident that rehabilitation should begin with the first contact. Reviews of cases done prior to the meeting provided the information necessary for the various papers presented. Throughout the studies it was evident that about two-thirds of the allowances granted were to the older age-group or persons for whom there was little possibility of rehabilitation. The remaining one-third were capable of rehabilitation ... (pp. 30, 31)

In 1954, the Branch also described the case of Mr. Y. who was prevented from following his usual work as a tractor operator because of a chronic bone condition of his leg. Mr. Y was brought to a larger center where training was available and where he could receive assistance while he took the course in the form of tuition and other fees, transportation, and later clothing as required for employment. He endeavoured to find employment for himself, with the result that within a year of the beginning of the rehabilitation plan he had found suitable employment as a timekeeper in a centre near his home, and his family no longer needed public assistance (p. 40).

In 1956, the administrator for region three described the assistance that was given to "another typical rehabilitation case" who attended business college under Schedule R of the Dominion-Provincial Vocational Training Grants.

> Prior to being accepted for training, he had received treatment from the Western Society for Rehabilitation as he was physically handicapped. While he was taking his business course, social assistance was granted to him for comforts allowance, as the grant under Schedule R had not included anything for comforts. He also required assistance in obtaining clothing. Upon completion of his course, in which he had made good progress, he experienced great difficulty in obtaining employment, as prospective employers were reluctant to consider him because of his disability. He was granted assistance for two months until he was able

> to obtain employment, and during this time and his period of training he was given encouragement and support by the staff in his plans to be self-supporting. He is now working and is earning $140 a month.(p. 24).

During the 1958 to 1959 fiscal year, "the Social Welfare Branch, and responsible municipalities, where and when applicable, sponsored a total of eighty-nine trainees and patients in the G.F. Strong Rehabilitation and the Canadian Arthritis and Rheumatism Society Medical Centre for approximately 4,400 days of resident care and training"(p. 33).[49]

Beginning in 1960, the first thrust towards reviewing all social allowance caseloads in the Province was made for the purpose of selecting those individuals whose need for financial assistance was complicated by a medical problem and for whom a satisfactory rehabilitation plan could be worked out (1961, p. 31). Out of these survey attempts, evolved vocational rehabilitation committees across the province which functioned "for the benefit of persons needing this special service as an aid to employment and self-support" (1963, p. 16). These committees were a formal service delivery mechanism on which the Branch participated along with other government departments and community agencies.

The administrator for one region reported that,

> the joint rehabilitation survey made in Chilliwack during the previous year resulted in the selection of 60 cases as a demonstration group of rehabilitation cases. There were social welfare recipients who had health problems, long-term disabilities, marginal skills and social problems. At the end of the year, 21 of the 60 cases were considered rehabilitated and 8 were still under review. One young person seriously handicapped by a congenital deformity may have qualified for public assistance for the next 40 years. At the time this report is tabled, he is training on the job as a radio and television bench-man. This was accomplished through the concentrated

> efforts of medical, social, and vocational professionals working as a rehabilitation team.
>
> A local rehabilitation committee was set up in Chilliwack in the year under review to assist in the rehabilitation of disabled persons in that area, whether in receipt of public assistance or not. (1963, p. 28).

From 1962 to 1963, "local employment committees were formed or reactivated in Kamloops, Vernon, Kelowna, and Penticton. Each of these committees function slightly differently, but they all have the same goal - that is, helping the unemployed to become the employed". The administrator for this region stated that,

> whether there is a small or large number of unemployed, whether the employment market is falling or rising, there are certain areas in which casework services and employment committees can be productive. First, at any time there are always some unfilled jobs because properly trained or qualified persons are not available. Likely unemployed persons can be directed to, and, if necessary, given financial assistance for, qualifying training or education. Some persons are unable to accept available employment because of physical disability and can be referred to, and again, if necessary, given financial assistance for, necessary medical care or physical retraining. (1963, p. 20).

Rehabilitation Services stated that,

> specific rehabilitative services have included individual counselling and referrals for training under the Provincial vocational training programme. The latter may make provision for payment of maintenance, tuition, books, and travelling expenses on behalf of successful candidates. Approximately one in five of those accepted for training were social assistance recipients.(1963, p. 37)

In 1965, the Branch stated that "services of a rehabilitative nature are provided for a variety of problems. Greatest attention is focused on return to employment" (p. 36). The Assistant Director of Social Welfare reported that,

> our department, together with the Public Health Branch and the National Employment Service, has continued

> to expand and develop rehabilitative services throughout the Province. Some 13 communities now have local rehabilitation committees at work attempting to assist the handicapped to regain their independence ... A case-worker studies each situation and tries to assess the causes of the problem and then plan with those concerned along an avenue of rehabilitation. (pp. 11,16, 19,27,32)[51]

A regional administrator stated that "these committees work very hard to make available vocational training and practice work experience" (1966, p. 29). In annual reports through 1967 to 1969, the Social Welfare Branch stated that rehabilitation is usually

> directed to employment but it may also involve upgrading individual functioning, as for example with an elderly or disabled person where employment may not be a feasible objective. Many persons are assisted monthly returning to employment ... many others are referred for retraining. During the fiscal year 706 recipients were accepted for vocational training under Federal-Provincial programmes. Numbers of others were assisted or encouraged to upgrade their knowledge and skills through local adult education programmes, and occasionally through correspondence courses. Where indicated the Department has provided fees. Rehabilitation committees are now functioning in most areas of the Province. These combine the knowledge and resources of Departments of Health, Social Welfare, and Manpower in assessing and rehabilitating persons handicapped by physical or mental health problems. (1967, pp. 14,42,53)

In 1969, the Social Assistance and Rehabilitation Division reported that "rehabilitation committees are functioning in most of the larger centres ... on behalf of disabled persons who require more intensive help before they can return to employment" (p. 15).

In 1971, under the auspices of the newly named Department of Rehabilitation and Social Improvement, the Provincial Alliance of Businessmen Division "was established to enable rehabilitation by appropriate job placement of unemployed

employable recipients of financial assistance and those who would be dependent without those services" (p. 13). The 1971 report for the Prince George Region stated that,

> the Provincial Alliance of Businessmen functions, as does any other employment placement service, to assist unemployed persons to obtain gainful occupations. It must be emphasized that the primary function of PAB is to assist the disadvantaged person. The disadvantage may be due to any one of numerous causes - old age, school drop out, physical disability, personal problems, all of which too often create cases requiring assistance from the Department of Rehabilitation and Social Improvement or other similar agencies. In this context, PAB personnel, when completing a vacancy order, must at times persuade an employer to accept as an employee a person who has not the ability to sell himself. (p. 60)

In the annual report for the same year, the Social Assistance and Rehabilitation Division described the new Opportunities Program begun in 1970.

> This provides an opportunity for recipients to be involved in providing non-profit community services. It is intended primarily for one-parent families and has also been made available for a number of handicapped men with families and for handicapped single persons as well. The results have been impressive as most participants have reported restored pride and confidence. Private and public agencies have responded positively, and there has been a great deal of public interest and support. It has been handicapped by insufficient availability of part- and full-time employment opportunities for those ready to move into regular employment. (p. 25)[52]

As pointed out, this program also operated within the constraints imposed by the general employment situation.

The local rehabilitative committees continued to operate to assist "severely disabled persons to achieve employment or improved capacity for self-care. (1971, p. 25)[53]

Thus while rehabilitation directed towards employment was a focus of the branch, a number of boundary spanning mechanisms

were put into place to limit and control the extent of its involvement in the actual provision of these services.

Negative Structural Selection Boundary Decisions

Examination of the data for the Social Welfare Branch revealed the existence of a set of negative structural selection boundary decisions similar to those of Alberta's Department of Public Welfare. Boundary-spanning mechanisms, similar to those employed by the Department, were implemented to fulfill the conditions that were described in the analysis of the Department of Public Welfare. The bargaining model, gate-keeping positions, and boundary coding were used to regulate mainly the positive allocative, but also the residual, boundary decisions of the Branch. The following examples verified the existence of these similar properties for British Columbia.

Bargaining

A Division of Tuberculosis Control had been set up by the Public Health Branch of the province. Within this division, however, the Social Welfare Branch assumed responsibility for the provision of social services to TB patients. The social service staff subsequently had attempted to provide rehabilitation planning for their patients, before utilizing the services of the British Columbia Tuberculosis Society. When they became available to the Division, they were readily accepted. The following statement made by this Division in 1948, illustrated the exchange of services that occurred.

> Early in the year the British Columbia Tuberculosis Society had appointed a rehabilitation director. The members of the Social Service staff were extremely pleased with this development, as they had been attempting to help patients plan a rehabilitation programme which would carry them from the first days in hospital until they were placed in jobs. It was not possible to do an adequate job because understanding the condition of the labour market and knowledge of skills and training needed for certain types of jobs was outside our field. The rehabilitation officer has some training and a great deal of understanding of these problems, and is able to work with us in planning for our patients ... Every patient in the unit is discussed at the rehabilitation conference, consisting of the doctor in charge of the case, the nurse, the occupational therapist, the school-teacher, the rehabilitation officer and the social worker. In this way it is hoped that useful training will be obtained for patients, that job counselling and placement will be possible, and that the patient's individual preferences and emotional problems will all be given consideration in any planning being done for him. (p. 117)

In 1950, the Division made it clear that "the rehabilitation officer is not actually a part of the Social Service Department but, to all intents and purposes, is considered to be a member of our staff" (p. 108).

The Child Welfare Division was responsible for those permanently physically handicapped children who required foster-home placement. This Division identified a need in this area for a long-term institutional programme, yet recognized the existence of certain constraints. These were identified in the following statement made by the Division in 1949.

> We are still trying to plan through foster-home placement for a number of permanently physically handicapped children, and are discouraged in the knowledge that we are not nearly meeting their needs. ... Through the use of proper teaching and retraining facilities, however, many of them could be helped toward a less-limited adult life. There is a sufficient number of such children throughout the Province, already known to the Division, to warrant the establishment of a long-term institutional programme for their care, as

> has been previously suggested. If, however, in view of other expanding and costly Government Programmes, it would seem inadvisable to develop such an institution within Government services at this time, then it is strongly recommended that some interim plan, probably in co-operation with some private organization, be made whereby these children can receive the kind of instruction and care they so urgently need.(p. 43)

In 1950, the services of a private institution were engaged to care for these children. The Division reported that,

> we are pleased to report that our concern about the lack of facilities available for this group of children has resulted in an arrangement being made with the Queen Alexandra Solarium, Cobble Hill, Vancouver Island, by which it will admit certain children who, in the opinion of their medical advisor, can benefit by the programme offered. Some will still have to be excluded because of the limitations of the present buildings. However, the board of the Solarium is deeply interested in this so far "forgotten" group of children, and in their new building plans, adequate space and facilities to meet their needs will be provided.(p. 55)[54]

The resources of other private voluntary agencies were relied upon for the provision of rehabilitation services to the physically disabled. In 1952, the Medical Services Division of the Branch noted that,

> worthy of special mention is the assistance to this Division by the Western Society for Rehabilitation. This centre was opened in January, 1949, through private funds. The function of this society is the rehabilitation of the orthopaedically disabled, which can include paraplegics, polios with permanent paralysis, arthritics, leg amputees, etc. The Social Welfare Branch became interested in the possibilities of utilization of their facilities. Under the Branch's sponsorship, three cases were underwritten for care and treatment on an experimental basis. This was accomplished with the co-operation of the municipalities and the Western Society for Rehabilitation and the Canadian Arthritis and Rheumatism Society. This is a splendid example of what can be accomplished through a co-operative spirit when municipal governments, the Provincial Government, and private agencies band together in the interests of the handicapped

> individual. Careful watch will be necessary to make certain that the expansion of this service keeps pace with the public needs and availability of accommodation. (p. 77).

In 1950, the Branch described other private resources that were tapped to assist a man who had been recently discharged from a treatment centre towards rehabilitation.

> Arrangements were made for a suitable boarding-place, and he enrolled in a shoe-making course. Maintenance costs were met by the Social Welfare Branch, not only for the man in Vancouver, but for his wife and family as well, who had remained in the small town where the man formerly worked, and the costs of the training were met by the Kinsmen Club of Vancouver ... Eventually, the time came to re-establish him in a shoe-making business in his home locality, and, as a result of a generous undertaking by the Kinsmen Club of Vancouver, plans were under way at the end of the year to provide him with a shop as well as the necessary equipment and material, ... Everything pointed to a most satisfactory conclusion, with favourable indication that the family would shortly achieve economic independence. This particular case is a valuable example of close co-operation between private and public agencies and organizations and their workers, ... It meant long and hard training for him, but with public and private support he has achieved his goal. (pp. 28,29)[55]

The Social Welfare Branch advocated the exchange of services directed towards rehabilitation between themselves and other agencies. The Branch described a rehabilitation plan in 1953 that "was not achieved by financial assistance alone, but was the result of close co-operation with community health agencies and resources and employment services, as well as the organization which gave him his training, ..." (p. 32).

The Social Medical Work Services Department within the Branch for the Division of Tuberculosis Control (Health Branch) and the Poliomyelitis Pavilion identified in 1965, that,

> one of the most time-consuming problems is obtaining suitable housing or other accommodation for paraplegic

> and quadraplegic patients who are able to live outside the hospital and some of whom are able to work. One poliomyelitis patient who had been in hospital for nine years became very anxious to spend a month's holiday with his family, who lived on one of the Gulf Islands. Through the co-operation of many people and agencies, such as the British Columbia Poliomyelitis and Rehabilitation Society and a district office of the Social Welfare Department, the holiday was accomplished and was of great benefit to the patient psychologically (p. 98).

The Branch also relied, as did Alberta's Department of Public Welfare, upon the Department of Education for the administration of the vocational training program, limiting themselves to the provision of some financial assistance, and referral to the appropriate agencies.

> Again this year through the resource of the Dominion-Provincial Vocational Training Grants, administered by the Department of Education, many recipients of Social Allowance have received vocational training to enable them to achieve economic independence. The Branch participates financially in some instances and offers help with social planning to any trainees or their families requiring such help. This is an extremely valuable resource to the Branch. (1959, p. 33)[56]

The survey of all social allowance clients in British Columbia also relied upon the exchange of services with the province's Health Branch. The Social Allowances Section of the Family Division stated in 1961 that,

> during this year, in co-operation with the Health Branch ... a Rehabilitation Consultant was appointed. It is hoped that ultimately it will be possible to review all Social Allowance case loads in the Province for the purpose of selecting those individuals whose need for financial assistance is complicated by a medical problem and for whom a satisfactory rehabilitation plan can be worked out. (p. 31).

These surveys were also undertaken"in co-operation with the National Employment Service" (1962, p. 16).

From 1962 to 1963, rehabilitation survey projects in

Nanaimo, Prince George and Chilliwack developed into the vocational rehabilitation committees whose membership was made up of representatives from Public Health, the Employment Services, other community services, along with Social Welfare.

In 1964, the Social Allowances and Rehabilitation Division stated that,

> for this purpose special rehabilitation committees for disabled persons have been established in Nanaimo, Chilliwack, and Prince George, bringing together representatives of the National Employment Service, the Provincial health Branch, and the Department of Social Welfare in joint planning on behalf of a selected number of disabled persons. By these means, it has been possible to assist disabled persons back to employment, who would otherwise have required continued assistance. (p. 37)[52]

The Social Welfare Branch made it clear however, that "the responsibility for the administration of this service falls under the Department of Health's administration, with our Department fully involved in the planning and work at the field level". (1966, pp. 11)

The following statement made by the Social Assistance and Rehabilitation Division in 1969 illustrated their reliance on the services offered by other official government agencies for the physically disabled.

> With the co-operation of the Department of Education, school boards, and other educational agencies, approximately 600 persons were assisted in this way during the fiscal year. In the majority of instances, sponsorship was by the Department. Some 165 disabled persons were helped by the Rehabilitation Division, Health Branch, others were assisted directly by the Department of Manpower ... Locating employment opportunities has been considered a function of the Canada Manpower. Social assistance recipients, however, cannot compete well with other job registrants for available jobs. Further, many

> employers do not work through Canada Manpower. From time to time, individual social workers have undertaken to canvas local employers and reported success in placing recipients in jobs. (p. 15)[58]

In addition, "sheltered workshops, such as Goodwill Industries in Victoria" were relied upon "to provide both on-the-job assessment and employment opportunity" (1968, p. 16). The Branch stated that they "have proved particularly valuable, and it is hoped that an expansion of this kind of provision will be possible" (p. 56).[59]

In 1972, "financial assistance became available for staffing of centres providing activities to 10 or more adult handicapped persons, regardless of the person's handicapping condition" (p. 57). The involvement of the Department of Rehabilitation and Social Improvement (previously Department of Social Welfare) with these 'Activity Centres' for the handicapped was solely in terms of funding that appeared to be rather minimal as the following statement indicated.

> Over 25 centres were assisted and continue to be assisted in varying amounts from $300 to $1,700 per month. (p. 57).

The Branch also extended its reliance upon community and other voluntary agencies for the provision of housekeeper/homemaker services to persons with physical disabilities. For instance in 1962, the Branch stated that,

> one of our more difficult and time-consuming problems is that of arranging housekeeper or homemaker services for the families of the women who are admitted to hospital or the occasional one who is being treated in her own home, particularly where the husband is earning more than social assistance but where his earnings are only sufficient to meet the month-to-month expenses. The Family Service Agency of Vancouver assisted in one case and the British Columbia

> Tuberculosis Society helped in other tuberculosis cases, while the Polio Rehabiliation Foundation of British Columbia assisted in the poliomyelitis cases. (p. 92).

In 1966, several regional administrators identified the need for Homemaker Services, but observed that they were a community responsibility.

> During the year our association with community Homemaker services has continued and we have utilized this important resource on many occasions in our rehabilitative work. We appreciate the services of this resource and we look forward to and are assisting areas that do not have this established resource to develop Homemaker resources.(pp. 20,23,32)

During 1967, a more formal bargaining model was developed to facilitate the exchange of homemaker services between the Branch and communities. The following statement made by the Assistant Director of Social Welfare has verified this point.

> A programme was launched early in the year to stimulate the development of Homemaker Services throughout the Province and a grants system of assistance was established. Many communities responded enthusiastically and by the end of the year we were assisting 25 different homemaker societies. Their work is producing many positive results by providing a helpful resource for families in difficulty than would otherwise have to be utilized. Financial assistance enabled the Family Service Association in Vancouver to expand its service from 19 to 60 homemakers, and the Red Cross Homemaker Service, Victoria, from 20 to 60 homemakers. The New Westminster Homemaker Service was developed during the year by the Kiwanas and then handed to the Red Cross to administer on a continued basis. ... There are many more examples of similar developments throughout the Province and there will be many more to come during the following year. (pp. 10,39)[60]

A regional administrator stated that,

> the number of cases involving citizens who receive a disability pension or assistance for the aged, show over-all decreases. However, the need for community resources continues. In Penticton the Soroptomist Club sponsored a Meals on Wheels service which has been quite successful ... All communities in the region are taking an ever-increasing interest in activities that

> will provide services for those needing them and will co-ordinate existing services. Homemaker Services have started in Merritt and Kamloops and planning is under way for one in Salmon Arm. Staff have assisted in the planning of these services and the new Homemaker Services, along with the existing Homemaker Services in Penticton and Kelowna, have received grants from the Department.(1967, p. 42)[61]

Responsibility for the operation of home-maker services was also delegated to other communities in exchange for financial assistance.

In Region six,

> staff played a vital part in helping three communities create resources for the prevention of dependency. Community Homemaker Services were established in Abbotsford, Chilliwack, and Surrey. Each qualified for a Department grant, along with the existing Homemaker Service at White Rock ... Community-based homemaker services continue as community agencies as well as an integral part of the social welfare programme ... At the end of the year, five community homemaker services were receiving Provincial grants. (1967, p. 56)

In Region five,

> a most significant development was the formation of the Prince George and District Community Welfare Council in November, 1966. That council with a broad base in community, has co-ordinated and encouraged a number of projects. It has been involved in a Directory of Resources, a Homemaker Services Agency, which is presently prepared to function once a manager has been found, ... (1967, p. 49).

In Region eight,

> the Dawson Creek Homemakers' Association commenced operation October, 1966. (1967, p. 57)

By 1969, "community groups ... organized or" were "in the process of organizing a homemaker service in every large centre on Vancouver Island". Where budget was low, government met the costs of this "fine preventive service, ..." (pp. 42,47, 53).[62] During 1970, meals-on-wheels services were established

in two other communities in different regions.

> Municipalities have shown leadership in the "meals-on-wheels" idea that, with the help of Civil Defence and vocational schools, has worked well in Vancouver, New Westminster, and on the North Shore (p. 39)... The Chilliwack Community Chest and Services this year, ... established a "meals-on-wheels" service. The Soroptomists look after administration costs, the hospitals provide the food and the volunteer organizations deliver the meals at 55 cents each. This Council also administers the Homemaker Service, ... (p. 52)

In 1971, the Division of Aging reported that late in 1970 "the sponsorship of this 'Meals on Wheels' programme came under the Victorian Order of Nurses ... the Co-ordinator's office was moved to the headquarters of the Victorian Order of Nurses" (p. 34).

Gate-Keeping

The rehabilitation committees that have been discussed were also implemented as gate-keeping mechanisms to screen and select out from the applicants for rehabilitation services those who would be able to benefit the most.

In 1963, the Rehabilitation section of the Family Division stated that,

> such a comprehensive programme for disabled people has been continued from the previous year on a project basis in Nanaimo, Chilliwack, and Prince George. Representatives of the National Employment Service, Provincial Health Department and Department of Social Welfare, meeting at regular intervals, screen and process selected cases. Casework services are provided by the Department of Social Welfare. A number of disabled people have been successfully rehabilitated by this means, ... (p. 36)

In 1966, a regional administrator described the operation of rehabilitation committees in that region as,

> a team approach, designed to encourage self-support among some individuals and families receiving Social Allowance. This Committee, in a systematic way, reviews the physical, mental, and vocational powers of the individual, and vocational counselling is given. To help some men and women give up the security of public assistance for the satisfaction of self-support is not easy ... (p. 27)

The gate-keeping role of the rehabilitation committees to increase the selectivity of the intake process was also reinforced by gate-keeping that occurred at the initial boundary of the regional social welfare office. One of the regional administrators stated that,

> it should be mentioned that referral to rehabilitation committees is selective and perhaps greater numbers should have been referred. However, a great deal of planning for education upgrading, training, and job placement is concluded in the district offices and because of the increased service pressures from other categories, time limitation is a factor in making full use of the consultative machinery available. (1967, p. 38)

Coding

The data indicated that coding the boundaries with sets of criteria occurred within the residual boundary decisions taken by the Branch. The intake of physically disabled persons into the pensions programme was limited by a certain set of criteria. Thus the federal Disabled Persons' Allowances were available to those totally and permanently disabled persons, 18 years of age or over, who also had "resided in Canada ten years immediately prior to the effective date of the allowance, and who, if single," had "an income of less than $720 a year, or, if married," had "an income of less than $1,200 a year" (1956, p. 62). In 1960, it was stated that "with the exception of the first year, approximately 37 per cent of the new applications

received are refused for various reasons, the main one being that the applicants are considered not totally and permanently disabled within the meaning of the regulations" (p. 49).

The manifest consequence of using these boundary spanning mechanisms was to shift the responsibilities for the provision of services, other than financial assistance for support or towards employment, towards other departments, and in particular, the community.

Establishing Similarities and Differences with the Data from the Public Health Branch in British Columbia

Introduction

It will be recalled that the decisions made by the Department of Public Health in Alberta took within its functioning, policies directed towards the case-finding, diagnosis and treatment of medically diagnosed problems of the physically disabled. These met the condition of providing an economic return in the future. The scope of these policies included, along with financial provision, some limited direct service provision as well.

Although the conceptual category of boundary decisions also emerged from the data of the Health Branch of British Columbia, several notable differences in the characteristics described by these same properties became evident. Firstly, the domain of the policies taken within the positive allocative selection decisions of the Health Branch was broader. Not only were case-finding, diagnosis and treatment policies included, but rehabilitation programs directed towards the employment of the physically disabled were also included within this domain.

The scope of the latter was limited to the provision as well of minimal financial assistance and some individual case-work services. The condition that these policies must meet an economic criteria underpinned most of the policies taken in, although it varied in degree among them.

The following examples verified the existence of these similarities between the two health departments, while differences were accounted for by an extension of the range of the data accounted for by properties of the conceptual category.

Positive Allocative Boundary Decisions

As early as 1949, the Division of Tuberculosis Control identified rehabilitation of patients with TB as being within their domain, when the rehabilitation programme, which was initiated by the British Columbia Tuberculosis Society, was transferred to its jurisdiction. The Director of the Division described the services offered by it to the tuberculosis target group.

> Organizations set up for the control of tuberculosis must approach the problem and organize their forces for attack along four major fronts, namely, treatment, case-finding, prevention, and rehabilitation. Treatment for many years at the outset of the campaign demanded all the Division's attention, and the other phases gradually developed and increased in importance ..." (British Columbia, Department of Health and Welfare, Health Branch 1955, p. 132)[64]

During the fifties the rehabilitation work of the Division increased, as described below.

> In May, 1954, the Tuberculosis Rehabilitation Service was expanded, and two rehabilitation officers were added to the staff. Integrated rehabilitation services, which include vocational counselling, pre-vocational training and academic instruction, occupational

> therapy, and post-hospital vocational training and placement guidance are now offered to patients in all sanatoria.(1954, p. 126)

Another component to the treatment program was added in 1959, by applying the principles of progressive care according to the degree of illness or nursing care required by the patient. With the advent of antimicrobial therapy for tuberculosis it had become apparent that many TB patients "could look after many of their own needs and would become less dependent and better able to make the transition from sanatorium to the home environment on discharge" (1961, p. 88). Thus in May 1959,

> a method was worked out whereby patients would be classified according to their nursing-care needs, whether this should be intensive care, intermediate care, minimal care, or self-care.... The progressive-care plan in the form of a minimal-care unit was introduced at Pearson Hospital in November, 1959, with accommodation for seventy-eight ambulatory patients. The objective was to provide a type of environment that would encourage self-help and a greater sense of personal responsibility towards the patient's care and welfare during hospitalization and after discharge.(1961, p. 88)

In 1955, another programme for the care of a special group of the physically disabled was set up under the Division of Tuberculosis Control. This initiated the trend towards taking policies concerned with custodial care (not treatment for cure or adaptation) of the physically disabled into the functioning of the Health Branch.

It must be noted, however that up until 1949, the Provincial Infirmary had been within the jurisdiction of the Health Branch. The three branches of the Infirmary (at Marpole, Vancouver; Allco, in Haney; and Mount St. Mary in Victoria) were used "to provide custodial sympathetic care for persons with

incapacitating disabilities" (1947, p. 77) who could not be rehabilitated or whose life could not be saved. Special and acute treatment was provided for these patients at the larger general hospitals in Vancouver and Victoria. In January 1949, the jurisdiction of the Provincial Infirmary was transferred to the British Columbia Hospital Insurance Service (a separate branch of the Department of Health and Welfare). The Division reported that,

> in 1955 the Provincial Government undertook to provide care and treatment for chronic poliomyelitis patients who were accumulating in general hospitals. This group represented those cases that had been left with severe residual paralysis and could not be taken care of outside of hospital. Almost all had chest paralysis as well as paralysis of their limbs and were in respirators. It was decided that they could be best cared for by those who had experience in the treatment of lung diseases, so a programme was set up under the Division of Tuberculosis Control and a Poliomyelitis Pavilion was built at Pearson to accommodate these people... Because at the outset the field of endeavour had not been well developed, most emphasis was placed on the custodial aspects of care. However, the objective has always been to help these patients do more for themselves and to make them as independent as possible.... Through these efforts a well-developed programme of physical and vocational rehabilitation has been developed. During the past eighteen months the Provincial Rehabilitation Service has helped considerably by providing splints and other prosthetics for these patients... there is a special liaison with the G.F. Strong Rehabilitation Centre by which a consultant visits the patients to advise on physical rehabilitation and to arrange transfer of the patients to the Rehabilitation Centre when they are able to benefit from the facilities that are available there.(1955, p.)[65]

Efforts were made in this program to encourage the adaptation of the poliomyelitis patient to his disability.

> Every effort is made to develop any capability that the patient may possess so that he may become less dependent on help from others. Occupational therapy also plays a large part in the rehabilitation of these patients, and this is encouraged to stimulate them

> to greater effort... One patient has almost reached the stage of being self-supporting through the sale of his paintings.(1955, p. 86).

Prior to 1960, patients were expected to pay for rehabilitation services. However with coverage beginning for chronic treatment and convalescent programs, cases with "similar conditions caused by other diseases and necessitating the same type of treatment as poliomyelitis" (1962, p. 86) began to be cared for in the pavilion. This trend was identified in the 1964 annual report of the Division of Tuberculosis Control (the year in which the Health Branch resumed operational control of the Provincial Infirmaries).

> Besides facilities for tuberculous patients at Pearson Hospital, there are beds for continuing care, and these consist of the Poliomyelitis Pavilion, which has been in operation for several years, and a block of 132 beds previously used for tuberculosis which have now been assigned to replace the Allco Infirmary and Marpole Infirmary.
>
> With the decline in poliomyelitis incidence there has been no demand for the admission of chronic poliomyelitis cases for about two years, and this has resulted in some empty beds in the Poliomyelitis Pavilion. This unit was designed essentially to deal with the respiratory problems of chronic poliomyelitis, and highly specialized facilities have been set up for this purpose. When beds became vacant, it was decided that other chronic and severe neurological conditions complicated by respiratory problems could benefit from the facilities, such as iron lungs and rocking beds, and should be admitted. As a result there are now six such cases in the poliomyelitis unit as well as 30 poliomyelitis patients.
>
> In May of 1964 all of the patients from Allco Infirmary were moved to Pearson Hospital, and there are at present 27 of these cases in the institution. A programme of activation was instituted for this group, 111 The transfer of the patients from Marpole Infirmary is dependent on the building of an activities area... it is hoped that the building will start early in the new year.(pp. 79,80)[66]

In 1966, the Division described that "the programme for long-term care of non-tuberculous patients at Pearson Hospital

continues to expand. There are now 35 patients in the Poliomyelitis Pavilion and 128 patients in the other long-term beds, including those devoted to severely disabled persons now termed 'extended care' patients" (pp. 60,61).[67] Commencing December 1, 1965, hospital coverage for patients in non-profit extended care hospitals and units was begun. In 1970, the Health Branch stated that Pearson Hospital served two broad categories of patients - "those with tuberculosis or other respiratory problems and those who are in need of extended care, including those suffering from the effects of poliomyelitis" (p. 37). The Pearson extended-care program became known as the Division of In-patient Care in 1971.

In 1954, the provision of rehabilitation services to the physically disabled group was expanded with the signing on April 15 of the Co-ordination of the Rehabilitation of Disabled Persons Agreement. The Health Branch announced the "appointment of a Provincial Co-ordinator of Rehabilitation who" was "directly responsible to the Deputy Minister of Health" (p. 126).

The allocation of resources was directed in the main towards facilitating the provision of vocational rehabilitation services. Individual case-work services were provided by the Co-ordinator towards this end. In addition a small case-finding service was set up. The following examples illustrated the scope of this program as well as the existence of the economic condition under which it was implemented.

The following statement made by the Co-ordinator in 1961 as well in preceding and subsequent annual reports described the limitations that were placed on the provision of direct services to the physically disabled individual.

> While direct services, with the exception of some vocational counselling, are not undertaken by the Rehabilitation Services, a careful analysis of the presenting problems is made in each accepted case. Such services as may be relevant are arranged in a logical sequence, and appropriate agencies are requested to provide such attention as may be required in each individual case. Thus the resources within the community are mobilized and co-ordinated for the benefit of the disabled person. ... The Rehabilitation Service then follows the patient through the rehabilitation process until a conclusion is reached.(pp, 110,113)[68]

In 1969, the Branch stated that,

> many persons with physical handicaps need the special skills of medicine, psychology, social work, and vocational training. The function of the Division of Rehabilitation is to integrate and co-ordinate these skills so as to develop or restore as much as possible the ability of the person to compete in employment, and to foster independence and self-determination. To accomplish these purposes it is necessary to marshal the resources of the individual and many of the resources of the community.(p. 40)

A case-finding service was also part of the Branch's responsibilities. In 1955, the Co-ordinator stated that,

> a modest beginning was made early this year to gather this information and to record it centrally by a survey of public records. The "Disabled Persons' Allowances Act" provides for the referral of certain applicants to the rehabilitation service, and such referrals by the Disabled Persons' Allowance Board have been made consistently to the office of the Rehabilitation Co-ordinator. Referrals from various agencies interested in the handicapped and self-referrals of handicapped individuals also have been accepted. As a result, a register of adult disabled persons has been started.(p.139)[69]

In 1962, the Co-ordinator stated that "the Rehabilitation Services has continued to carry a small load of its own in the field of vocational rehabilitation" (p. 102). Although the "ultimate goal" was to "assist the referred person to industrial competence and financial independence" (1960, p. 111) ... some clients did "not become either gainfully employed or financially independent ..." (1956, p. 130).[20] It was felt however that the "attention and

service they ... received ... resulted in a greater degree of physical and social independence" (1956, p. 130).[31] In 1968, Rehabilitation Services identified that "in the past the major effort in rehabilitation has been toward assisting people to become financially independent" but added that "it has always been the aim of the Health Branch to develop a programme which would be diversified and extended to include those who might be restored to self-care and personal, if not financial, independence" (p. 52).

These statements reflected the existence of a humanitarian value that has been described more fully in valuation contexts.

Under Schedule R of the Canadian Vocational Training Agreement, provision was made through the Branch for disabled persons to take vocational-training courses. The employment orientation of the services offered by the Rehabilitative Services was illustrated again in the following statement made by Co-ordinator in 1959.

> The experience of the Rehabilitation service to date has demonstrated that one of the prime needs of disabled persons after physical restoration is assistance toward proper preparation for work.(p. 88).

and in 1960 that,

> to the majority, rehabilitation is synonymous with productive work and gainful employment. It is for this reason that vocational rehabilitation measures are so vital to the rehabilitation process.(p. 112)

In 1968, the statement was made that,

> this Division is responsible for administration of the provisions of the Federal-Provincial Agreement for the Vocational Rehabilitation of Disabled Persons. Schedule 3 of the Agreement provides for vocational training for the Handicapped.

> This aspect of the programme is a most valuable one. In most cases it is the means by which the disabled are prepared to overcome the effects of a handicap imposed by their disability so that they may again be economically self-sufficient.(pp. 50,51)

Other services and aids provided by the Health Branch for the rehabilitation of the disabled were listed in the annual report for 1970 as follows:

> Diagnostic and treatment services not covered under plans such as the British Columbia Medical Plan and the British Columbia Hospital Insurance Service, which may be deemed necessary to correct or alleviate a disability.
>
> Provision of prostheses, braces, hearing-aids, and such other medical services or items that may be required to further a vocational rehabilitation plan. Psychological and vocational testing and counselling services.
>
> Specific vocational training or retraining where necessary. (The Health Branch, therefore underwrites the cost of job-training at almost any level from industrial workshops through vocational schools, schools of technology, junior colleges, and universities, when such training will result in employment. In addition to tuition, maintenance allowances, textbooks, supplies, and transportation may be paid for.).(p. 40)

In 1971, the Division of Rehabilitation became the Division for Aid to Handicapped (the Registry for Handicapped Children and Adults once again became an independent entity under the Division of Vital Statistics). Although the 1971 annual report stated that the "important name change ... from the Division of Rehabilitation to the Division for Aid to Handicapped ... describes more accurately the function and philosophy of the Division, which of necessity, was preoccupied with the vocational rehabilitation of the handicapped but now provides assistance to handicapped individuals without reference to a vocational settlement", the completion of this statement indicated that

economic criteria remained as its basic underpinning. The Division went on to state that it "still believes that the goal for most disabled people is gainful employment, and it is toward this end that services are directed" (p. 48). The committee structures that served the disabled in the province were renamed Aid to Handicapped Committees.

In 1965, the rehabilitation programme was extended to include a number of patients who were maintained on a routine of peritoneal dialysis within their own home. "In view of the costs involved, the inability of the patients to meet these costs and the lack of any alternative resources, the Division of Rehabilitation Services ... assumed the administrative responsibility for arranging financial assistance from Provincial Government funds" (1965, p. 80).[72] During 1968 funds were also made available by the Government to set up a training programme for home hemodialysis of patients suffering from chronic renal failure. The costs of out patient treatment were also assisted by the government. The Rehabilitation Services Division gave assistance to "... people toward the purchase of drugs and other medications for the control of infection and blood electrolytes" (1969, p. 42).

The main focus of the kidney failure program's expansion in 1972 was to "provide supplies for other patients who" could "be cared for at home" in order to reduce institutional costs. The Health Branch stated that,

> for example, there is one patient with Crohn's disease who must receive most feeding intravenously. The maintenance cost is $287 a month. Although it may seem costly to maintain these patients, it is

> much less than the $1,500 or more that it would cost to occupy a hospital bed for a month.(p. 23)

Funds for the rehabilitation of children born with thalidomide deformities were also administered by the Division. Funds included medical care, travel for consultations, and the purchase of prosthetic equipment.[73]

The only other treatment programme for a medically diagnosed pathology, other than TB, that was included in the Branch's functioning, was a rheumatic fever prophylaxis programme. In 1959, the Branch stated that "a rheumatic fever prophylaxis pilot project was commenced whereby oral penicillin was supplied to patients in four health units within the Province" (p. 35). In 1960 it was expanded "to include all the Provincial health units, together with the Metropolitan Health Committee of Greater Vancouver" (p. 36). Free medication was distributed to all children in the province who had had "an established attack of rheumatic fever" (1960, p. 41) in order to protect the patient from "further attacks of streptococcal infection, which might again aggravate the rheumatic condition and lead to permanent cardiac damage" (1962, p. 72). The Branch stated in 1964 that "there is little doubt that the programme obtains results in prevention of cardiac damage among this group, allowing them to attain maturity in as healthful physical state as possible" (p. 13).[74]

Case-finding services were well developed within the Public Health Nursing arm of the Health Branch. "The public health nursing program with its aim to prevent disease, reduce sickness, and to produce positive health, ..." participated

"in programs for the prevention of handicaps, finding of orthopaedic cases, and the correction of known physical or mental defects ..." and assisted "in finding tuberculosis individuals through individual and group examination methods" (1956, p. 35).[75]

The public health nurse carried out this case-finding function in infant, preschool and school health programs as indicated in the following statement made by the Director of Public Health Nursing in 1953 and in subsequent annual reports.

> the child-health program is concerned with the physical and mental well-being of all children, and is continued throughout the growing period from infancy to adulthood. The programme is effected through child-health conferences, health supervision in the school, and through visits to the mother in the home ... (p. 40) During these contacts the public health nurse has the opportunity of finding physical or emotional defects and will suggest medical follow-up as indicated ... (1955, p. 43) Assistance is given parents in providing resources for the correction of defects and medical care as indicated.(1960, p. 50)[76]

In 1949, case-finding directed specifically towards detecting the extent of disability in children was implemented through public health nursing. The Director of the program stated that,

> following a trial survey of the crippling diseases of children in the Matsqui-Abbotsford-Sumas public health nursing service, plans were drawn up for a survey to be completed throughout the Province for a one-year period... The survey is being carried out in conjunction with the general programme. It is expected that the results of the survey will indicate where the emphasis should be placed in providing the best preventive and treatment services for children suffering from crippling diseases.(p. 55)

This condition of an expected economic return, underpinning the implementation of the survey, was made explicit in the following statement by the public health nursing division. It stated that

> the public nursing service has continued to expand and broaden, requiring that the public health nurse readily adapt herself to new programmes as the emphasis shifts towards the less spectacular but equally important phases of health as related to our economic and social system. This trend has been exemplified during the past year by such developments as the survey of crippling diseases of children.(1953, p. 43).

The public health nurse carried much of this case-finding function into the schools of B.C. The purpose of case-finding, as expressed by the Bureau of Local Health Services, was to direct "attention to the health problems which can be given attention during the early formative years of the child in the prevention of much later physical defect, with its possible suffering" (1950, p. 43).[77]

The aims of the school health programme with respect to the physically disabled were expressed as those stated by the Illinois Joint Committee on School Health, in the annual report for 1953.

> ... To protect the child against communicable and preventable diseases and avoidable physical defects by providing effective public health control measures, both individual and social, throughout the school and the community.
>
> ... To discover early any physical defects the child may have, secure their correction to the extent that they are remedial, and assist the child to adapt himself to any individual handicap.(pp. 25,40)[78]

In 1955 changes were made in school health screening programs so that after the routine examination of the pre-school and Grade 1 school child, attention was "concentrated upon those pupils ... more likely to have a physical, mental, or emotional condition, requiring some remedial action, ..." (1955, p. 53).[79]

In 1956, the role of the public health nurse was clearly identified as that of a case-finder and referral agent.

The Division of Public Health Nursing stated that,

> the public health nurse supervises the health of the school-children in her district...
>
> The public health nurse concentrates on the children needing special attention as her time can best be used in this manner... The nurse will refer children needing special treatment or care to their private physicians and may in turn assist in obtaining special help if required from voluntary agencies such as the Canadian National Institute, the Junior Red Cross, the Crippled Children's Hospital, the Health Centre for Children, the Queen Alexandra Solarium, and the Preventorium ... During these visits the public health nurse may discuss such items as ... need for correction of physical defects such as cleft palate and harelip, speech defects and crippling conditions.(p. 53)[80]

During the sixties, the Bureau of Local Health Services described the function of the school health program.

> It was reasoned that the referral system accomplishes the primary purpose of the school health examination as a case-finding technique, and permits a rapid identification by the health team (including the teacher) of the majority of conditions which are picked up on routine examination, such as deafness, eye defects, orthopaedic defects, etc., but entails much less time and less disruption of the day-to-day school programme. It is reasoned that efforts should be devoted to identification of these children with many of these debilities while they are still of pre-school age, since correction of the defects is more readily obtainable at this age. Ideally, then, if routine examinations are to be done, the parents should be encouraged to take the child to the family physician at an early pre-school age.(1961, pp. 20,21)[81]

Although the case-finding technique had become altered, the role of the public health nurse had not changed, since "emphasis continued on identification of pupils having special problems and the channelling of community health services to those in need of assistance" (1966, p. 42).[82]

By 1956, the Division of Public Health Nursing was beginning to consider that the provision of some rehabilitation services was within its domain. The Division stated that,

> ten years have now elapsed since the public health nurses became Provincial Government employees. During this time unprecedented growth and expansion has taken place in the Province. This has led to a much larger public health nursing service than could have been anticipated ten years ago. During the interval there have been many new scientific and medical discoveries which have altered the public health nursing service to fit in with the changing concepts of prevention and treatment of disease, and the promotion of positive health. Some of the developments include, ... nursing care and housekeeper service in the home, ... use of expanded resources for the treatment of crippled and handicapped children and adults, and more emphasis on rehabilitation, mental health, and health education. (1956, p. 48).

In 1960, "due to the need for special emphasis on rehabilitation, the public health nursing consultant in Vancouver was assigned the task of stimulating interest and developing more emphasis on this phase of the public health programme". The Division stated that the consultant "is working closely with rehabilitation specialists to help work up a programme which can suit the situation in this Province. Some progress has been made in extending and improving loan cupboards in areas providing home nursing-care service. In addition, a closer working relationship is being developed with the Victorian Order of Nurses so that rehabilitation nursing can be extended in areas served by both agencies" (p. 48). Rehabilitation was "considered an integral part of all care, and every effort" was "made to have each patient become as self-sufficient as possible" (1961, p. 52).

During 1961,

> the special organized home nursing programme continued to expand, and ten new areas took advantage of the home nursing service as the first step in the larger programme of home care and rehabilitation ... Local communities arrange for the home nursing and rehabilitation service to be provided as part of the health unit service by agreeing to pay an additional

> assessment of 10 cents per capita ... As there has been an increased emphasis on the need for rehabilitation procedures to be carried out, not only on a community level, but in the actual nursing care of the patient, the public health nursing consultant with special training in this work has been able to give special assistance to field staff on the rehabilitation aspects of home care. It is hoped that as the public health nursing staff develops new skills in this field, more patients will be referred for care and receive special help in the home. (see page 252 for establishment of economic condition).
>
> During the latter part of 1961 a physiotherapist was employed on a part-time trial basis to demonstrate the values of consultative assistance to the public health nurses in the Saanich and South Vancouver Island Health Unit in assessing the physiotherapy procedures applicable to selected patients. This added service proved successful, and plans are now under way to employ a full-time physiotherapist so that the entire area contained in the Greater Victoria metropolitan services will benefit from this type of guidance in rehabilitation nursing procedures. In this area also, close liaison has been established this year with the "activation" ward of Gorge Road Hospital in Victoria, so that patients are able to receive required nursing care and health supervision on return home... It is anticipated, ..., that the rehabilitation nursing programme will develop on a similar pattern throughout the Province.(1961, p. 52).[83]

In 1962, the Division of Public Health Nursing identified that,

> in areas where committees of the Joint Rehabilitation Project ... have been set up ... the public health nursing staff are in a position to fulfil an active role in the follow-up of certain individuals referred to this committee for assistance. To this date, Prince George is the only area which conducts a home care programme in association with the Joint Rehabilitation Project, and it is hoped that the additional resources- for example, vocational training and placement services made available through this committee--can be used to assist some of the patients receiving home care. (p. 56)

In 1966, the Health Branch reported that,

> we continued to extend the HOME CARE PROGRAMME to new areas as eight new centres initiated home nursing

> service. The service is now provided from 56 health centres in 102 communities, and this includes 84.6 per cent of the population within the Provincial health unit areas. Rehabilitation nursing has continued to be emphasized, and two additional part-time consultant physiotherapists were employed. Ten of the health units had the advantage of a consultant physiotherapist from the home care programme, and this made a great contribution to the improvement in physical and mental rehabilitation of patients.(p. 45).

The particular function of the consultant physiotherapists was described in 1968 by the Division of Public Health Nursing.

> Their main function is to assist with home care, which often involves rehabilitation nursing. Physiotherapists supervise the progress of selected patients so that suitable rehabilitation plans can be developed. In some cases homes are assessed and alterations and adaptations suggested prior to a patient's discharge from rehabilitation facilities to his home. They help to extend the benefits of rehabilitation by the provision of in-service training to the public health nurses. In addition, they provide help to some operators of personal-care institutions and private nursing homes in the development of rehabilitation nursing and recreational programmes for patients in these institutions. (p. 64)

In 1970, under the Home Care Programme, "83,255 visits were made for tertiary prevention concerned with improving, rehabilitating, or maintaining patients with both mental and physical conditions at home" (p. 28).

By 1972, home care was available in 114 communities to over 80 per cent of the population in the Provincial health units. During this year two separate categories of home care began to be distinguished. The traditional home care program had provided nursing and social work services at no cost to the patient. If other services were required and available they were paid through insurance plans or paid for by the patient according to his means. In 1971, "a special home care project to serve

persons discharged early from the acute general hospitals in the Coquitlam-New Westminster area" was begun. "All services, including nursing, physiotherapy, homemaker, meals-on-wheels, medication, and supplies were paid for by Provincial Health Branch funds" (1972, p. 29). Home Care stated that the "cost of replacement days" was "approximately one-quarter the cost had the patient remained in an acute hospital" (p. 29). This hospital replacement home care program began to be introduced across the province in 1972.

In 1952, as a result of the survey of crippling diseases of children conducted from 1949 to 1950, it was recommended that a registry of crippled children be set up. The Health Branch stated that, "at the first meeting of this panel on May 9th, 1951, it was explained by the chairman,..., that the function of the panel would be to advise as to the type of cases to be registered and, after registration, to advise as to plans for treatment. The registry" was "to be a voluntary one, cases being reported from the private physicians, hospital, and public health authorities" (1951, p. 30). In 1952, it was reported that,

> the Registry of Crippling Diseases in Children has shown steady progress this year. Crippled children are now registered routinely by the local health services, who consult with the family physician before submitting the registration, and all new-borns with congenital malformations or birth injuries are automatically registered by the Provincial Division of Vital Statistics. A technical medical committee representing the various specialities concerned is available for advice in particular cases. A definite working liaison has been established with the local hospitals, the Provincial School for the Deaf and the Blind, Child Guidance Clinics, and the Woodlands School, and private agencies such as the Junior Red Cross, Canadian National Institute for the Blind, and the Cerebral Palsy Association of British Columbia. There are definite indications of increasing the

use made of this Registry.(p. 96)[84]

The following example indicates that although one of the Registry's main objectives was "the procurement of needed medical services for handicapped children", it was also concerned about "problems encountered by handicapped children... related to special vocational training and placement".

> During the year, several groups of older children on the registry files were selected and their needs examined with respect to specific help in job placement. The rehabilitation service of the Health Branch and registry staff worked closely together in carrying out these studies.(1959, p. 65)

In 1961, the registration of adults was initiated by the Registry,[85] and during 1963, "arrangements were made to develop a registry of congenital anomalies within the framework of the Registry of Handicapped Children and Adults" (p. 22).

In 1962, since the "majority of the registrations... on file respecting adults ... originated with the G.F. Strong Rehabilitation Centre, or ... were originally registered in the Children's Registry and ... reached the age of 21 years ... arrangements were made for the registration of cases being seen at the local rehabilitation councils under the welfare rehabilitation survey plan" (p. 10). Arrangements were also made during that year for the registration of children with handicapping conditions who attended the Health Centre for Children in Vancouver, and for the registration of disabled persons who came within the purview of the Canadian Arthritis and Rheumatism Society.

The data indicating the existence of the negative structural selective boundary decisions has illustrated,

especially with respect to the rehabilitation policies, that the resources that were made available to the physically disabled through the Branch usually came from the voluntary sector.

Negative Structural Selection Boundary Decisions

Negative structural boundary decisions, similar to those made by the Social Welfare Branch, were also taken by the Health Branch to regulate the boundaries of their positive allocative policy decisions. The conditions met by the boundary-spanning mechanisms that were implemented by the Branch were also similar to those utilized by both Alberta, and B.C.'s Social Welfare Branch. Although the manifest consequence of initiating these mechanisms in Alberta was to shift the responsibility for the direct provision of rehabilitation services onto other government agencies and especially the private sector, the evidence from B.C. also indicated that the boundary spanning mechanisms employed by the Branch were implemented more with the specific intention of increasing its control over the voluntary sector.

Uniformities in the data indicated that the voluntary organizations were often seen as tools. Perrow (197) has stated that "a tool is something you can get something done with. It is a resource if you control it. It gives you power others do not have" (p. 7). The services of these agencies were used to allow the Health Branch to choose its own domain and to allow it to maintain the boundaries of that domain.

One of the main boundary spanning designs that was chosen for these purposes was a co-ordinative design that was implemented as a "lead agency" (Agranoff, 1977, p. 23) at the

local level. Under this design, a single agency among other agencies delivering related services was designated for the system wide coordination of these particular agencies. A bargaining model developed by the Branch led to the development of this model by effecting the exchange of service with other government departments and agencies. Examples that verified the existence of the bargaining model have been presented first, leading into those examples that illustrated the implementation of the lead agency model.

Bargaining

In 1952, the Health Branch stated that,

> the people of British Columbia are provided with official public health and preventive medical services by field-workers stationed throughout the Province, institutions, clinics, laboratories, and special consultants. These official services are strengthened and supplemented by the physicians and dentists in private practice and by the voluntary health agencies whose services are well-coordinated with those of the Provincial and local health departments.(p. 12)[86]

In 1950, the Branch also stated that "it is felt that the people of the province are being well served by these voluntary organizations" (p. 20). This exchange of services to the voluntary sector was deemed necessary by the Branch because it had not "yet considered it desirable or necessary to enter into those specialized fields on an operational basis" (1954, p. 14). Thus in exchange for the operation of certain services by the private sector, "considerable financial support" was provided them "through the Health Branch" (1954, p. 14).

In 1949, the Health Branch described the services of several voluntary organizations that it utilized.

> During the year the Provincial Government made substantial grants to such official non-government health agencies as the Western Society for Physical Rehabilitation, the British Columbia Division of the Canadian Arthritis and Rheumatism Society, and the British Columbia Cancer Institute. Through the Health Branch office the Government was kept informed on the administration of these organizations, and the integration of their services with the general public health services in the Province.(p. 15)[87]

Lead Agencies

The Provincial government began to be involved in encouraging the establishment of a lead agency for the co-ordination of services towards a specific disability group, the arthritic, in 1946. Statements from the Health Branch described these events.

> The Provincial Department of Health, especially through its relations with the Dominion Council of Health, has maintained continued interest in this field of public health work. Increasing study of the problem of arthritis has been evident throughout the Dominion, and public health officials in British Columbia have shared fully in this. Leaders in public health throughout Canada have felt the need for a national organization to study arthritis and its control. They anticipate the establishment of such a body which will provide central leadership and direction in matters pertaining to prevention, diagnosis, treatment, research, education and training of technical and professional personnel.(p. 11)

Then in 1947, the Branch stated,

> thus, at the year's end, a national organization for the study of arthritis and its control awaited only one further and imminent meeting to make it a reality.
>
> It is anticipated that this organization will give direction to the logical development of research and co-ordination to the activities of all agencies concerned with the treatment and control of arthritis. (p. 14).

During 1948,

> ... the British Columbia division of this national

> organization was the first in Canada to organize and develop a programme for arthritis. This programme is planned to start functioning early in 1949 in co-operation with the Provincial Department of Health, certain key hospitals, the British Columbia Medical Association, other professional associations, and voluntary organizations.(p. 21).

In 1949, the British Columbia Branch of the society had established a pilot centre for the treatment of arthritis as part of Vancouver General Hospital's out-patient department, with plans for expansion already under consideration. The programme itself was "financed by Federal, Provincial, and voluntary funds" (p. 13). Branches of the society were organized in eight centres throughout the Province with plans under way in most of the centres for the establishment of physiotherapy services. In Vancouver "four physiotherapists" provided "treatment and education at the clinic and in the home to patients referred to them by physicians" (p. 13).[88]

In 1949, the Branch began to obtain the services of another agency for the retraining of patients suffering from poliomyelitis, as the following example indicated.

> A new development, which is being financed this year but which will easily become an integral part of any Provincial programme, is the provision of staff and facilities whereby patients under the age of twenty-one will receive the necessary investigation, retraining and rehabilitation following an attack of poliomyelitis... The opportunity thus provided for these patients with residual paralysis to have retraining will enable them, as far, as possible to return to normal living.(p. 30).

This program was managed

> under the Western Society for Physical Rehabilitation, Vancouver, in co-operation with the Poliomyelitis Advisory Committee of the Vancouver General Hospital and the private physician.(p. 30)[89]

The Branch described this organization as providing "leadership in the rehabilitation problem amongst paraplegics, not only in British Columbia, but in all of Canada" (1950, p. 20).[90] The importance of this lead agency in co-ordinating other services offered to the physically disabled population become apparent in the following statement made in 1951.

> The services given by the Western Society for Physical Rehabilitation were improved and extended by the establishment of a brace-shop at the centre this year ... Although the service is presently limited to those attending the centre, it is hoped that this will eventually provide brace-making services for the Province as a whole. Further expansion of this programme took place when an out-patient unit for cerebral palsied children was opened at the Rehabilitation Centre this spring. The training for these children includes speech therapy as well as formal and informal education". Arrangements were also made "for the medical branch of the Canadian Arthritis and Rheumatism Society to be housed in the Rehabilitation Centre. In addition, space and facilities were allocated the medical branch for the treatment of arthritics on an in-patient and out-patient basis. (p. 30).

Beginning in 1951, the expansion of the Society's facilities took place with the addition of a new wing on to the centre, and an expansion of their services occurred when a combined social worker and vocational placement officer was engaged, and an institutional training program for academic and vocational training was commenced.[91] The Branch's reliance on the Society for co-ordinating services to the disabled became very evident in the following statement made by the Bureau of Special Preventive and Treatment Services in 1952. The Bureau stated that

> it is hoped that ... the majority of rehabilitation services for the Province will be centralized here; in a field as highly skilled as rehabilitation, it is of paramount importance that the skilled personnel who are few in numbers, and the expensive equipment

be centralized if our programme in rehabilitation is to advance to the full benefit of the people of this Province.(p. 92)[92]

Similar statements, presented below, appeared in 1954, and in subsequent annual reports.

Early in 1954 there will be an additional twenty beds and 15,062 square feet of diagnostic, treatment, and out-patient facilities completed at the Western Society for Rehabilitation. This will aid materially in increasing the services now available to the people of the Province of British Columbia through the Western Society for Rehabilitation, Canadian Arthritis and Rheumatism Society (British Columbia Division), and the Cerebral Palsy Association.(p. 101)

The Western Society is continuing to study plans to further develop and strengthen the services of the Centre in order to keep up with the rehabilitation requirements of this Province.(1955, p. 110)

Currently, preliminary planning is under way to provide a multi-storey addition to this Centre. This expansion is not only required for the G.F. Strong Rehabilitation Centre programme, but for the other agencies served by the Centre, particularly the Cerebral Palsy Association of Greater Vancouver and the Canadian Arthritis and Rheumatism Society, British Columbia Division (1957, p. 33). (The name of the centre was changed from Western Rehabilitation Centre to the above when in 1957, its founder died).

The G.F. Strong Rehabilitation Centre is a non-profit community organization registered under the Societies Act and the Hospital Act of British Columbia.

Its primary purpose is to assist in the rehabilitation of disabled children and adults, on an in-patient and out-patient basis, through an integrated programme of medical, psychological, social, educational, and vocational evaluation and services under competent professional supervision. The major portion of such evaluation and services is furnished within the Centre, and all medical and related health services are prescribed by and under the supervision of physicians employed by the Centre who are licensed to practise medicine in British Columbia.

In fulfilling its purpose, the Centre has developed a co-operative working relationship with other community organizations in order to bring the maximum resources possible to bear on the problems experience by disabled individuals in the Province.(1960, p. 37)[93]

The importance of the Canadian Arthritis Society's services to the population emerged from the following examples.

In 1956, the Bureau of Special Preventive and Treatment Services noted that,

> the physiotherapy, medical consultant, and other special services offered by this Society were extended to the Prince Rupert, Terrace, Princeton, Lytton, and Grand Forks areas of the Province during the year. Thus, a network of Canadian Arthritis and Rheumatism Society services is available at the request of the family physician, for patients with rheumatic disease, in all parts of British Columbia except Golden, Dawson Creek, Burns Lake, and William Lake areas.(p. 110)[94]

By 1958,

> a supervised Provincial Treatment programme as nearly complete as staff, facilities and funds will allow, is now in operation for those in British Columbia who have rheumatic disease.(p. 28)[95]

The Society had also made available the provision of special drugs to the border-line economic group of patients, as requested by physicians (1957, p. 32), and from 1961 onwards it undertook the care of those with "disabilities caused by other diseases as well as arthritis" (p. 32) where the only physiotherapy service available was provided through their agency.[96]

The establishment of these two primary lead agencies also allowed the Health Branch to remove the responsibility of providing training facilities for the physically disabled from their domain. The Branch made explicit their recognition of the Arthritis Society's reliance "... on established facilities for job training and placement," and that "although maximum function can be restored physically, total rehabilitation cannot be achieved in some cases because present facilities cannot meet the demand" (1957, p. 32). Thus the Society was compelled to

direct some of their efforts towards providing some job opportunities for their patients that would not otherwise be available. In 1960 the Bureau reported on these efforts.

> Every effort is made to restore to useful living those patients who have achieved maximum function. Courses are arranged where needed and work found for those able to return to remunerative employment. Some, however, are unable to work in a competitive field, and, for 138 of these, instruction in arts and crafts has been supplied. Thirty have achieved a sufficiently high standard of skill to produce saleable articles. These articles are sold on the open market with financial returns to the patients, some of whom have become independent of social assistance by this means. (p. 37).

In 1961, it was also made clear that the Health Branch was not willing to be responsible for the operation of community workshops for the disabled.

> Until a community-wide special training and production workshop for disabled persons is established on a proper basis, the Canadian Arthritis and Rheumatism Society is continuing the operation of the Carscraft Instruction Centre, followed by the Bluebird shop for sales at Christmas time. Because the Canadian Arthritis and Rheumatism Society believes that such a centre is both necessary, and possible, a limited number of referrals are being accepted from the G.F. Strong Rehabilitation Centre and the Canadian Paraplegic Association ... they have produced articles which are sold on a competitive market. The workers receive the proceeds.....
>
> The Canadian Arthritis and Rheumatism Society board of directors is exploring sub-contracts which could be handled by disabled people.(p. 60).

In 1964, emphasis was still given to the need for vocational rehabilitation services by the Society, but, as the Bureau reported, "so far it has not been possible to find a community group to sponsor co-ordinated sheltered employment for the disabled" (p. 60).

Aside from these two lead agencies that were developed

through the Health Branch, the services of other voluntary agencies were also used in exchange for financial support.

During 1952, the Cerebral Palsy Association was established. Its objectives were "to promote diagnosis, treatment, education, and welfare of cerebral-palsied children and to promote an environment in which the cerebral palsied child may have the opportunity for the best possible adjustment and development of personality, including occupational training and opportunity for employment". Thus facilities were provided at the Western Society for Rehabilitation "at a nominal rental". The Health Branch also noted that "the latter organization has also assisted in many other ways to get the programme for cerebral palsied children established on a firm basis" (1952, pp. 92,96).[97]

In 1954, the Bureau stated that

> it is expected that through the leadership being given by the Chairman of the Cerebral Palsy Association of British Columbia, ..., a satisfactory Provincial programme for the care of cerebral palsy children will gradually evolve. Assistance is being given this year to three branches of the Cerebral Palsy Association of British Columbia, ... Although these branches operate independently, co-ordination is achieved through the Provincial organization.(p. 103)

Three of the chief concerns of the Association were identified in 1966 as, "plans for new accommodation, transportation costs for child patients, and the rehabilitation of adult patients" (p.56).

In June 1961, the Multiple Sclerosis Society of British Columbia commenced operations with the opening of the Vancouver Chapter. The annual report for that year stated that the Society

> ... established to provide assistance to those suffering from multiple sclerosis, has, in its first year, concentrated much of its effort on locating patients

> outside the city centres of the Province.... As knowledge of the Society spreads, registration increases, and it is planned, in the coming year, to continue efforts towards having every multiple sclerosis patient in the Province registered with the Society. Direct aid is provided for needy patients in the form of wheelchairs, orthopaedic appliances, drugs, and physical and occupational therapy, and these services have been provided in fifteen different centres in the Province during the year. (p. 35)[98]

In 1965, the Bureau described the exchange of financial support from the government for the operation of direct services to those persons with M.S.

> The chief aims of the Society are to administer financial and other aid to multiple sclerosis patients throughout the Province.
>
> The patients' aid programme is financed by the Provincial Government from the money made available through grants and is exclusively used to meet the medical needs of the patients. Other financial assistance is received from the various United Appeals and from private supporters of the programme.(p. 55)[99]

In 1960 the Canadian Cystic Fibrosis Foundation was formed to assist C.F. patients and their parents in acquiring the resources needed for their "lengthy and expensive treatment" (1964, p. 61). In 1965, the Health Branch began to provide monthly grants to the foundation (p. 55). The 1966 report from the Bureau of Special Preventive and Treatment Services described the services delivered by the foundation.

> The Cystic Fibrosis Foundation has set as its main objective the giving of direct assistance to the families of children afflicted by this disease. In the past year the Foundation and the Health Branch co-operated very closely in providing drugs and equipment as well as clinical medicine through the Children's Health Centre in the Vancouver General Hospital. The Foundation has also assisted in providing teaching of physiotherapy treatment methods to parents, as well as educational programmes for the children in co-operation with the Vancouver School Board. The Foundation has received welcome assistance

> from the British Columbia Society for Crippled Children and the Women's Committee in its operations. (p. 56)

The resources of the British Columbia Foundation for Poliomyelitis were also used to provide support for the provincial program throughout the fifties. In 1953, the Bureau of Local Health Services reported that,

> The British Columbia Foundation for Poliomyelitis is a voluntary agency supported largely through the efforts of the Kinsmen's Clubs throughout the Province. In addition to the provision of equipment, funds have been given toward the purchase of equipment for one or two other institutions, the provision of additional physiotherapists, and research. Because of the greater flexibility in the use of voluntary funds, it has also been possible for this organization to assume extraordinary expenses.(p. 32)[100]

And in 1954, the Health Branch stated that,

> for some few patients this agency has been able to provide financial assistance for treatment where no other sources of financial aid could be obtained, without the Poliomyelitis Foundation, such patients might have remained crippled for life because of financial inability to obtain complete treatment and rehabilitation services.(p. 15)

since it was generally expected that patients would pay for their own rehabilitation services.

In 1962, the Division of Tuberculosis Control began to utilize the resources of the Foundation as well. The Division stated that,

> ... the Poliomyelitis Foundation has been very generous in its assistance to the patients and in providing money for special equipment for them, such as positive pressure breathing apparatus, chest respirators, and wheelchairs, this help being directed toward assisting the patients to spend regular intervals in their homes.(p. 86).

In 1966, the British Columbia Heart Foundation was provided with financial assistance towards the operation of two

community service programs, described below by the report from the Bureau.

> The Cardiac Work Evaluation Unit accepts referrals of problem-heart patients, attempts to assess their capacity for work, and reinstate them in gainful employment. The transportation assistance programme for needy heart patients now helps bring heart patients from all parts of the Province whose "marginal income" entitles them to the free facilities available at the Vancouver cardiac surgery centres. (p. 65).

Finally, a statement made by the Assistant Provincial Health Officer in 1968, illustrated again the government's commitment to shifting the responsibility for the operation of many programs for the physically disabled onto the private sector.

> Through the Bureau of Special Health Services the Provincial Government each year maintains liaison with and makes grants to certain voluntary health agencies. These agencies - British Columbia Cancer Treatment and Research Foundation, ... , G.F. Strong Rehabilitation Centre, Multiple Sclerosis Society of British Columbia, Canadian Arthritis and Rheumatism Society, British Columbia Epilepsy Society, British Columbia Heart Foundation, Canadian Cystic Fibrosis Foundation, and the Cerebral Palsy Association of British Columbia - have continued to show great enthusiasm for the various tasks they have undertaken and deserve great credit for the dedicated services they have performed and for the leadership they have given in the development of their respective fields of endeavour. Each agency submits an annual budget and audited financial statement to the Health Branch, and an effort is made to meet as many of their financial needs as is possible within the policy of the grants programme and within the limitations of the total funds available. (pp. 26,27)

The Rehabilitation of Disabled Persons' Branch also relied upon the exchange of services between other government departments and themselves. For example, the vocational assessment services of both the Vancouver Youth Counselling Service and the G. F. Strong Rehabilitation Centre were used by the Rehabilitation service. In 1960, the Branch noted that although

"vocational training is an important area of vocational rehabilitation ... Special facilities for vocational assessment have not been extensively developed, but many of the disabled are eligible for admission to normal vocational training schools" (p. 111). "In training persons for employment, use" was "made of the services of the Department of Education in its vocational institutes, and in the technical training schools. The numbers, accommodation, and scope of such services "were" gradually being increased, thus adding considerably to the training facilities for the handicapped" (1961, p. 162). The costs of retraining in a new occupation were shared equally by the Provincial Department of Education and then the Federal Department of Labour under the Canadian Vocational Training Co-ordination Act (1955, p. 139). "Another essential phase of the rehabilitation process" was "job placement of the handicapped person in selected employment" (1959, p. 89). The Branch stated that "from the inception of the Rehabilitation Service in 1954, the Unemployment Insurance Commission, through the National Employment Service, has accepted responsibility for job placement of handicapped persons referred by the Rehabilitation Service" (1959, p. 89).

Considerable time was spent by the Rehabilitation Service in an attempt "to stimulate the development of new facilities for the purpose of work assessment and training of severely handicapped persons" (1964, p. 92). The bargaining nature of this boundary spanning design is clarified in the concluding statement to the above remark as follows.

> This has necessitated the laying-down of standards of operation, and of holding consultations with

existing agencies in an attempt to see how their operations might be adapted to these standards.

Some progress has been made in this field, but such progress is slow. The Poliomyelitis and Rehabilitation Foundation is providing a limited service in this field, which has proved invaluable, and has received considerable support from members of the Provincial Rehabilitation Services, both on a consultative basis as well as on payment for services to handicapped persons who have been assessed in their workshop. In view of the policy of the Department of Education to provide additional vocational training schools throughout the Province, it has been possible to place an increasing number of handicapped persons into training programmes, and to enable many of them to take such training nearer to their own homes ... A manual has been prepared by the Rehabilitation Services outlining the recommended methods of operation of local vocational rehabilitation committees, how additional services might be obtained, and the conditions under which payment may be made for such services under the terms of the Federal Act and the Federal-Provincial Agreement relating to the vocational rehabilitation of disabled persons. (p. 92)

In 1966, the following statement was made in the Rehabilitation Services annual report.

Adequate workshop facilities have been slow in developing, and this has imposed a limitation on certain aspects of the rehabilitation process. The Goodwill Enterprises for the Handicapped in Victoria has, however, recently increased its facilities and staff; with Government financial assistance, this organization has provided assessment and training services for certain special categories of the handicapped in Victoria and throughout the Province. The Rehabilitation Workshop in Vancouver has also provided a similar type of service in Vancouver; negotiations have been under way toward giving that organization also financial help, provided its services can be expanded to meet the growing needs. (p. 73)[101]

In 1968, it was reported that

the Vancouver Training Workshop for the Handicapped, through assistance which was provided by the Government of British Columbia and a private donor, has been able to expand and has recently purchased a salvage operation, ... , with potential for becoming an industrial rehabilitation centre ... It is believed

> that, in as far as the Goodwill Enterprises of Victoria is concerned, the combination of official and voluntary service which has been developed in the field of rehabilitation in the Vancouver Island region may well be one of the most sophisticated combinations of government and voluntary agency co-operation in Canada.(p. 51).

The annual report for 1969 stated the following:

> An important feature of the Rehabilitation Service is the support given to certain REHABILITATION AGENCIES to improve their contribution to the vocational rehabilitation of the disabled. These agencies receive financial assistance to the extent of approximately 80 per cent of salaries and fees-for-service of the professional personnel involved. The three most notable agencies are: The Goodwill Enterprises of Victoria; the Western Institute for the Deaf, located in Vancouver; and the Opportunity Rehabilitation Workshop, formerly known as the Vancouver Training Workshop for the Handicapped. (p. 40)[102]

The commitment of the Division for Aid to Handicapped (previously Rehabilitation Services) towards delegating responsibility to the voluntary sector for the delivery of services to the physically disabled was exemplified in the following statement made by it in 1971.

> During the year, the Division increased its financial assistance to selected rehabilitation agencies. According to a policy established some years ago, the funds were designated specifically to assist in the employment of professional staff. As a result, there has been a considerable improvement in the ability of the agencies to deliver better services to a greater number of disabled persons, services which otherwise would have to be provided by the Division.(p. 49)

In 1972, the Division addressed again the need for more vocational assessment services for the handicapped, including the physically disabled, that would involve the exchange of services between other public established agencies.

> A matter of need which should be a high priority in the development of services for the handicapped is that of planning for competent vocational assessment

> services which should be more widely available than they are. The Division has felt for some time that considerable effort should be directed toward the development of such services either within or in conjunction with the presently available vocational schools which are well equipped, competently staffed, and located in every region in the Province. Advantage should be taken of these circumstances and an effort made to add what is required in staff and equipment to make the assessment services available.(p. 49)

The one attempt made in this direction during 1972 was the initiation of an assessment service for the hearing disabled.

Co-ordinating

A co-ordination mechanism established by the Health Branch facilitated its ability to regulate its boundaries by effectively controlling the exchange of services between itself and the voluntary sector. In 1954, the Branch stated that because "the headquarters of most of the voluntary agencies are in Vancouver, the Assistant Provincial Health Officer has the responsibility of effecting proper liaison and co-ordination. This close tie between the official health agencies and the voluntary groups has done much to prevent misdirection of energies and duplication of omissions in services" (p. 14). He directed the Bureau of Special Preventive and Treatment Services.

Other annual reports described how,

> the Assistant Provincial Health Officer, aided by the Departmental Comptroller, devoted much time and thought to effecting this integration and assessing the requests of the voluntary agencies for financial assistance from Provincial and Federal sources. (1953, p. 32)[103]

In the field of poliomyelitis, the Director of the Bureau also acted as "co-ordinator of all the agencies concerned with the care of poliomyelitis patients ..." (1955, p. 108).[104]

In 1956, the Health Branch stated that

> the responsibility of this Bureau in interpreting the policy of the Health Branch to voluntary health agencies continues to grow. The services of the voluntary health agencies are many and varied but their aims and objectives must be co-ordinated with the plans and policy of the Health Branch if possible. It has been the responsibility of this Bureau to endeavour to carry this out (p. 98).[105]

This co-ordination policy pursued by the Health Branch and fueled by its financial assistance policies allowed the formulation of a dependency relationship with the voluntary organizations. The following examples illustrated this strategy.

In 1956, the Health Branch stated that,

> the relationships with voluntary health agencies have continued on a sound basis. Those agencies receiving financial aid from the Provincial Government have co-ordinated their programmes with those of the official health services. This has helped to avoid duplication of effort and unnecessary expenditures (p. 11) ... Some of the voluntary health agencies may be considered as agents of the Government, since they have assumed major responsibility for certain programmes..., rather only brief reports will be given relative to those which receive financial assistance from the Government ... (p. 98).[106]

And in 1959,

> it might be mentioned at this point that each of these agencies plays a vital role in the maintenance and development of public health services in the Province (p. 30).

The Public Health Nursing component of local health services also relied upon the utilization of resources from the voluntary sector. In 1953, the Bureau of Local Health Services reported that,

> the public health nurse supervises the health of the school-children in the schools of her district... She encourages parents to correct defects and refers children needing financial assistance for this

> purpose to suitable agencies ... The staff has been grateful for the financial assistance received from the Junior Red Cross Crippled and Handicapped Childrens Fund. This was rendered to children who would not otherwise have been able to have physical defects corrected.(pp. 20,45).

In 1955 and ensuing years, the Division of Public Health Nursing reported that,

> children needing financial aid for medical care are referred to suitable agencies. Local organizations may help by providing financial assistance. When this is not available, children may be referred to organizations such as ... the Junior Red Cross, the Crippled Children's Hospital, the Health Centre for Children, the Queen Alexandra Solarium, and the Preventorium (p. 53)[107]

A nursing consultant position was developed within the Division to facilitate the liaison between voluntary organizations. In 1955, the Bureau of Special Preventive and Treatment Services reported that,

> the Consultant in Public Health Nursing attached to this Bureau from the Bureau of Local Health Services, continues to be most valuable in co-ordinating the relationship between local health services, this Bureau, and those specialized agencies in Vancouver responsible for the care of the sick child in British Columbia. The Consultant in Public Health Nursing also accepts much of the responsibility in co-ordinating the services of the Crippled Children's Registry with local health services.(p. 108)[108]

Within the home care programme, "close working arrangements with local welfare and other agencies" were evolved through the Division "so that needed services" could "be channelled into the home". These latter included homemakers, medical supply cupboards, "meals-on-wheels", and visiting social services" (1969, p. 30).

A co-ordinated model was also employed by the Rehabilitation of Disabled Persons Branch. In 1956, the Co-ordinator stated that,

> in planning a programme for the rehabilitation of disabled persons in British Columbia, it has always been considered that two broad areas of development should initially receive close attention. First, it was felt that it was essential that the existing voluntary and public agencies, particularly in the fields of health, welfare, and education, co-ordinate services for the benefit of the handicapped person who sought rehabilitation ...
>
> The experience gained in the last two years has shown these methods of approach are sound. In the past, almost all the special agencies have found that, working alone it was difficult, if not impossible to assist those for whom they were responsible to become independent. It has been notable in this Province, that, as the philosophy of co-ordination is recognized, there is a distinctly developing tendency to broaden services and appreciate the value of inter-agency relationships. There is also apparent an increasing appreciation and comprehension of each agency's function in the rehabilitation process and an understanding of each other's capabilities and limitations. (p. 29) [110]

The 1957 annual report of the Co-ordinator described some of the agencies with which liaison was maintained.

> ... Regular consultation with agencies directly involved in the rehabilitation of disabled persons has been important in improving co-ordination. In this respect the agencies discussed below may be cited.
>
> THE G.F. STRONG REHABILITATION CENTRE
>
> Meetings are held twice each month with the professional staff of the Centre to discuss and plan for the rehabilitation of selected patients....
>
> THE REGISTRY FOR HANDICAPPED CHILDREN
>
> Both the Registry and the Rehabilitation Service are concerned with the rehabilitation of the group of registered young disabled persons between the ages of 16 and 21....
>
> SOCIAL WELFARE SERVICES
>
> No programme or regular meetings with the personnel of the various social welfare agencies has been established, but the Rehabilitation Service is continuously in communication with the social welfare agencies about individual cases.
>
> DEPARTMENT OF EDUCATION
>
> Effective liaison and co-ordination has been maintained with this Department through the Director of Technical and Vocational Education....
>
> NATIONAL EMPLOYMENT SERVICE
>
> The Rehabilitation Service and the regional officers

> of the National Employment Service have taken steps which, it is hoped, will ensure a closer working relationship with placement officers throughout the Province ... (pp. 91,92).

It is notable that even though liaison was maintained with the Social Welfare Branch that, at that time, the Co-ordinator perceived the operation of their rehabilitative functions to be divorced from those of his office.

Later with the development of local rehabilitation teams, a co-ordinative device developed by the Health Branch to shift the responsibility for the operation and planning of rehabilitation services onto the community, more integration with the Social Welfare Branch was achieved. In 1961, Rehabilitation Services stated that,

> ..., the staff of this department has devoted much time to the setting-up of rehabilitation teams in the local areas to deal with rehabilitation problems on the local level....It is hoped that eventually many of the outlying population areas will have their own rehabilitation teams capable of conducting their own programmes, but with a loose control and supervision by the Central Rehabilitation Services. This should increase considerably the scope of rehabilitation throughout the province, besides stimulating interest in the development of local services. (p. 113)[111]

The annual report for 1964, described the effect of creating this co-ordinative device.

> The policy of developing rehabilitation resources in local communities has now been fully accepted and advocated by the Rehabilitation Services. This has required a close working relationship among physicians, Public and Mental Health Services, Social Welfare Service, National Employment Service, The Department of Education, local community agencies, and "Employment"....Local community vocational rehabilitation committees have been established in 10 Provincial communities, while another five are now in the preliminary planning stages. Thus vocational rehabilitation services are being provided to the handicapped increasingly throughout the Province, and the local communities are becoming fully involved

> in this responsibility, with advice and assistance from members of this central service...Authority has been obtained to employ two field rehabilitation consultants, who will regularly provide such service to two or more committees on a regional basis, thus providing a more continuous service and ultimately relieving the Central Rehabilitation Services staff from making such frequent journeys to the areas served...Co-ordination of services which may be used in each local area is an important part of the duties of the field consultant, as well as advising the local rehabilitation committees regarding services that may be used in the metropolitan areas, should such services not be available locally. Some aspects of casework will also be handled by them.(p. 91)[112]

In 1965, the Rehabilitation Division stated that the team "members...continued to serve on boards and advisory committees of many of the community agencies. They thus are able to remain aware of existing policies of those agencies, as well as taking some part in shaping their future interest for the benefit of the general rehabilitation programme" (p. 80).

And in 1966,

> In order that society in general shall become involved in the process of rehabilitation, emphasis on the Division's activities has been on promoting the operation of rehabilitation programmes on a local basis, with administrative and financial assistance from the Division....These committees are now operating in 19 separate local communities. They consist essentially of the local medical officer of health, the local supervisor of welfare, and the local Canadian Manpower Special Services Officer. The committees have full local autonomy, with powers to enlist whatever help is necessary from other resources, local or central. Regional rehabilitation consultants have been appointed to four of the main geographical areas, to give help and to co-ordinate the activities and services of rehabilitatoin workers in those regions.(p. 73)

Gate-Keeping

The elaboration of the rehabilitation committees into a gatekeeping device is illustrated in the following statement

made by the Rehabilitation Division in 1968.

> It was through this developmental work that the concept of a local rehabilitation committee was formed and has now become the mechanism through which referrals for rehabilitation in communities in the Province are made. This aspect of the programme has now developed to the point where, at the present time there are 29 local rehabilitation committees actively at work, located in 16 health unit areas. (p. 50)

In 1969, it was announced that

> the rehabilitation needs of handicapped people in the whole Province are now served through LOCAL REHABILITATION COMMITTEES, which are located in 28 areas. ...The presence of welfare and Manpower representatives on the committee is instrumental in bringing rapidly to the committee's attention those disabled persons in need of service toward rehabilitation. The needs of the patient are assessed by the committee, which makes recommendations to the Division of Rehabilitation, so that the appropriate services can be supplied or arranged. They may include medical, social, and vocational assessments, followed by physical restoration, social and vocational counselling, vocational training, and job placement. The general aim of the Division is to work toward the provision of those services that will lead to vocational rehabilitation.(p. 40)

A gate-keeping mechanism identical to one implemented by Alberta's Department of Public Welfare was put into place by the Branch. In this situation as well, once applications were filtered through the initial boundary of the Rehabilitation Service, a Special Placements Liaison Officer provided "advice and assistance in the job placement of disabled persons" (1960, p. 113). The seconding of this officer from the National Employment Service also provided further evidence for the bargaining model that was employed by the Branch, since it was not prepared or equipped to place disabled persons in employment successfully. The Rehabilitation Service stated that beginning in February, 1959,

> the Unemployment Insurance Commission would second a well-trained senior placement officer to the Rehabilitation Service for an experimental period of six months to act as Special Placements Liaison Officer. The officer was attached to the regional office of the Unemployment Insurance Commission to afford better administrative and functional control of the experimental programme on a Province-wide basis. The Rehabilitation Service undertook to provide a thorough rehabilitation work-up on each referred individual and to arrange for appropriate physical restoration or other attention necessary prior to job-placement service.(p. 90).

The service was confirmed on a permanent basis in April, 1961 (p. 112).

A boundary spanning gate-keeping mechanism was also implemented by the Branch through the Registry of Handicapped Children and Adults. The Registry funneled the case-finding of the physically disabled into one central agency. However, as in Alberta, its function was also weakened by maintaining registration only on a voluntary basis. As the Division of Vital Statistics reported in 1953,

> physicians throughout the Province have been made aware of the purpose of the registry and have been encouraged to register on a voluntary basis those children under their care who are suffering from any one of a group of specified disabilities which might prevent them from completing their education and becoming self-supporting. The registry has established close liaison with all public health authorities in the Province as well as with numerous private agencies concerned wtih the care of children (p. 76)[113].

When the registry was extended to include adults in 1960, it found that the registration of adults was very slow. During 1965 then, "members of the Registry staff addressed meetings of each health unit in the Vancouver metropolitan area and informed them of the work that" was "being done by the Registry" (p. 17). The Registry stated that "the observed

increase in registrations may be partly due to greater awareness of these operations" (p. 17). However, the policy of keeping registration on a voluntary basis remained, and was illustrated in the completion of the Registry's report for 1965. It stated that,

> the Child Care Committee of the British Columbia Division of the Canadian Medical Association expressed concern that the medical profession was not adequately informed of the work of the Registry. To meet this complaint, a meeting was arranged between Registry personnel and the Child Care Committee. As a result, it was proposed that contact with physicians, individually and collectively, should be intensified by means of journal articles, displays, and discussions with individual physicians. Following the meeting, all physicians in Vancouver were circularized as proposed. Many physicians have subsequently registered at least one case and several have written requesting further copies of registration forms".(p. 17)

The Registry also relied upon a co-ordinated model to limit their functioning to that of case finding and information gathering as the following statement made in 1955 illustrated.

> The Registry does not provide treatment or transportation, having no funds for such purposes, but it has served a very useful purpose in that it co-ordinates all agencies dealing with children in the Province so that a child receives the necessary treatment, and it also provides a follow-up service after treatment if such is necessary....The problems are sorted out and directed to the agency that can best help in their particular field".(p. 112)[114]

> ..., the Registry is being used as a co-ordinating unit for the care of children by supplying information as to the facilities available and giving assistance in planning care for children who are registered. (1954, p. 103).

The co-ordination of services for the physically disabled who were on social assistance was perceived to belong to the domain of the Social Welfare Branch. In 1953, it was stated that,

> in order to enlarge the scope of the registry, it was suggested toward the end of the year that a procedure be set up whereby cases known to the Welfare Branch would be routinely registered. Regular social-assistance cases continue to be handled by the Welfare Branch, their addition to the registry being primarily for record and statistical purposes. It is hoped that the care of border-line social-assistance cases which are sometimes handled by the Welfare Branch would be facilitated if they are made known to the registry. (p. 76)

In 1960, the Registry and Rehabilitation Services stated that,

> the Registry and Rehabilitation Services beside registering handicapped persons of all ages, has taken an active part in advising and arranging for the rehabilitation of those considered likely to benefit from this service. Such an arrangement has necessitated the co-ordination of many facilities within the community capable of offering assistance. These include medical rehabilitation services, psychological education, vocational assessment and training, social welfare, and the assistance of the National Employment Service, besides the assistance of many community organizations.(p. 111).

One of the more unusual examples of gate-keeping occurred in the Extended Care program at Pearson Hospital in Vancouver. In 1969, the Branch reported that,

> after the programme began in 1964, the number of beds for extended-care patients gradually increased to 170, but during the past year it was not possible to convert any additional beds to extended care. One of the main reasons for this is the extremely heavy physical work load imposed on nursing staff by this class of patient. Many extended-care patients require considerable lifting, and even with the use of a hoist wherever possible, the constant lifting and general heavy nursing work results in staff members becoming exhausted at the end of their shift, and this in turn brings about a high rate of absenteeism due to illness. This situation compounds itself, and staff willing to work hard for a limited period are unable to do so when the situation continues. To cope with this, it has regrettably been necessary to temporarily discontinue the admission of quadraplegics and other new patients so as to ease the strain on the nursing load.(p. 34)

This quote suggests that those severely disabled who are unable to make an economic contribution to the community, are most likely to have their effectiveness reduced in the event of external constraints. (In 1975, Pearson hospital was again opened to spinal cord patients).

The comparison of the four provincial departments along this dimension of the conceptual category of boundary decisions has demonstrated that the establishment of limits on the policy making process for the physically disabled was very much dependent upon the implementation of different structural boundary spanning mechanisms. This interaction between policy making and organizational design occurred consistently from 1945 to 1972, albeit in different forms, for all of the departments.

The property of negative structural selective boundary decisions showed quite clearly that the responsibility for the physically disabled was divided among many different public and private jurisdictions. There was, obviously, no formal mandate that allocated final responsibility to one particular jurisdiction. All departments preferred to utilize voluntary resources for the development of services that did not provide some reasonable amount of economic return.

Summary

The physically disabled were not considered to be a priority by either province by the end of the sixties. While this conceptual category has indicated the nature of the reasons why this was so, the category of contextual constraints illustrates the process whereby specific policies that once were

taken by the provincial departments for the physically disabled were altered so that they lost the visibility that they once had and thus their priority.

The following chapter on valuation contexts provides evidence for the existence of two types of values that underpinned the boundary decisions made as well as the labelling contexts within which the problems of the physically disabled were defined.

Notes to Chapter 6

[1]Alberta, Department of Public Welfare, Annual Report for the Fiscal Year Ending 31st, March, 1946, p. 2; 1947, p. 2; 1948, p. 13; 1949, p. 8.

[2]Idem, 1946, p. 4; 1947, p. 6; 1948, p. 7; 1949, p. 10; 1950, p. 11; 1951, p. 11; 1952, p. 10; 1954, p. 12; 1959, p. 12.

[3]Idem, 1962, p. 9; 1963, p. 6.

[4]Idem, 1964, p. 10; 1965, p. 18; 1966, pp. 22-24; 1968, p. 15; 1969, p. 14.

[5]Idem, 1945, p. 2; 1946, p. 2; 1947, p. 2; 1949, p. 8; 1950, p. 9; 1951, p. 9; 1952, p. 9; 1954, p. 9; 1955, p. 9; 1956, p. 9.

[6]Idem, 1952, p. 12; 1953, p. 11; 1954, p. 12.

[7]Idem, 1958, p. 47; 1959, p. 43.

[8]Idem, 1957, p. 48.

[9]Idem, 1959, p. 43.

[10]Idem, 1959, p. 44.

[11]Idem, 1960, p. 40.

[12]Idem, 1961, p. 37; 1962, p. 24; 1963, p. 20.

[13]Idem, 1963, p. 18.

[14]Idem, 1956, p. 47.

[15]Idem, 1958, p. 47; 1959, p. 43.

[16]Idem, 1960, p. 39.

[17]Idem, 1964, p. 42; 1965, p. 46.

[18]Idem, 1965, p. 46; 1966, pp. 48,49; 1967, p. 48.

[19]Idem, 1961, p. 13; 1962, p. 10; 1966, p. 24; 1967, p. 23; 1968, p. 16; 1969, p. 15.

[20]Alberta Department of Public Health, Annual Report. Idem, 1952, p. 25; 1953, p. 141; 1954, p. 132; 1955, p. 60; 1959, p. 91; 1960, p. 92; 1961, p. 92; 1964, p. 114; 1965, p. 122.

[21]Idem, 1953, p. 141.

[22]Idem, 1953, p. 139; 1954, p. 131; 1955, p. 58; 1956, p. 56; 1957, p. 65; 1959, p. 90; 1960, p. 96; 1961, p. 91; 1969, p. 23.

[23]Idem, 1969, p. 83.

[24]Idem, 1947, pp. 16,17; 1948, p. 19; 1949, p. 17; 1950, p. 17; 1951, p. 20.

[25]Idem, 1955, p. 55; 1956, p. 55; 1957, pp. 7,43.

[26]Idem, 1959, p. 61; 1960, p. 59; 1961, p. 58; 1960, p. 53; 1964, p. 71; 1966, p. 72; 1968, p. 73.

[27]Idem, 1966, p. 71; 1967, p. 42; 1968, p. 42; 1969, p. 37.

[28]Idem, 1965, p. 19; 1966, p. 71.

[29]Idem, 1960, p. 61; 1961, p. 60; 1964, p. 73; 1965, p. 72.

[30]Idem, 1949, pp. 103,107; 1950, p. 126; 1953, p. 149; 1958, p. 87; 1961, p. 100; 1962, p. 103; 1963, p. 117; 1964, p. 123; 1966, p. 133; 1967, p. 92; 1968, p. 86; 1969, p. 72; 1970, p. 82.

[31]Idem, 1954, p. 138; 1963, p. 116; 1965, p. 133.

[32]Idem, 1955, p. 67; 1958, p. 86; 1960, p. 104.

[33]Idem, 1954, p. 132; 1953, p. 143; 1956, p. 62; 1961, p. 96.

[34]Idem, 1967, p. 42.

[35]Idem, 1962, p. 12; 1963, p. 13.

[36]Idem, 1951, p. 54.

[37]Idem, 1953, p. 139; 1955, p. 58; 1959, p. 90; 1962, p. 93.

[38]Idem, 1960, p. 30; 1961, p. 30; 1962, p. 10; 1963, p. 11; 1966, p. 24; 1967, p. 23.

[39]British Columbia, Department of Health and Welfare, Social Welfare Branch, Annual Report for the Year Ended March 31, 1948, p. 40; 1950, pp. 23,24.

[40]Idem, 1951, pp. 76,77; 1952, pp. 25,77; 1953, p. 31; 1956, p. 84; 1959, p. 75; 1962, p. 33; 1963, p. 36; 1964, p. 58; 1965, pp. 36,57; 1969, p. 25; 1970, pp. 17,27; 1972, pp. 25,27.

[41]Idem, 1950, pp. 28,82; 1951, p. 76; 1967, p. 23.

[42]Idem, 1954, p. 38.

[43]Idem, 1964, p. 61.

[44]Idem, 1968, p. 15.

[45]Idem, 1962, p. 37; 1965, p. 42.

[46]Idem, 1951, p. 29.

[47]Idem, 1952, p. 26.

[48]Idem, 1953, p. 32.

[49]Idem, 1960, p. 31.

[50]Idem, 1964, p. 22.

[51]Idem, 1968, pp. 16,41,46,56,59; 1969, pp. 40,41.

[52]Idem, 1972, pp. 86,94.

[53]Idem, 1972, p. 89.

[54]Idem, 1951, p. 48.

[55]Idem, 1951, p. 29; 1954, p. 40.

[56]Idem, 1960, p. 31; 1962, p. 33.

[57]Idem, 1967, p. 53.

[58]Idem, 1970, pp. 60,62.

[59]Idem, 1969, p. 15.

[60]Idem, 1967, pp. 10,39; 1968, p. 12.

[61]Idem, 1971, p. 71.

[62]Idem, 1970, p. 51.

[63]Idem, 1965, p. 9.

[64]British Columbia, Department of Health and Welfare, Health Branch, 1961, p. 86; 1962, p. 77; 1963, p. 70; 1964, p. 64; 1965, p. 58; 1966, p. 59; 1968, p. 29; 1969, p. 12; 1970, p. 13.

[65]Idem, 1960, p. 30; 1962, p.84; 1963, pp. 78,79.

[66]Idem, 1965, pp. 54,62.

[67]Idem, 1969, p. 34; 1970, p. 53.

[68]Idem, 1956, p. 129; 1957, pp. 91,92; 1958, p. 84; 1959, p. 87; 1960, p. 111; 1961, pp. 110,113; 1962, p. 113; 1963, pp. 95,96.

[69]Idem, 1956, p. 129; 1960, p. 111.

[70]Idem, 1959, p. 87; 1960, p. 111; 1961, p. 114; 1962, p. 104.

[71]Ibid.

[72]Idem, 1965, p. 80; 1966, p. 74; 1969, p. 41; 1970, p. 40.

[73]Idem, 1963, p. 69; 1965, p. 80; 1966, p. 74; 1968, p. 51.

[74]Idem, 1966, p. 38; 1968, p. 59.

[75]Idem, 1946, p. 39; 1947, p. ; 1948, p. 57.

[76]Idem, 1957, p. 20; 1959, p. 17; 1962, p. 55; 1964, p. 47; 1965, p. 44; 1966, p. 42; 1968, p. 63; 1969, p. 24; 1970, p. 24.

[77]Idem, 1954, p. 47; 1955, p. 43; 1957, p. 43.

[78]Idem, 1954, p. 27; 1955, p. 30.

[79]Idem, 1956, p. 35; 1957, pp. 20,21; 1958, pp. 16,17; 1959, p. 19; 1963, p. 50.

[80]Idem, 1957, p. 43; 1958, p. 37; 1959, p. 42; 1960, p. 50; 1961, p. 50; 1963, p. 42.

[81]Idem, 1961, pp. 20,21; 1962, p. 36; 1963, p. 42; 1964, p. 48.

[82]Idem, 1968, p. 65; 1969, p. 28; 1970, p. 26.

[83]Idem, 1962, p. 55; 1963, p. 31; 1964, p. 51.

[84]Idem, 1953, p. 76; 1955, pp. 112,113.

[85]Idem, 1961, p. 110; 1962, p. 102; 1964, p. 90; 1965, p. 17.

[86]Idem, 1962, p. 64; 1963, p. 56.

[87]Idem, 1950, p. 19; 1951, p. 26.

[88]Idem, 1950, pp. 20,21; 1951, p. 27; 1952, p. 92; 1953, p. 85.

[89]Idem, 1950, pp. 20,24; 1955, p. 44.

[90]Idem, 1950, p. 20; 1951, p. 30; 1952, pp. 20,21.

[91]Idem, 1951, p. 27; 1952, p. 92; 1953, p. 85; 1955, p. 110; 1956, p. 103; 1957, pp. 38,39.

[92]Idem, 1953, pp. 86,95; 1954, p. 101; 1959, p. 33.

[93]Idem, 1961, p. 33; 1962, p. 65; 1963, p. 57; 1964, p. 60; 1965, p. 55; 1966, p. 54.

[94]Idem, 1952, p. 92; 1954, p. 101; 1955, pp. 109,110.

[95]Idem, 1958, p. 28; 1959, p. 32; 1962, p. 67.

[96]Idem, 1963; p. 60; 1964, p. 60; 1965, p. 55; 1966, p. 55.

[97]Idem, 1959, p. 33.

[98]Idem, 1962, p. 67; 1963, p. 59; 1964, p. 60.

[99]Idem, 1966, p. 54.

[100]Idem, 1954, p. 15; 1955, p. 44; 1956, p. 42; 1957, p. 28; 1958, p. 24.

[101]Idem, 1968, p. 51.

[102]Idem, 1970, p. 39.

[103]Idem, 1954, p. 44.

[104]Idem, 1956, p. 98.

[105]Idem, 1957, p. 30; 1958, p. 27; 1959, p. 30.

[106]Idem, 1957, p. 30; 1958, p. 27.

[107]Idem, 1956, p. 53; 1957, p. 43; 1958, p. 37; 1959, p. 42; 1960, p. 50; 1963, p. 42.

[108]Idem, 1954, p. 100; 1956, p. 48; 1958, p. 36; 1959, p. 41; 1961, p. 48.

[109]Idem, 1970, p. 28.

[110]Idem, 1954, p. 126.

[111]Idem, 1962, p. 103.

[112]idem, 1965, p. 79.

[113]Idem, 1955, p. 112.

[114]Idem, 1954, p. 103; 1956, p. 88.

CHAPTER SEVEN

VALUATION CONTEXTS FROM 1945 TO 1972

Preamble

By comparing the data from the four departments in Alberta and British Columbia, it became apparent that this category explicated how the value bases of the decision-makers, concerned with policy making for the disabled, extended beyond the boundaries of their respective organizations and reflected fundamental features of the larger socio-economic system of an industrialized nation.

Two types of valuation contexts emerged from the analysis of the annual reports. The predominant one was based upon the principle of economic rationality, concerned as it was with the effective use of resources. The subsidiary value was humanitarian in nature.

Topliss (1979) has talked about how the principle of economic rationality has marked the development of the view that providing for the personal social welfare of individuals is not only compatible with, but conducive to, the economic and social well-being of a society as a whole. The strength of this relationship is not constant however, but varies according to whose personal social welfare is of concern.

The relationship between helping the individual and promoting the welfare of society is more tenuous in the case of groups that have special needs outside of those of the general public. The relevant social provision in the former case tends to be universalistic in coverage according to clearly defined standard criteria of eligibility which do not depend on a personal assessment of the individual recipient. In contrast to those areas of welfare (i.e. universal health insurance schemes) where the harmony of individual and collective benefit is most clear, the policies taken for the disabled were those that were legitimated by the claim that they enabled the recipients to participate in fulfilling the production and consumption roles of community members.

According to Pinker (1979, p. 9), Sleeman has stated that

> most forms of social service expenditure provide, in varying degrees, not only consumer goods but also investment goods. They also improve the productive capacity of those who receive them and enable them to make a larger contribution through their work to the national product.

Facts emerged from the annual reports that clearly demonstrated a number of strategies that legitimated the taking of a certain policy by having related it to some kind of economic gain. Among these were assertions that the economic benefits of a program (in terms of the increased ability of the disabled to produce), outweighed its costs or that a program would bring the same benefits as existing programs but at less cost (providing services in the home as opposed to institutions).

The overriding presence of this economic value again points to the contradictions that exist between definitions of

social policy function. Thus the prevalence of these economic criteria tends to reflect the existence of the Handmaiden conception of the function of social policy within government. The existence of this perception also reflects the constraints imposed by the larger context of industrialized society within which provincial bureaucrats/politicians must make their decisions.

As Macarov (1978) has commented, in all industrialized countries there is a heavy emphasis on production, since the production of goods and services make possible employment which in turn distributes the resources of a society. He also has pointed out that an economy based on production requires in exactly equal amounts, the ability to consume, and suggests that industrial societies place a high value on the role of social welfare programs in order to help maintain stable and progressive growth in the total economy (p. 118). The existence of this conceptual category and its properties has provided strong evidence for the proposition that policies were only taken in for the physically disabled (aside from those of a residual nature) if they had been legitimated by the assertion that they contributed or were perceived to contribute in a positive manner to the provincial economies.

In contrast to the principle of economic rationality, an humanitarian ideal was found to underpin some of the policy statements in the annual reports for British Columbia's Social Welfare and Health Branchs. The emphasis placed upon the attainment of an economic goal was often tempered by the expression of a humanitarian concern that the physically disabled

should be helped to have as decent a life as possible. Although data to explain this dichotomy did not emerge from the reports, it is interesting to speculate on the possible reasons for a more humanitarian approach to social problems in B.C., than in Alberta, given that both during the time period in question operated within similar political ideologies.

The ensuing sections present evidence that emerged from the data that established the existence of both of these types of values and their properties.

Establishing Similarities among the Data from the Department of Public Welfare in Alberta

The analysis of the annual reports indicated that a certain type of value was fairly often made explicit to legitimate the allocation of resources towards the pursuit of the residual category of general assistance policies and the rehabilitation policies for the physically disabled.

The type of valuation context utilized by the decision makers to legitimate these policies was economic in nature. It was characterized by the twin conditions of return on public money spent and investment in the future. Besides the type of value itself and the conditions under which it was made explicit, properties that described other of its characteristics emerged. These properties, expressive of the bases of orientation which operated in the department as shared assumptions about the way to approach and proceed in given situations, included evaluative sentiments about the relative worth of things and systems of belief. A number of examples have illustrated these points.

During the fifties, the following statement was frequently made by the Department of Public Welfare. It was underpinned by a strong belief in the Protestant ethic as the means to ensure community stability and survival.

> The Public Welfare Department is more closely related to the community at large than most other Government Departments. We in the field of welfare must necessarily have an intimate knowledge of all applicants who are part of a community... We must develop an increasing understanding of the perplexities that have temporarily blocked the unfortunate's path. For this reason, the Public Assistance Branch has stressed the importance of rehabilitation; the continuance of the family as a unit and return to an active and assisted place in the community. Temporary public assistance, as in the past, was given to eligible and worthy families, when their home was endangered beyond their control. Jobs were found for many, and follow-up contacts were continued until the family became self-supporting. (Alberta, Department of Public Welfare, Annual Report for the Fiscal Year Ending 31st, March, 1952, p. 12)[1]

The category of values that underpinned the first type of boundary decisions clarified that the actual purposes of those policies was directed towards achieving some return on the public monies spent. In 1948, the Department of Public Welfare stated that,

> in the knowledge that individuals feel more independent when providing for their own support, the rehabilitation and re-establishment policy followed by the Province continues to show satisfactory results. Several families formerly in receipt of assistance have been successfully re-established and are now fully maintaining themselves. (p. 3)[2]

and in 1957 that

> the matter of providing for their immediate need is of vital importance, however, it is equally essential to assist these families to the point where they can become useful and productive members of the community ... (p. 18)[3]

The belief in the value of and necessity of economic

independence was reiterated by the Public Assistance Branch in 1959.

> Public Assistance is provided more particularly to assist families and aid them to become self-supporting and gain independence through self-care and better family life. The granting of assistance in whatever measure required at the time of emergency, is not meant to lead the individual to an attitude of dependency but to help him to do something concrete about his problems and eventually become self-supporting... The Public Assistance Branch has continued to give services where the need has arisen, to help families through times of crisis, to supplement pensions and... aid is also given to the disabled while receiving training in a scheme for rehabilitation.(p. 12).

The Public Assistance Branch was motivated to provide financial aid to those persons identified in need to allow them to "obtain the necessary, skills, education and medical attention that will give them the opportunity for more independent living" (1963, p. 9).[4] Specifically, the Social Allowance program "would appear to be flexible enough to meet the needs of the persons for whom it was intended in a manner that allows them to dwell in the community...and at a level on which they can reasonably be expected to care for and educate their children" (1964, p. 12).[5]

The economic value that legitimated the allocation of resources for the direct provision of services to the physically disabled in cases where there was a reasonable expectation of employment was illustrated by several examples. In 1957 the Rehabilitation of Disabled Persons Branch reported that "rehabilitation services were able to make her self-supporting before the pension was ever put into pay" (p. 51). The aim of this branch was defined as the restoration of the disabled to the fullest physical, mental, social, vocational, and economic usefulness of

which they were considered capable (1959, p. 43). Attention to the dividends that would accrue to the public with such a program was made explicit by the Branch in the following examples.

> The economic advantages of taking people off relief and off government pensions and making them taxpaying citizens show that rehabilitation services do not cost the taxpayer anything, but rather, put money into his pocket.(1957, p. 53).

> The Rehabilitation of Disabled Persons Branch provides services to those persons who, because of physical or mental impairment, require special assistance to enable them to make their full contribution to the life of the community.(1959, p. 43).

When the agreement between the Federal Government and Alberta for the co-ordination of the rehabilitation of disabled persons was renewed in 1962, the objective of the comprehensive program for vocational rehabilitation was,

> to remove the disadvantages experienced by disabled persons, to avoid their dependence upon the public or relatives and to restore them to usefulness by making available to them appropriate rehabilitation services so that as far as possible they are enabled to contribute to Canada by sharing the same opportunities and accepting the same responsibilities as other members of the community.(1963, p. 19).

The concern that the vocational rehabilitation program take its role as part of a national plan to stimulate overall economic growth was made explicit in the following statement by the Co-ordinator of Rehabilitation.

> The Co-ordinator attended twelve major conferences and meetings during the year, which included the national meeting on Mental Retardation in Saskatoon, the annual meetings of the National Advisory Council on Rehabilitation and the Provincial Co-ordinators, Ottawa. These meetings considered proposals to strengthen and expand national vocational rehabilitation services in Canada, which were presented as forming "an essential part of the total manpower development, to be listed among those resources upon which the Canada Assistance Plan, the Work and Opportunity Program, and other activities will draw

for attainment of their end" (1966, p. 48).

A certain condition had to be met before dollars would actually be spent for the benefit of the physically disabled. The property, criterion of worth, articulated the assumption made by the decision-makers that the recipient had to have the ability to use the help, or more accurately, to use the help properly or well. The acceptance of this criterion helped to determine the way that would be proceeded by the decision-makers in a given situation.

This criterion of worth was applied to the availability of funds for the cost of medical examinations, reports, and for treatment where recommended. The Rehabilitation of Disabled Persons Branch stated that, "treatment is only provided where it is believed that it will lead to the applicant being able to return to gainful employment..." (1960, p. 37). This general criterion of 'worth' was elaborated into certain selective criteria in 1964 when the structure of the Branch was altered.

> In November of 1964, the Rehabilitation Division of the Public Assistance Branch was merged with the Social Allowance and Social Assistance Divisions, with a resulting change in emphasis from vocational rehabilitation of the disabled to a program designed to assist as many families and individuals, physically disabled or not, as is feasible within the resources of this Department and the potential of the recipients concerned. Certain criteria, based on the philosophy that each individual should be helped to recognize and use those skills and personal resources with which he has been endowed or which can be developed or re-developed and that those who are incapable of becoming independent should continue to be provided with economic and social assistance, have been devised by which a selection could be made of families and individuals who could best benefit from intensive counselling (1965, pp. 8,18).[6]

Criteria were devised whereby the resources of the

Public Welfare Department could best be utilized in "working most intensively with those persons who have the potential to take advantage of the opportunities provided for training, education or physical restoration" (1965, p. 18).

This criterion of worth formed the basis of the selection procedure for vocational rehabilitation in succeeding years.

> Continued emphasis is being placed on the rehabilitative services available to persons in receipt of assistance...Each person on making application for financial assistance and on a continuing basis is carefully considered for rehabilitative or alleviating services. However, it is recognized that all persons in need are not capable of benefitting from a rehabilitative program; e.g. the older person, those whose strength is severely limited, etc., and certain criteria, therefore, have been devised to help the worker in selecting persons with the potential to make use of the services that may be available to them.(1967, p. 24)[7]

Establishing Similarities among the Data from the Department of Public Health in Alberta

The analysis of the annual reports for the Department of Public Health indicated that most goals were also strongly expressed within an economic valuation context. The following examples verified the existence of this conceptual category by establishing similarities with the data from the Department of Public Welfare.

During the forties, the Alberta Tuberculosis Association was closely affiliated with and cooperated with the Division of Tuberculosis in the fight against TB. In one of the association's reports that was represented in the public health annual reports, it stated:

> Mr. Cameron is a veteran of the last war and has had extensive experience in the problem of restoring disabled persons to useful, remunerative employment. All sanatorium persons are interviewed, their individual adaptability estimated and assistance given while still in sanatorium, to make them useful citizens upon discharge. (Alberta, Department of Public Health, Annual Report, 1974, p. 104).

In 1950, the Association stated that "through such training it has been possible for many patients to become re-established and to become largely and completely self-supporting. ...Economic security in employment" would "safeguard their health" (p. 28).

The Cerebral Palsy Clinics of Alberta also stated their opinion that,

> these crippled children are learning...such use of their hands as will remove them from the group which is a family handicap, into the class of self-supporting citizens.(1952, p. 119).

The belief that economic security was linked to the maintenance of health was expressed in another statement made by the Tuberculosis Association.

> Rehabilitation is closely linked with the educational plan...Undoubtedly, many ex-patients if they had to make a living in their old occupations, would suffer breakdowns and require re-admission to the sanatoria. (1951, p. 126)[8]

It was expected that with the broadening rehabilitation programme, the number of re-admissions would be decreased.

> To assist the patient to aspire to employment in keeping with his health a broad educational programme, has been carried on for several years by school teachers of the Department of Health along with rehabilitation officers of the Alberta Tuberculosis Association.(1951, p. 126).

The value of an economic return was used to justify the need for a rehabilitation program of a vocational nature, as

a means to prevent the unnecessary spending of dollars in the future. Other services used the same reasoning to legitimate their policies.

In 1956, the Division of Arthritis Services stated that,

> there has been a further reduction in total hospitalization and this further strengthens the impression of former years that early and active care of the Rheumatoid youngster reduces the over-all cost to society by diminishing the need for hospitalization and particularly long-term hospitalization care. (p. 56)[9]

In 1957, the Division stressed that "adequate early treatment is reducing long hospital stay and degree of permanent disability..." (p. 65). The intrusion of new knowledge further legitimized the investment values of the future. The Division described how because cases were seen earlier, the clinic or doctor could institute effective treatments on an out-patient or home level. The ability of patients to use physio-therapy aids at home was also given to explain the reduction in hospital utilization, as it kept people on a home regime and left hospital beds for more active usage (1955, p. 58).

The economic return on saving hospital beds, in this case, made the economic value that underpinned these policies even more explicit. Prevention of a disease was also perceived to be a legitimate use of funds since they were allocated with the expectation that future dollars need not be spent. In 1959, the Division of Medical Services stated that the Rheumatic Fever Prophylaxis Program "was implemented...to prevent recurring attacks and thereby prevent incapacitating disabilities in these children" (p. 61).[10] As there were a considerable number of such

cases in the province "it was considered in the best interests of the patient and residents of the province to provide such cases with medication to prevent recurring attacks of rheumatic fever..." (1958, p. 42).

As the data were analyzed, similarities between the orientation of the Department of Public Health and Public Welfare towards their physically disabled clients emerged. Again a criterion of worth was found to underpin policies that dealt iwth this group.

The Division of Cerebral Palsy Clinics stated that,

> we do not feel that we are treating patients in Edmonton or in Calgary who have not the capacity to progress...We have instituted a system of recording improvement in each of the modalities for every child under treatment, which lets us know at a glance what degree of benefit is being received by the individual, and at what rate. This, coupled with a better use of our Guidance Clinics, is quickly narrowing the number of cases to be treatable, and, hence, saving our facilities for only those children who are deriving satisfactory benefit. (1956, p. 57)[11]

In 1959, the Division stated that "it has become increasingly evident that to function economically, treatment facilities should largely be reserved for those children who have the mental ability to be educable" (p. 91).

The Division of Arthritis Services also expressed its view that only those patients who required lengthy hospitalization would actually be eligible for treatment. The Division stated that "it is notable that the majority of patients who have become ineligible by virtue of having reached the age of twenty-five, have reached a stage of stability in treatment which obviates the need for long hospitalization" (1956, p. 56).

Establishing Similarities and Differences with the Data from the Social Welfare Branch in British Columbia

The comparison of the data from the annual reports of the Social Welfare Branch in B.C. verified the existence of a category of valuation contexts for the time period under study. It became clear, however, that not just one type of value, but two types were fairly often made explicit to legitimate the allocation of resources towards the development of a consolidated social assistance and rehabilitation program. While an economic value, characterized again by the twin conditions of a return on public money spent and investment in the future, underpinned the majority of policy/program statements, it co-existed with a humanitarian value that was also made explicit in many of the reports.

The juxtaposition of economic and humanitarian values was a property that continually appeared throughout the annual reports for British Columbia as an important indicator of difference between that province's values and those of Alberta's. A number of examples have illustrated these points.

In 1947, the Assistant Director of Welfare for the Social Welfare Branch of the Department of Health and Welfare stated that,

> the way is now clear to do more and more constructive rehabilitation work, resulting in an ultimate saving of public money and a more immediate saving of human values and family life throughout the Province. (British Columbia, Department of Health and Welfare, Social Welfare Branch, Annual Report for the Fiscal Year Ended March 31st, 1947, p. 13)[12]

The residual financial assistance policies were under-

pinned by motives of an eventual economic return that predominated the expression of a humanitarian concern for these clients, as indicated in the following example.

> In conclusion and once again it should be emphasized that the granting of financial assistance should not be merely the giving of a cheque. Primarily, the purpose of financial assistance is supportive while the need exists, but it should also be rehabilitative, and, therefore, it cannot be given without regard or thought for the recipient and his capabilities, potentialities, and resources.
>
> Too often when the person does make some effort toward independence, it is his feeling that he is penalized by a reduction in his cheque. Rather, the emphasis should be on what he is able to do himself toward meeting his own financial needs, with the assurance that if this is not sufficient, public assistance is there to supplement his own efforts within the limits of Branch policy.
>
> Service to recipients of financial assistance should not be resolved into a checking for eligibility, but should be casework at its highest level of skill to know all members of the family and be ready to help with their problems and encourage them wherever possible toward the goal of independence. For those where the goal cannot be that of financial independence, there is still much that can be achieved through casework to strengthen the family or restore the self-esteem of individual persons. Financial assistance is only a tool in such a plan of service. (1947, p. 38).

This concern to save public money in concert with the concern that the disabled should have a decent life, was reiterated in 1949 and 1950 in a statement made by the Family Division of the Branch.

> Public thinking has gradually turned to the attitude that a person unable to maintain himself and his family by his own efforts has a certain right to expect assistance to supply the necessities of living. We no longer make it as difficult as possible to obtain assistance,...often regarding the assistance as a tool whereby the individual can be rehabilitated and restored to independent living if rehabilitation is at all possible. (1948, p. 40)[12]

> In addition, too, there are many single individuals who, though totally incapacitated for one reason or other, with the help of social allowance and the advice and counsel of the worker, are helped to lead satisfying lives in the community within the limits of their disability.(1950, p. 30)[13]

Onus was placed on the individual social workers to ensure that the spending of public funds was directed primarily towards facilitating the achievement of financial independence for the client. In 1951, the Family Division stated that,

> it should be repeated here, however, that it is recognized that financial assistance is not enough in many or most instances. The job of the worker is not only to determine eligibility and grant assistance where indicated, but to do so in such a way that the recipient may retain his self-respect and receive every encouragement to be independent where possible. Such a job cannot be a routine one, but involves an understanding of the needs of people, coupled with a sense of responsibility to help them with their emotional and personal problems wherever possible. The social workers are the trustees of the welfare of the people they serve, as well as of public funds which they administer.(1951, p. 29)

Rehabilitation efforts were legitimated by the economic value of removing the physically disabled from the public assistance rolls. In 1953, a regional administrator stated that,

> considerable time is being expended by the social workers in an effort to rehabilitate persons in the border-line employment and handicapped groups. ..., some success in these efforts has resulted, and the time spent has been worth while, not only from a financial point of view, but because of the moral uplift given to the handicapped, who in many cases had become resigned to remain on public assistance, with little or no thought being given to the possibility of regaining their independence.(p. 24)[14]

The provision of financial assistance for the maintenance of health was also linked to an expected return to work in the following statement made by the Director of the Medical Services Division in 1959.

> as for most other services, there has been no lessening in the providing of transportation for welfare recipients for medical reasons, but in fact a definite increase...Although no tabulation has been kept of welfare patients seen by the various travelling clinics of the British Columbia Cancer Clinic, Children's Hospital, and the Canadian Arthritis and Rheumatism Society, considerable numbers of such persons require financial aid to attend these clinics or for treatment at their respective centres. The travelling costs in such instances cannot be measured in dollars and cents but in the benefits of improved health and also frequently the return to self-maintenance.(p. 75).

The economic values of a return on public money spent and investment in the future in concert with the humanitarian value of conserving family life were used to legitimate efforts to get social assistance recipients back to work by a regional administrator, who in 1963, stated that,

> there were a number of goals in mind, and they included recognition of the general benefits of economic independence (social, psychological, physical, etc). and the benefits to the community as a whole in increased earnings and decreased drain on the public purse, but underlying all this was the goal of improved opportunity for the survival and growth of family life. Family income derived from productive labour cannot alone work miracles in preserving family life, but in its absence small problems have a tendency to become large ones.(p. 20).

Dual values were also employed by the Child Welfare Division to legitimate their pursual of a foster-home care policy for those physically handicapped children who came under their care.

> The increased foster-home rates we have to pay for this type of foster-home care may, at first glance, look excessive, but compared to what hospital or other institutional care would cost, it is actually a more economical means of providing for these children whose care will extend over a long period of time. Foster-home placement also represents for them a chance to share, in at least a small way, some family living before they know the closing-

> in walls of the inevitable institution as they reach adulthood. (1951, p. 49).

In 1964, the Social Assistance and Rehabilitation Division stated that,

> the social assistance programme has three prime objectives. The first is to relieve want and to enable a minimum standard of living for persons who are unable to provide for themselves because of health, lack of a bread-winner, or unemployment. The second is to bring about a return to self-independence or to a higher level of self-care. The third is to reduce or prevent the many serious social effects that accompany deprivation. (p. 34)[15]

The aim of the Branch's Medical Services Division was "to help restore health and useful function while still encouraging the integrity and responsibility of the individual and his family as citizens" (1967, p. 23). The implicit assumption made by the decision-makers was that following the beliefs of the Protestant work ethic and instilling them in the recipients of public assistance would contribute towards the overall welfare of the community. In 1954, the Assistant Director of Welfare stated,

> the purpose of the Social Welfare Branch is to do more than merely relieve need. It is to help people restore themselves to a state of independence wherever that can be done. This not only safeguards public money, but safeguards human values for self-dependence is a cherished component of our democratic culture. (p. 13).

The economic value of investing in the future, however, demands more attention. The ultimate goal of various positive allocative policies for the physically disabled was that of economic independence so they would not become a drain on the public purse. The Western Society for the Rehabilitation of the Physically Handicapped began to offer services to its clientele

in 1949. It received grants that were administered by the province and was described as "a school for retraining paraplegics and other physically handicapped people so they may become socially and economically independent" (p. 16). The Social Welfare Branch stated that

> on the success of such an experiment may be built a full-scale programme for paraplegic and post-polio patients who otherwise will have to be maintained indefinitely on social allowance. Indeed, it may well set the example for a general rehabilitation service for all civilian disabled...To underwrite the cost of this undertaking called for special financial consideration in each case, but the outlay will be well worth while if these three are restored to economic independence.(p. 18).

Although the economic motivations for developing certain policies for the physically disabled usually took first place, attention was also given to the humanitarian aspects of providing financial assistance towards rehabilitation services. The following examples illustrated this point. During 1950 to 1956, the following statements were made by various divisions of the Social Welfare Branch.

> During the year we have tried to emphasize the rehabilitative aspects of our work. Rehabilitation is, of course, an all-inclusive term with mental, physical, social, and economic aspects, none of which is more important than the others. However, for the individuals and families in receipt of public assistance, economic rehabilitation independence can be a truly major factor in their total rehabilitation.(1950, p. 26)

> The second example was that of a young man for whom, because of physical and educational factors, the future did not hold the same promise of entire independence. However, with the training he received in the treatment centre, together with encouragement and training in the skills which he had--music and leather work and saddlery--he was able to return to his family in the small community where he lived to lead a more satisfying life. It has been necessary to continue financial assistance to him, but he is

> able to supplement this by sale of his leather handicraft....While his activity is limited, the financial assistance granted to enable him to take the necessary treatment and training has enabled him to return to a more normal life with his family and in the community--outside a hospital where otherwise he would have had to remain for many months, if not years, or for life.(1950, p. 29)[16]

> For some of these persons, training in the Western Rehabilitation Centre meant primarily a lessening of pain or discomfort or degree of handicap and an increase in their ability to care for themselves and enter into other activities even though they might never become financially independent. For others, training in the Western Rehabilitation Centre was also the stepping-stone to vocational training if required, and return to former employment or a new type of employment, which would not otherwise have been possible for them (1955, p. 33)[17]

However even the humanitarian value of improving the quality of life for the physically disabled was often underpinned by an economic rationale as well. In 1959, the Branch described the effects of the training program of the rehabilitation centre.

> Many trainees do return to employment or receive vocational training for employment other than that in which they had previously earned their living. Others were helped to become more sufficient in self-help and care, thus eliminating the necessity of boarding- or nursing-home care. Others are trained to operate more efficiently in their own home, and in greater comfort. (p. 33)[18]

The Medical Services Division legitimated the funding allocated to the Western Society for Rehabilitation by reporting on the potential savings to be made by institutions and public assistance. The Director of the Division stated that,

> the Western Society for Rehabilitation continued to give excellent assistance to the handicapped. When closer study from a medical-social view-point can be given cases, a greater demand will be made on this society. Illustrative of the Division's thinking are:--
> (1) The cases taught self-care who otherwise would be occupying beds in institutions; e.g., the post-poliomyelitis cases, the arthritis cases. This service

> enables these people to be kept at home in their own surroundings.
> (2) Those who are suffering from a permanent handicap are given an opportunity for re-education and retraining to become self-supporting....
>
> It is certain that this approach must be carried out on a wide basis if the Branch hopes to deal with the ever-growing problem in a sane manner.(1953, p. 76).

In the same year, the Branch described the case of a family "who could have been an intermittent and long-term charge on the municipality and Province for public assistance, with the consequent disappointments and frustrations to themselves in their lack of independence" who "were helped and supported in their plans for physical and economic rehabilitation" (p. 32).

In 1954, the Regional Administrator of the Social Welfare Branch made explicit values for legitimizing training programs for handicapped people. He stated,

> the work in connection with the rehabilitation of people continued this year. Many individuals were provided with training of various kinds in order to overcome handicaps which had necessitated the use of public funds for their support. The extra money used for this type of retraining will be more than repaid as the majority of these people are now self-supporting and no longer in need of financial help. (p. 23).

This sentiment was echoed in 1955 by a region's administrator who stated,

> casework services continued to emphasize rehabilitation of people, and extra funds were provided to enable individuals to take special training. Each individual who has benefitted this way means a saving in public funds and, more important, an asset to his own community.(p. 20).

The Family Division stated in 1954 that,

> with the prospect of an expanded rehabilitation programme in conjunction with the proposed disability allowances, it is hoped that many persons now

> receiving Social Allowance (or incapacitated husbands in Mothers' Allowance families) may be physically and vocationally rehabilitated to the end that they and their families may become economically independent. For those whose disability or handicap does not permit such a plan, the granting of disability allowances when such become effective should also have a considerable effect on the Social Allowance case load. Meanwhile the services of the Branch have to a large extent had as their focus the rehabilitation of the individual in so far as is possible with the ultimate hope of economic independence.(pp. 39,40).

The Director of Social Welfare validated the economic worthwhileness of the rehabilitation program for the disabled in 1963. He stated that,

> rehabilitation is essential when a person is in need of retraining or extra training to make him available for work. The effects of automation are being felt, and the untrained and handicapped persons are finding more and more difficulty in obtaining employment. These people must be helped to readjust, otherwise they would become a permanent charge on the community. The rehabilitation team and committees throughout the Province are concentrating on this phase of the programme of the Department.(p. 9).

A certain condition had to be met however before dollars would actually be spent for the benefit of the physically disabled. Similarly, a criterion of 'worth' also articulated the assumptions that decision makers had about the manner to proceed in a given situation. A statement made by a regional administrator of the Social Welfare Branch in 1963 made this criteria of worth explicit.

> This economic improvement was reflected in the Social Welfare case loads, and it became increasingly important that the social workers spend as much time as possible on the rehabilitation of the considerable numbers of individuals and families capable of reaching greater social and economic independence when extended some assistance from our Department and other community agencies.(p. 19).

Again in 1964, the Social Allowances and Rehabilitation

Division asserted that,

> emphasis is being placed on sorting out for rehabilitation services those who appear most likely to achieve return to employment. Rehabilitation services are provided for disabled persons in co-ordination with the Health Branch and the National Employment Service...More intensive professional services, including diagnosis of social problems and skilled help in their resolution, are provided in selected instances. Because this is a more time-consuming service, it is considered that priority for this service should go to young families and to persons who can be more readily helped.(p. 37).

In 1969, this criterion of worth was made even more explicit by the Division, narrowing down the range of physically disabled who would be considered acceptable for the service.

> Our rehabilitation services are primarily concerned with the return to employment of employable persons. The majority who receive social assistance are not employable. These include mothers with children, older men and women, or persons with serious handicaps such as alcoholism, mental illness, or severe physical disability...., approximately 20 per cent of social assistance recipients are presumed employable when jobs are available that suit their capabilities. Most are handicapped because of insufficient education or training. Emphasis has, therefore, been placed on educational training for those who can benefit.(p. 15).

The first report of the newly named Department of Rehabilitation and Social Improvement for 1971 (prior to the NDP coming into power) provided an example of the existence of both an economic and a humanitarian value. It stated that,

> the reports also show that the vulnerable members of our society - children, the aged, and the handicapped - are being provided services that assist each individual to achieve his maximum potential for fulfilment and independence.(p. 21).

Establishing Similarities and Differences with the Data from the Health Branch in British Columbia

Comparison of the data from the annual reports for the Health Branch of British Columbia verified the existence of an economic value yet again complimented by a humanitarian value.

For example, the financing of programs for the physically disabled operated by voluntary agencies was legitimated by the economic expectation of a return on public money spent.

In 1949, the Health Branch discussed the services offered by the Canadian Arthritic and Rheumatism Society, and stated that,

> ...Many of these patients can, with this assistance, progress from a completely bed-ridden state to a point where they can again become wholly or partly self-supporting.(p. 13).

In 1958, this expectation was met when the Bureau of Special Preventive and Treatment Services announced that,

> ...a two-year follow-up survey of thirty-four cases treated at the Canadian Arthritis and Rheumatism Society medical centre showed the change in employment status from five out of thirty-four working at admission, compared with nineteen, in full-time and eight in part-time employment, with only seven being out of work at the end of the two years.(p. 28).

Similarly, the financing of the program for the rehabilitation of patients suffering from poliomyelitis was supported by the Health Branch.

> The opportunity thus provided for these patients with residual paralysis to have retraining will enable them, as far as possible, to return to normal living.(1949, p. 30).

In a 1954 annual report, the Health Branch made explicit the condition that there should be an economic return

on monies allocated to the voluntary agencies that carried out programs for the physically disabled.

The Bureau of Special Preventive and Treatment Services stated that,

> the voluntary health agencies located in...Vancouver which receive grants from the Provincial Government continue to receive close supervision, and once again it is felt that the programmes of these organizations are sound and the money invested in them by the people of this Province, through the Provincial Government, is well spent.(1954, p. 100).[19]

The economic value of developing certain programs for the physically disabled operated by the government was expressed by other divisions of the Health Branch.

In 1950, Public Health Nursing noted that the public health nurse must

> readily adapt herself to new programmes as the emphasis shifts toward the less spectacular but equally important phases of health as related to our economic and social system, this trend has been exemplified during the year by such developments as the survey of crippling diseases of children.(p. 43).

Concern with investing in the future was particularly strong where children were involved. During the fifties, the Division of Vital Statistics in the Health Branch noted that,

> physicians throughout the Province have been made aware of the purpose of the registry and have been encouraged to register on a voluntary basis those children under their care who are suffering from any one of a group of specified disabilities which might prevent them from completing their education and becoming self-supporting.(1953, p. 76).

and, "to determine their needs for assistance in becoming self-supporting" (1958, p. 61).

In 1970, the report for public health nursing that carried out child health programmes stated that "it is felt that

emphasis on prevention and early correction of defects will contribute a great deal to future progress and eliminate costly treatment at a later date" (p. 24).

Early rehabilitation of the tuberculosis patient in the Branch's progressive patient care program was also equated with obvious savings in the cost of sanatorium care (1957, p. 77).[20]

The Division was also concerned about its increasing proportion of tuberculosis patients in the older age group. They recognized that "there is an increasing concentration of older persons in our institutions for whom little can be done either in the matter of curing their disease or in vocational rehabilitation" (1954, p. 123). A humanitarian value legitimized, in tandem with an implied economic value, the continuance of services to this age group.

> They must be cared, for and because many have no adequate domicile, they must be retained so that they will not become spreaders of disease, which would occur if allowed to return to inadequate surroundings. (p. 123).

The humanitarian value of providing programs for the physically disabled was noted in several annual reports by the Rehabilitation Co-ordinator for the Branch. In 1954, he stated that,

> accidents and disease continue to take their toll, and thousands of victims are left with physical disabilities. Some, of course, are still beyond our present knowledge and skill, but it has been estimated that with co-ordinated rehabilitation service 80 per cent could become productive and live relatively normal, useful lives. It no longer is considered sufficient to save lives. Our society must face the challenge of giving meaning and purpose to the life which is saved.(p. 126).

And in 1955,

> Gradually, as the serious humanitarian and economic implications of disability become apparent, rehabilitation of the handicapped is seen to be a goal toward which all must strive together.(p. 139)

And in 1958,

> The humanitarian value of a rehabilitation service for handicapped persons is recognized by everyone. There can be little argument that the economic value of a rehabilitation service has an equal significance both for the individual who suffers a disability and the community in which he lives.(p. 83)

In 1961, and in subsequent annual reports, the Division of Public Health Nursing in conjunction with an expressed belief in the humanitarian value of home care, discussed how actual savings in cost to the family or subsidizing agency for home care could be estimated by calculating the number of days which might have been spent in an institution by a patient. They stated,

> of greater importance is the fact that many patients have been able to live complete and healthy lives as the result of professional nursing care available at home.(p. 52)[21]

In 1969, a report on Home Care drew more attention to the economic rationality of the programme.

> such professional nursing service in the home may in some case obviate necessity for admission to hospital, or in others may allow for early hospital discharge; this service, therefore, promoted more efficient use of hospital beds to the community at large. That hospital admissions of such patients are obviated is evident from the fact that 73.9 per cent of the patients are admitted directly to home care from the community...It is possible that savings to the British Columbia Medical Plan amounted to over $166,000, as comparisons with nursing visits made by a voluntary nursing organization indicate this would be an acceptable charge to the plan at $2 per visit.(p. 28)

A humanitarian value also had underpinned the care of

patients at the Poliomyelitis Pavilion. In 1962, the Division of Tuberculosis Control stated that,

> from this it will be seen that the Poliomyelitis Pavilion is an active-treatment and rehabilitation centre where everything possible is done to help patients to do more for themselves and to lead as normal a life as possible even if it only means getting home occasionally for week-ends. If, after some months of work, a patient is able to feed himself to some degree we feel that this is an achievement in rehabilitation.(p. 86)

The data from the annual reports have made it clear, however, that whereas the humanitarian motive for operating or financing programs for the physically disabled existed, that economic criterion was used as the bottom line for justifying the continuation of a program. For example in 1958, the Rehabilitation Co-ordinator reported the following statistics concerning applicants for rehabilitation services.

> At referral 45 or 62 per cent were receiving public assistance for their support and the support of their dependents. Twenty-one or 29.1 per cent were supported by parents, relatives, or private resources, and six or 8.9 per cent were receiving Unemployment Insurance...
>
> At closure forty-four or 61 per cent were gainfully employed and financially independent, seven or 9.7 per cent continued on Social Allowance, eight or 11.1 per cent were receiving Disabled Person's Allowance, and five or 6.1 per cent continued to be supported privately...
>
> It is interesting to note that the forty-four rehabilitated individuals have forty-nine dependents. The total number of persons affected favourably by the attention given was ninety-three.
>
> ANNUAL EARNINGS OF CASES CLOSED "REHABILITATED"
>
> | | |
> |---|---|
> | $500 to $1,000 | 3 |
> | $1,001 to $2,000 | 13 |
> | Over $2,000 | 28 |
>
> In every instance when a case is closed "rehabilitated,"

> an attempt is made to obtain accurate information about the earnings of the individual...
>
> The amount of public assistance received by the individual at acceptance usually is known to the Rehabilitation Service. It is known that the amount of public assistance paid out to the forty-four rehabilitated cases and their dependents was $30,846 per year. Public assistance can be, and frequently is, a recurring annual expense. The funds expended to rehabilitate an individual usually are not recurring expenditures. The earnings of the forty-four rehabilitated cases are estimated to be $103,710 per year. The economic values can easily be seen. As stated above, a total of ninety-three individuals have benefited. The public purse has been relieved of an expenditure of over $30,000 per year. The purchasing power of the individuals affected has been increased more than threefold.... (pp. 84,85)[22]

In 1959 and in subsequent years, statements of the following type were made by the Co-ordinator.

> It is notable that twenty of the thirty-eight patients had been in receipt of social assistance at acceptance. The annual total cost of maintaining this group on social assistance was $16,862, and the average annual cost per patient, $843.10. The cost of training this group was $9,300 for maintenance allowances, plus $2,227 for training fees, a total of $11,527. The average length of time required to complete the training was eight months. The average cost of training, including allowances for maintenance during training and training fees, was $576 per patient.
>
> Social assistance frequently is a continuing public expense, particularly when provided to disabled persons. The cost of vocational training is a non-recurring expense. The financial advantage accruing to the community by the provision of vocational training to disabled persons as part of the preparation for work is manifest...
>
> The total cost of vocational training for the group of thirty-eight persons was $19,417. The total amount of the annual earnings of the group is $92,307. None were gainfully employed or self-supporting at the time of their acceptance for rehabilitation service.(p. 89)[23]

In 1960, the Co-ordinator added that, "not only was it less expensive to provide vocational training than to maintain

the group on Social Allowance, but the need for Social Allowance disappeared and a substantial economic gain was achieved by the group (p. 113).

Humanitarian values were initially used to legitimize the development of the peritoneal dialysis program for patients with chronic renal failure. In 1965, the Division of Rehabilitation Services stated that,

> a number of patients are being maintained on a programme of peritoneal dialysis within their own homes. In view of the costs involved, the inability of the patients to meet these costs, and the lack of any alternative resources, the Division of Rehabilitation Services has assumed the administrative responsibility for arranging financial assistance from Provincial Government funds. Dialysis is a necessary procedure to maintain life in these patients, and will continue until such time as renal transplantation becomes a practical possibility. (p. 80)

In 1969, an economic value was added to the rationale for providing this service.

> Since 1965, the Division has offered a RENAL DIALYSIS service to patients who suffer from chronic renal (kidney) failure. This was initiated as a humanitarian relief to patients who needed to undergo peritoneal dialysis, with appropriate drugs and medication, in order to stay alive. The cost of this treatment was so high that, with few exceptions, patients needed financial or professional assistance to carry on. When the programme was first put into operation the patients assisted by the Division were maintained in their homes on peritoneal dialysis. In recent years a more sophisticated and efficient method of dialysis has become available - haemodialysis,... Since early 1968, planning has proceeded which envisaged most patients being trained to operate their own haemodialysis equipment...in any one of the three major hospitals which presently are participating in the programme...Of the 56 persons who have received assistance through the renal dialysis service, 26 are now in regular employment and 15 are going about their daily occupation as housewives. (pp. 41,42)

By 1970, most persons who suffered kidney failure were maintained by haemodialysis carried out in the patient's own

home where an artificial kidney machine had been installed. The Rehabilitation Division stated that,

> This is much less costly than providing the service in a hospital, although it is still necessary to train the patient in the hospital before he is sent home...It costs an average of $6,000 to establish a patient in his home in this way. In addition, it costs an average of $2,150 a year for supplies and materials. (This form of treatment in hospital costs an average of $14,000 a year per patient.) While maintained on this service, the patient is able to work and live a nearly normal life for many years.(p. 40)

Besides the types of values themselves, other properties that described other of their characteristics emerged. These properties were again expressive of evaluative sentiments about the relative worth of things and systems of belief.

The value of investing in the future was preserved and strengthened by a belief in the economic wastefulness of disability. The Health Branch noted in 1950 that,

> there has been compiled very little formal information with respect to the incidence of sickness as it besets the individual and the family. In view of the fact that such sickness is of vast economic importance and has immense bearing on the happiness and well-being of the people, plans were laid on a Canada-wide scale, to conduct a morbidity study or "sickness survey".(p. 13)

This belief was also made explicit in a statement made by the Division of Tuberculosis Control in 1954.

> It was shown earlier that the problem of tuberculosis is shifting from the younger to the older age-groups: 60.1 per cent of deaths are in persons 50 years and over and 39.5 per cent of those under treatment in sanatorium are over 50 years of age. This has considerable economic significance. Obviously fewer young people are developing tuberculosis and fewer are dying of it. It used to be that the disease affected persons in their most productive years, and meant a great loss to the country through loss of production. Incapacitation of the bread-winner

> while the children still needed support and longer periods of disability than under modern therapy placed many families on social assistance. As the disease shifts to the older age-groups, while it does create problems in chronic care, it is alleviating many of the problems connected with the disease in the younger groups and should prove less of a burden on the economic structure of the country.(p. 123)

In 1955, a cost study of the 1953 poliomyelitis epidemic was completed. The average cost of a case of poliomyelitis was estimated to be at least $1,100 per patient. It was considered to be a conservative estimate and did not include,

> the cost of lost wages, the cost of diminished earning capacity for those suffering permanent disability, nor the variety of incidental costs which occur in the average home when normal routine is dislocated by serious illness of any type.(p. 99)[24]

The impact that disability had on the labour market was reflected in a report of the Rehabilitation Co-ordinator in 1955.

> Economically, the problems of the disabled are the cause of sober reflection on the part of administrators of public and private welfare agencies. Although in Canada we are not yet faced with general labour shortages and to a great extent can afford to be prodigal with our available labour supply, industry and trade unions are becoming more aware of the implications and cost of the loss of an increasing segment of our population to the labour market. (p. 139)[25]

A criterion of worth was made explicit in the following statement by the Rehabilitation Service in 1959.

> The only criteria for acceptance was that the patient was considered employable and that a reasonable prospect of job placement existed. Apart from these limitations, no exclusions were made because of age or severity of disability.(p. 40).

The Registry and Rehabilitation Services Branch (previously two separate branches) described their selection method in 1961. The report stated that,

> services to such cases include, initially, consolidation of known information about the patient and an assessment of his potential to benefit from vocational rehabilitation measures.
>
> Where vocational rehabilitation appeared to be indicated, further attention was given with respect to physical restoration, social adjustment, vocational assessment and counselling, vocational training and placement in suitable employment through existing agencies.(p. 112)

Summary

The data that has just been presented has illustrated quite clearly the existence of a positive relationship between social values and the general direction that was taken by the policies/programs developed for the disabled. The value of economic rationality implicated the general boundaries within which policies that were not residual in nature could be developed for the physically disabled. The definition of the solutions to the problem of disability in economic terms also interacted with the previously described labelling contexts that were applied to this group.

The following chapter on contextual constraints provides evidence for the grounding of the power bases of decision-makers with in the provincial departments in a larger political-economic power bloc - the federal government. The emergence of an impact made by other types of constraints is illustrated as well.

Notes to Chapter 7

[1]Alberta, Department of Public Welfare, Annual Report for the Fiscal Year Ending 31st, March, 1953, p. 11; 1957, p. 9; 1958, p. 8.

[2]Idem, 1950, p. 9; 1951, p. 9; 1952, p. 9; 1953, p. 8; 1954, p. 9; 1955, p. 9.

[3]Idem, 1958, p.8.

[4]Idem, 1964, p. 10; 1965, p. 18; 1966, p. 22.

[5]Idem, 1966, p. 25.

[6]Idem, 1967, p. 24; 1968, pp. 17,44.

[7]Idem, 1968, p. 44.

[8]Alberta, Department of Public Health, Annual Report, 1952, p. 127.

[9]Idem, 1953, p. 139.

[10]Idem, 1960, p. 59.

[11]Idem, 1950, p. 4; 1951, p. 4; 1953, p. 143.

[12]British Columbia, Department of Health and Welfare, Social Welfare Branch, Annual Report for the Fiscal Year Ended March 31st, 1953, p. 21; 1954, p. 29.

[13]Idem, 1949, p. 22.

[14]Idem, 1954, p. 29.

[15]Idem, 1965, p. 28; 1967, p. 14.

[16]Idem, 1951, p. 29; 1953, p. 32.

[17]Idem, 1956, p. 32.

[18]Idem, 1960, p. 31.

[19]British Columbia, Department of Health and Welfare, health Branch, 1952, p. 92; 1953, p. 85.

[20]Idem, 1959, pp. 10,12,30,76; 1960, pp. 13,89,90; 1961, p. 31.

[21]Idem, 1963, p. 56; 1966, p. 45; 1970, p. 28.

[22]Idem, 1957, p. 93; 1959, p.88.

[23]Idem, 1960, pp. 112,113; 1961, p. 114; 1962, p. 104; 1963, p. 96.

[24]Idem, 1961, p. 114.

[25]Idem, 1954, p. 126.

CHAPTER EIGHT

CONTEXTUAL CONSTRAINTS FROM 1945 TO 1972

Preamble

Salancik and Pfeffer (1977) have stated that the,

> critical contingencies facing most organizations derive from the environmental context within which they operate. This context determines the available needed resources and thus determines the problems to be dealt with.(p. 10)

Benson (1977) has also noted that "developments within the organization often appear to be intricately related to events occurring in the larger society" and that "in many ways the organization is a part of these larger patterns" (p. 12).

Both of these themes emerged from the analysis of the annual reports for Alberta and British Columbia. On the one hand, it was clearly shown that the federal government's superior access to financial resources (the socio-economic contextual constraint) indirectly and directly influenced the outcomes of the provinces' policy making process for the physically disabled. On the other hand, the priorities that the provincial governments attached to the development of policy for the disabled were often a result of federal priorities as well as of decisions concerning federal departmental organization. For example, with respect to the latter, one of the facts that provided an indicator of the existence of this institutionalized environment as a contextual

constraint was the recognition given in 1967 by the federal government that vocational rehabilitation was a function of the Department of Manpower and Immigration rather than of the Department of Labour whose jurisdiction it had previously been within. This transfer of function to a new department was instrumental in reallocating priority from the needs of the physically disabled (and other disabled groups) specifically, to the needs of the entire unemployed population. The goal of Manpower was extracted by Armitage (1975) from this Department's brief to the Senate Committee on Poverty. It stated that,

> the primary goal of the Department is to contribute to the attainment of economic and social goals for Canada by optimizing the use, quality, and mobility of all manpower resources available to the country. Thus the policies and programmes of the Department are essentially economic in character.(p. 122).

Thus the federal government's preoccupation at that time with maintaining a well trained work force that was suitably equipped to manage the advancing technological demand of production supplanted the original function of the Rehabilitation of Disabled Persons Branches.

The fact that vocational rehab was perceived to be a function of the Department of Labour and later the Department of Manpower and Immigration is in contrast to the location of this function within the welfare department of Alberta and the Health Branch of British Columbia. This lack of hierarchial organizational continuity was recognized by the Report of the Royal Commission on Government Organization (1963) for Canada. It stated that "the Department of Labour is charged with the coordination at the federal level of a comprehensive civil

rehabilitation programme, but provincial coordinators are generally in provincial departments of health or welfare rather than labour departments" (p. 212). Hodgett (1973) in his review of the Canadian public service also stated that

> Labour and National Health and Welfare share between them the programmes more broadly directed to the citizen body as a whole. Even here, clear-cut jurisdictional lines are confused by the semi-clientele status of the Labour Department in which certain welfare and rehabilitation functions, which otherwise have been in Health and Welfare, have been assigned to the Department of Labour.

Although the explanation for this phenomenon at the federal level did not emerge from the data, it seems reasonable to suggest, on the basis of the differences in organizational certainty as to where the rehabilitation of disabled persons function belonged in the provinces, that the differences in determination of administrative jurisdiction reflected a lack of commitment on the part of both levels of government as to whose responsibility the provision of rehabilitation services (excluding income and health-related services) was to the disabled.

Child (1972) has said that the "boundaries between an organization and its environment are similarly defined in large degree by the kinds of relationships which its decision-makers choose to enter upon with their equivalents in other organizations, or by the constraints, which more dominant counterparts impose upon them" (p. 10). The data also described in detail the various financial relationships that the provincial government entered into with the federal government, oftentimes with criteria imposed by the latter that constrained the provinces' use of the resources offered. Predominant among these financial

arrangements was funding for the universal hospital and medical insurance plans, the vocational rehabilitation of disabled persons, the Canada Pension Plan, and the Canada Assistance Plan. However as the data on boundary decisions indicated, the provinces determined what kind of priority would be assigned to programs that would be developed within the funding offered by the federal government and what type of policies would be taken within their departments' functioning.

One of the properties that emerged from the analysis of this data, that of consequence, illustrated the interaction that occurred between policy making and the organizational structure of the departments. Two types of consequence were recognized - manifest and latent. The primary manifest consequence of reacting to external constraints was recategorisation of the physically disabled into jurisdictions that were responsible not so much for specific client groups but for services that cut across the needs of these special groups. For example, rehabilitation changes its focus from the disabled to a broader group of socially disadvantaged or unemployed individuals (not necessarily unemployable due to physical or mental status). These policy changes were accompanied by structural adaptations to the organizational units within which the policies had been located. The latent consequence of this was a shifting of priorities. Thus as the needs and expectations of the federal bureaucrats changed, the provincial departments of health and of welfare were redesigned to accommodate their new demands.

This switch from a clientele based structure to a more service-oriented program raises questions, that have not been

addressed in the sections on the analysis of the data, to do with equality. As early as 1918, the "Haldane Report on the Machinery of Government" (Baker, 1972) for Britain discussed the distribution of functions within a government department according to the benefits of the service versus client based model. The report concluded that "there appear to be only two alternatives... distribution according to persons or classes to be dealt with and distribution according to services to be performed" (p. 161). According to Baker they rejected the first because they believed the fragmentation and dispersal of expertise would lead to a lowering of standards of service. They recommended the second alternative so that "acquisition of knowledge and the development of specialized capacity can be acknowledged to the full" (p. 161).

However as Warham (1974) has pointed out, that whereas there may be circumstances in which equality of treatment, as occurs in a service distribution of functions, is regarded as essential to justice and equality, it also implies the retention of existing inequalities when unlike cases are treated equally. As the data have indicated, the needs of the physically disabled group became more generalised with the structural reorganization of the Rehabilitation of Disabled Persons Branch in Alberta and the shift in priorities for the Rehabilitation and Social Assistance Division in British Columbia. A number of quotes indicated that the particular situations of the physically disabled could not be as well considered under the new boundary arrangements.

The question that arose from the consideration of this data, was whether or not the physically disabled should be

treated as like cases by government policies and structures? Even though meeting needs on a service basis may allow its deliverers the discretion to consider each case on its own merits, it also implies that only those who are judged to be most capable of benefiting from the services offered will be creamed off the top for in depth consideration.

The ensuing sections present evidence that has emerged from the analysis of the annual reports for the existence of this conceptual category and its properties.

Establishing Similarities among the Data from the Department of Public Welfare in Alberta

This conceptual category provided the framework for analysing the underlying processes that were instrumental in shaping and reshaping policies for the physically disabled.

The contextual constraints that existed for the Department of Public Welfare have been defined as situational circumstances to which some form of organizational reaction was necessary. Two dominant types of constraint emerged from the data. These have been defined as the characteristics of the socioeconomic infrastructure into which the government department of Public Welfare was locked, and the institutionalized environment with which the department dealt.

The main socioeconomic constraint that impacted on the development of policies for the physically disabled was the pattern of resource availability to which the department had to relate. Examples taken from the annual reports verified that most changes in provincial policy making were precipitated by

the availability of federal funds.

In 1954, the Department stated that an amendment to Section 5(c) of the Public Welfare Act provided "for the rehabilitation of disabled persons...formerly in The Poliomyelitis Sufferers' Act..." The latter had previously extended "only to those who were suffering from the after effects of poliomyelitis". The effect of this amendment was to widen "the power of the Minister to permit him to make provision for the training and inspection of persons physically and mentally disabled". (Alberta, Department of Public Welfare, Annual Report for the Fiscal Year Ending 31st, March, 1954, p. 8)

This enabling amendment was made in order to take advantage of the Agreement regarding the Co-ordination of Rehabilitation of Disabled Persons between the provincial and federal governments. As a result of the signing of this agreement in Alberta in January, 1954, the Rehabilitation of Disabled Persons Branch was established in April, 1954. The staff of the Branch consisted of the Provincial Co-ordinator of Rehabilitation, one clerk and one stenographer. Under this agreement, the office of the National Co-ordinator of Civilian Rehabilitation, in the federal Department of Labour, shares half the cost of the administration of the provincial Co-ordinator's office. In addition, under the Vocational Training Agreement administered by the new Branch, both the Federal and Provincial (Department of Education) governments paid part of a disabled employees wages during the learning period of on-the-job training. The contribution "gradually decreased until the training period" was over and the employer was paying full wages (1956, p. 47).

In June 1961, the Department announced that the

> Vocational Rehabilitation of Disabled Persons Act was passed by the Federal Government and this provided for the expansion of existing programs and gave statutory recognition to Federal-provincial agreements. To benefit from this legislation a person must be suffering from physical or mental impairments which render him incapable of pursuing regularly any 'substantially gainful occupation'. (p. 22)

Then in April, 1962, "the Government of the Province of Alberta and the Government of Canada renewed a revised SIX-year agreement to provide for the payment of Canada to the province of contributions (50%) of costs incurred by the province in undertaking a comprehensive program for the vocational rehabilitation of disabled persons". (1963, p. 19) The federal objective that the provinces were to meet was,

> to remove the disadvantages experienced by disabled persons, to avoid their dependence upon the public or relatives and to restore them to usefulness by making available to them appropriate rehabilitation services so that as far as possible they are enabled to contribute to Canada by sharing the same opportunities and accepting the same responsibilities as other members of the community. (p. 19)

The Department of Public Welfare also reacted to the availability of federal funds for extending their own pension program for the disabled.

In June, 1953, Alberta passed the legislation necessary to introduce Disabled Persons' Pensions to those Albertans who were "physically unfit for gainful employment" (1953, p. 33). In 1955, a new section (section 4) added to the Public Welfare Act authorized the Lieutenant Governor in Council "to enter into agreements with the Government of Canada to secure to the Province the benefit of any plan of assistance or pensions to

disabled persons that the Government of Canada, by an Act of Parliament, is authorized to give or make" (1955, p. 8). At this time as well an amendment was made to the Pensions Act Section 2 Clause (c) "for the purpose of extending the meaning of a disabled person to include not only a person who is physically unfit for gainful employment by reason of a chronic disability but also a person who is mentally unfit for gainful employment by reason of a chronic disability". (p. 8)

In 1955, the anticipated intervention of the Federal Government became a reality. The Pensions Board stated that,

> An agreement was signed with the Federal Government effective January 1, 1955 whereby the Federal Government agreed to pay a share of pension paid to disabled persons under the Federal Disabled Persons Act. As the Province of Alberta was already paying a pension to disabled persons it meant that a review of all cases in pay including new applications had to be made by a Medical Review Board who studied each case to determine eligibility as far as the disability... (1955, p. 36)

Allowances under this Act, although administered by the Province, were contributed to on a 50-50 basis with the Federal Government under the federal Unemployment Assistance Agreement.

Directly related to this aspect of the property of contextual constraints was the property of consequence. A relationship between these two was demonstrated by the evidence that a federally directed pattern of resource availability facilitated the creation of new provincial policies for the physically disabled. However it also had the manifest consequences of: (1) recategorising the physically disabled and; (2) forcing the Department to make certain structural adaptations to the organizational units wherein these policies

were located, in order that they met the specific purposes of the recategorisation.

Another type of consequence also characterized the transformation of the policies' organizational units. I have called this a latent consequence because its effects were not as obvious as the observable changes made in either policy or organization. As Pfeffer (1981) has noted, "the creation of new subunits with new titles permits emphasis to be given to new aspects of the organization's operation. A restructuring... provides visible manifestation to those inside and outside of the organization that the activity presumably within the purview of the newly created" unit "has become more important to the organization" (p. 38).

The new boundary arrangements that were produced reflected the new priorities of the provincial government with respect to the physically disabled. Thus as policies were altered, the department also was redesigned in order that the purposes of the decision makers were served.

Before considering the examples that verified this property, another type of contextual constraint emerged. This constraint has been defined as the institutionalized environment of ideas which prescribe and condition the development of policies and the emergence of new organizational structures. These legitimating ideas include morally sustaining ideas or principles, and ideas about ways of organizing and styles of management.

The following examples verified the positive relationship between the two types of contextual constraints and the

alterations in policy and organizational from that occurred as a result.

The data from the annual reports verified that one principle or morally sustaining idea in particular operated to help legitimize the change from a pension program for the disabled (and others) to a broader non-categorical Social Allowance program.

In 1960, the Public Assistance Branch stated that,

> it has become apparent that some better approach should be made to the whole program of public assistance than the present method of categorical pensions augmented by a system of assistance administered by municipal authorities.(p. 10).

In response to this perceived need for change, on April 11, 1960, the Act to amend the Public Welfare Act, which included a Part III entitled Social Allowances, was given assent. It came into force on June 1, 1961. The following statement made by the Branch in 1960, illustrated that the principle of equality of treatment was implicitly used to legitimize the development of the new Social Allowances program.

> The effects of the Amendment will be far-reaching. It will serve as a means of basing welfare payments on the needs of the individual rather than on such artificial factors as age, disability or residence. It will serve as a means of merging the four provincial programs of Mothers' Allowances, Widow's, Disability and Supplementary Allowances. The province will have to assume a major portion of caseloads...any person who is unemployable will become a provincial responsibility... (p. 11)

The completion of this quote illustrated, however, that equality of treatment as a principle did not provide the only source of legitimation for change. Warham (1974) has pointed out that, "categories may be created to suit administrative or

organisational convenience..." (p. 117). The existence of this institutionalized contextual constraint has been confirmed in the next example.

> The pension programs are very specific in their regulations and have limited benefits in most cases quite unrealistic compared to a recipient's needs. The pension programs have achieved a certain prestige compared to the relief days of the depression, but for many people who do not qualify for a pension or for those who must seek assistance through a municipality to augment a pension there is still a great stigma attached to the term, "Public Assistance". For this reason and the desire to effect a more simplified administration The Public Welfare Act was amended by adding a new part to be known as Social Allowances.(1960, p. 10)

Even though in 1961, the Public Assistance Branch proclaimed that the amendment to the Public Welfare Act introduced "a new concept in welfare, basing assistance on the need of the individual" (p. 11), the re-categorisation of disabled persons again suited administrative convenience as described in the following statement.

> To avoid duplication of administration within Central Office and to bring all public assistance services under one supervisor it is planned to divide the Public Assistance Branch into the following divisions:
>
> Social Assistance Division
> Social Allowance Division
> Rehabilitation Division
> Pensions Division
>
> ...The Social Assistance Division will assume the former public assistance responsibilities including single men. Social Allowance will be restricted to those who are eligible under Part III of the The Public Welfare Act. Rehabilitation initially will administer services to the disabled under the agreement with the Federal Government but it is hoped it will become the nucleus for an expanding rehabilitation process. Pensions Division will continue to administer the pension programs, both those being continued as shared programs and

those remaining as provincial programs.

The latter Division existed until the change-over from pensions to social allowances could be completely effected as described next.

> Applicants in receipt of pension under the provincial programs of Mothers' Allowances, Disabled Persons' Pensions, Widows Pensions and Supplementary Allowances will be given the opportunity to transfer to the Social Allowance program if they wish to do so or they may continue to receive their original pension. However, no further applications for the provincial pensions will be taken after proclamation of the Act, known as the Welfare Statutes Act, is assented to. The Acts under the Federal-Provincial shared programs...will continue unchanged. (196, p. 7)[1]

In addition, it was "anticipated that more of the direct responsibility for providing rehabilitation services" would "be transferred to the regional offices of the Department" (1962, p. 23). In June, 1961, these separate Divisions were organized as the result of the proclamation of Part III of the Act to amend The Public Welfare Act. The Public Assistance Branch stated that "this program, based on the need of each person as an individual, reflects a new concept in welfare" (1962, p. 9).

The principle of equality of treatment underpinned the Department's move away from financial assistance programs founded on means to those founded on the concept of need. In 1965, the Public Assistance Branch made this clear. They stated that,

> ..., with the advent of Social Allowance, the Provincial pensions are declining rapidly and it is hoped by the Department of Public Welfare that in the not too distant future all welfare assistance will be paid through one inclusive program based on the test of need rather than the means test. (p. 23)[2]

In conjunction with the transformation of the pension programs into a broad social allowance program for unemployable persons, the Rehabilitation of Disabled Persons Branch also lost its separate identity as it became relocated within the Public Assistance Branch. During 1961, the Branch stated that,

> In keeping with Departmental policy of reducing the number of categorical programs and separately administered Branches, the former Rehabilitation of Disabled Persons Branch was officially dissolved. In its place, was formed the Rehabilitation Division of the Public Assistance Branch, with the Supervisor responsible to the Director of Public Assistance. The position and Office of the Provincial Co-ordinator of Rehabilitation remains,but the functions and duties of the Co-ordinator have been distinguished to conform with the establishment of the Rehabilitation Division and Supervisor (p. 37).

The latent consequences of relabelling and relocating the Rehabilitation of Disabled Persons Branch also emerged. Thompson (1973) has suggested that organizational members tend to develop and elaborate formal structural frameworks in ways that are symbolically appropriate to their complex values. With respect to this statement, the effect of subsuming the Branch under the Social Allowance program was to decrease its visibility as a functioning unit of the Department. This, along with broadening the title of the Branch from the descriptive 'Rehabilitation of Disabled persons' to the vague 'Rehabilitation Division' indicated a change in the priorities of the government with respect to disabled persons, and a structural consolidation of programs that had developed within the boundaries of the residual and positive allocative policy decisions.

In 1964, the principle of equality of treatment was

again called upon to legitimize another organizational change. The Rehabilitation Division stated that,

> within the coming fiscal year it is contemplated that the Rehabilitation Division will be merged with the Social Assistance and Social Allowance Divisions. This is being done in an effort to provide a more unified and consistent approach to the problems of the applicants who are in need of both rehabilitation and financial services.(p. 41)

This principle was also implied in the broadening definition of rehabilitation that was applied by the Branch. In the annual reports from 1965 to 1968, statements were made that defined rehabilitation as serving "not just a particular group, but all handicapped persons; the physically handicapped, the mentally handicapped, and the socially handicapped" (1965, p. 47).[3]

The trend towards recategorising the rehabilitation program from one that was specific to the disabled (physical as well as mental) to one that took within its boundaries the general category of unemployed/able persons was firmly entrenched with the proposal in 1964 "to merge rehabilitation with the social allowance and social assistance divisions, so that an integrated program of financial assistance and rehabilitation may be made available. It is increasingly evident that rehabilitation measures, training, retraining, education and re-education and the general upgrading of skills must become an essential part of any welfare program" (p. 8).

> In November of 1964, the Rehabilitation Division of the Public Assistance Branch was merged with the Social Allowance and Social Assistance Divisions, with a resulting change in emphasis from the vocational rehabilitation of the disabled to a program designed to assist as many families and individuals, physically disabled or not, as its feasible within the resources of this Department and the potential of the recipients concerned ...

> This change has been brought about in an effort to provide an integrated and equal approach to the rehabilitative needs of both the able bodied and the disabled.(1965, p. 18).

During 1964, the Welfare Statutes Amendment Act was enacted with the intent of enabling the Province "to give assistance in the form of Social Allowance to persons eligible for Blind and Disabled Persons' Allowances and Old Age Assistance" (1964, p. 7). The existence of an economic contextual constraint was revealed in the following statement however. The Department stated that,

> as this change depends on renegotiating agreements with the Federal Government, the legislation will only come into effect with the concurrence of the Federal Government and by Proclamation of the Lieutenant Governor in Council. Those persons in receipt of benefits at the time of the Proclamation will be given the choice of transferring to Social Allowance or of continuing to receive a pension. (p. 7).

Again the principle of equality of treatment was expressed as the motivation for yet another organizational change, although countered by the existence of the economic constraint just identified. In 1966, the Public Assistance Branch stated that,

> the present administrative structure of the Branch, which includes the Director and the Social Allowance, Social Assistance and Pensions Division, is in the process of being changed to one in which the Social Allowance and Social Assistance Division will be combined into one Division under the direction of a Program Supervisor. This Division will be divided into two units, one supervising all financial assistance cases in the northern areas, the other those in the southern part of the Province. This change reflects the feeling of the Department that all financial assistance, whether long or short term, should be considered as far as possible on the same basis. In line with this thinking, the Department is working towards the discontinuance of the pensions programs as soon as practicable in order that all assistance programs in Alberta may be based on the

> concept of "need" rather than "means and category". The Canada Assistance Plan, which is being proposed by the Federal Government will, if accepted by the Provincial Government, make this change possible ... In order to share with the Federal Government under the terms of the Canada Assistance Plan, all assistance given, whether by municipalities or the Provincial Government, must be based on the concept of need.(p. 22).

Amendments made to the Public Welfare Act in April, 1966 permitted "the inclusion in the Social Allowance program of those persons undertaking rehabilitative training..." (1967, p. 8). In that same year, the Department stated that "the Provincial Government continues to pay 80% of the costs incurred by municipalities in caring for its residents. Except for the costs of caring for those persons remaining on Mothers and Supplementary Allowances, all Provincial public assistance costs are shared by the Federal Government on an approximate 50-50 basis" (p. 22).

The following example illustrated that administrative reasons also played a part in determining the restructuring of the Social Assistance and Allowance programs. In 1968, the Department stated that,

> the fiscal year 1967/68 was one of re-appraisal and re-examination of existing policies and services of the Department in order to simplify, wherever possible, procedures and programs. In the public assistance section in particular a most intricate system of providing financial assistance had come in effect over the years, and this is particularly true of the pension programs where there are a maze of regulations concerning assets, residence, the degree of disability or blindness and provincial and federal responsibilities. In order to eliminate some of these complexities, The Welfare Statutes Amendment Act, 1964 was proclaimed on January 1, 1968. Under the provisions of this Act, no further applications could be accepted for the three remaining pensions, Old Age Assistance and Blind and Disabled Persons Allowances...

> To further simplify the public assistance services, consideration is being given to combining Social Allowance and Social Assistance programs into one to be known as Social Allowance. This would not only make for more efficient operation within the Public Assistance Branch, but would also add flexibility to the procedures by which assistance is given to the person in need of short-term help (p. 7)[4]

The annual report noted that "those in receipt of pension benefits at the time of proclamation were given the privilege of continuing to receive financial assistance in that manner as long as their individual incomes and other eligibility factors remained within the ceilings set by regulation" (p. 18).

In the annual report for 1967, it was reported that "the role of the Co-ordinator changed during the period under review..." (p. 48). Two administratively-related reasons were given. They were the "expansion of the rehabilitation service in the area of public assistance and the transfer of the federal service of civilian rehabilitation of the disabled from the Department of Labour, Ottawa to the Western Region, Civilian Rehabilitation, Manpower Services, Winnipeg" (p. 48).

During 1968, the Rehabilitation of Disabled Persons Agreement, which had a year to run,

> was amended to include the federal services of the Occupational Training of Adults program. The Technical and Vocational Training Agreement terminated March 31, 1967 and Schedules 3 and 4 of this were added to the amendment in order to continue Vocational Training Services. Further, Vocational Rehabilitation was recognized as a function of the Department of Manpower and Immigration, Manpower Division, through Manpower Centres (district offices of Manpower) by liaison with provincial rehabilitation authorities. This change expanded the involvement of Manpower with the rehabilitation program. (pp. 44,45)

The Co-ordinator also stated that "through-out the year co-ordination aimed to establish more clearly defined

procedures to assure uninterrupted service to the handicapped after the Rehabilitation of Disabled Persons Agreement expires" (p. 44).

In 1969, the Department of Public Welfare announced that, "the Social Allowance and Social Assistance programs were combined into one, the Social Allowance program, partly to provide more administrative flexibility and also to ensure that as far as possible that all persons in financial need and qualifying for provincial assistance will be considered on the same basis." Thus the new Division was made "responsible for the general administration of financial assistance to all persons in Alberta .... in need and ... eligible for provincial assistance" (p. 15).

This program included not only the physically disabled, but those persons "...unable to earn sufficient for their needs because of age,...because he is a parent with the sole custody and care of a dependent child or because he is unable to earn while attending a rehabilitation course, as well as those employable persons in financial need who do not have residence in any municipal area" (p. 15).

At the end of the 1968/69 fiscal year, a new piece of legislation went before the Legislature. This was the Department of Social Development Bill. It was "designed not only to change the name of the Department but to mark a change in philosophy and function from primarily that of maintenance and custody,..., to the concept of the social development of the individual and family" (p. 7). A Position Paper was presented to the Legislature, which outlined the social developmental approach.

The position paper was developed out of the "White Paper on Human Resources Development" (1967) that was presented by the Premier of Alberta in March 1967. The contents of the latter were examined first to provide further data on the 'principles' that underpinned the government's newly created department.

The paper stated that "above and beyond such provisions, there must exist a predominant framework of principles and values, explicitly understood and supported by citizen and government alike..." (p. 17). Among the principles and values to which the government stated it ascribed were several that emphasized the responsibility of the individual/community (i.e. non-government sector) towards human and physical development.

> ...(5) Society exists to enhance the development of free and creative human beings and should aspire toward the provision of full opportunity for every individual in every area of human endeavour...
> (8) The primary rights and responsibilities for the development of the human resources of a nation should reside with individual citizens and associations of citizens, with responsible government performing a supporting function.
> (9) The primary rights and responsibilities for the development of the physical resources of a nation (the national economy) should reside with private citizens and associations of citizens, with responsible government performing a supporting function. (p. 18)

While this statement described the institutionalized environment of 'principles' (in this case political), it also tended to verify the data on the negative selective boundary decisions that described the government's reluctance to intervene directly in certain areas concerning the physically disabled.

The paper also described a shift in values which was occurring from the economic, which the data verified as under-

pinning the taking of policies for the physically disabled, to the humanitarian.

> ...Alberta's pioneer period placed the emphasis on, and established the foundations for, the development of the physical resources of the province. In emerging from this pioneer period, there has developed an increasingly humanitarian outlook evidenced by greater social concern and thus providing the basis for a new emphasis on human resources development ... The time has come for an explicit commitment of private and public energies toward facilitating, to the greatest extent possible, the free and creative development of every human being in the Province of Alberta. In other words, the time has come for humanitarian values and social concern to be registered in a much more positive and explicit way.(p. 25)

However, the government's concern that humanitarian values become entrenched was restricted by the caveat that it was up to the individual to implement the humanitarian principle.

> In making such a commitment to human resources development, it is important, particularly from the standpoint of preserving individual liberty, that the emphasis be laid on the development of "the individual human being" in society rather than on society itself ... Alberta should avoid the error of those who define their utopia in collectivistic and socialistic terms (in terms of the ideal society rather than the ideal individual)... To ensure that expressions of social concern do not conflict with the preservation of individual liberty, it is imperative that the approach toward human resources development be oriented toward encouraging and enabling each individual to develop voluntarily to the maximum degree that he himself desires and to which he is capable.(pp. 25,26)

While the physical resources and economy of the province were to become "means to an end, and not ends in themselves...", the position paper stressed "the necessity of establishing and maintaining a strong provincial economy" (p. 26). It also stated that,

> in a free enterprise economy, physical resources development is primarily the responsibility and function of the private sector. A new orientation, bringing human resources development into better perspective, therefore calls for more explicit social concern and action on the part of those who believe in private ownership and freedom of economic activity.(p. 26)

To facilitate the development of a social climate in which "individual self-determination" was to be made possible, the paper stated that,

> Government programs in such fields as public health, education, public welfare, labor, industry, agriculture, community development, et cetera, will be specifically designed to help the individuals and associations involved to help themselves, and to equip individuals and associations with the capabilities required to achieve ultimate objectives and goals set by the individuals and associations themselves rather than by the state... to bring needed services within the financial reach of those requiring them, but not so as to give the impression that such services are in any way "free" or that the individual citizen has no responsibility to provide such services for himself and others to the extent that he is capable of doing so. (p. 51).

When the Position Paper on "Social Development" (Alberta, 1969) was presented in 1969, the physically disabled were described as having the potential to contribute to the society that "must be encouraged and developed where possible" (p. 11). However the Paper recognized that while children and adults who could not benefit from rehabilitation must be provided with the necessary medical and social care "at a standard consistent with society's desire for human dignity... the difficulty of priorizing services must still be faced" (p. 11).

Establishing Similarities among the Data from the Department of Public Health in Alberta

The comparison of the data from the annual reports of the Department of Public Health verified the existence of the conceptual category of contextual constraints. The socioeconomic type of constraint operated to explain most of the developments concerning policies for the physically disabled that occurred from 1945 to 1972. The following examples illustrated this point.

In April, 1949, the services available under the Poliomyelitis Sufferers' Act were extended "when money was made available from the Federal Health Grants to provide hospital, medical and rehabilitation care to children who had poliomyelitis prior to 1938 and were formerly not eligible for service under the Poliomyelitis Sufferers' Act". (Alberta, A Survey of Alberta's Health, p. 85)

In 1957 (Department of Public Health, Annual Report), the availability of federal funds for the Hospital and Diagnostic Services program, had a direct impact on the availability of hospitalization and treatment services to the disabled group. The division of Medical and Hospital Services stated that,

> hospital insurance has been under study in Alberta, periodically, for many years. 1956 and 1957 saw a revival of this work due to specific proposals that the Federal Government planned to come into this field with grants-in-aid. The work involved in Alberta planning was so great that effective July 1st, 1957, the former Division of Hospital and Medical Services was split to form a Division of Hospital Services and a Division of Medical Services (p. 7) ... The Ministerial Order creating the separate divisions established the duties and responsibilities of the hospitals Division as including all matters concerning all hospitals, except mental hospitals and

> tuberculosis sanatoria, covered under any plan of hospitalization operated by the Province of Alberta including facilities, ... The provincial statutes to be administered by the Hospitals Division are as follows: The Hospitals Act, The Municipal Hospitals Act, the Maternity Hospitalization Act, the Private Hospitals Act. Other statutes with which the hospitals Division is involved insofar as hospitalization is concerned are: The Hospitalization and Treatment Services Act, The Cancer Treatment and Prevention Act, The Poliomyelitis Sufferers' Act. (p. 1)

The result of the federal intervention was The "Hospitalization and Treatment Services Act Amendment Act (Chapter 27)" that "amended the Hospitalization and Treatment Services Act,..." (1958, p. 7). The Department stated that "Section 3 was amended to include among the persons to whom services may be provided persons receiving an allowance under the Blind Persons Act, the Disabled Persons Act and the Disabled Persons Pensions Act... The Act came into force on the 14th day of April, 1958" (p. 7).

The Department also became concerned about the need to establish a definitive policy concerning services for long term patients in chronic hospitals.

The Hospitals Division stated in 1957 that,

> the term "chronic" used in relation to hospitals is not definitive in that, although it indicates services for long term patients, it does not indicate whether or not active treatment services are available. This is a matter of increasing significance since the federal government has announced its intention to share with provinces the cost of an active treatment hospitalization program.... Some of these beds are in hospitals providing long-term active treatment care to patients who are benefitting therefrom or whose prognosis is such that they may benefit from active treatment services. On the other hand a number of these beds are utilized by patients not being rendered active treatment care. Consideration is being given to establishing a clearer definition as to the type of

services rendered in these institutions.

> To date "chronic" hospitals have not been paid any operating grants under any of the provincial plans operated by this department whether the service provided is active treatment, convalescent or rehabilitation care, nursing care, or of a domiciliary type of care. Municipalities and the Associated Hospitals of Alberta have submitted resolutions to include services rendered in the "chronic" hospitals as insured services under the provincial plan, and consideration is being given to this end.(p. 16)

Changes introduced in 1959, were reported by the Hospitals Division.

> On April 1st, 1959, Alberta introduced its insurance program covering auxiliary hospitals. These institutions take care of the type of case which requires some nursing care but does not require the expensive services of a full-fledged hospital. In the beginning, the Department accepted a group of 10 institutions that were already in operation, paying them about $4.50 per patient day, leaving the patient responsible for $1.50 per day. The Province has arranged to pay the debenture costs of new institutions of this nature. The Federal Government supports the capital cost at $1,500.00 per bed out of an estimated cost of $6,500.00. These new institutions will be built in units of fifty beds scattered at strategic points throughout the rural parts of the Province and in 100-bed units in the city. An active building program is under way aimed at making 3,000 beds available ... (...the Department of Public Welfare is building a number of Homes for the Aged...) (1960, p. 9)

The annual report for 1961 reported that "The Hospitalization and Treatment Services Act Amendment Act (Chapter 35) ... amends The Hospitalization and Treatment Services Act, to bring it into line with more recent legislation relating to hospitalization. The name of the Act is changed to Treatment Services Act and all references to hospitalization are removed as this is now covered by the new Alberta Hospitals Act...This Act came into force on the 30th day of March, 1961" (1961, p. 5). The Alberta Hospitals Act came into force on April 12th, 1961. The

Alberta Medical Plan, described in boundary decisions, began operation on October 1, 1963, under the Treatment Services Act.

Prior to 1967, the Treatment Services Act made provision for treatment services, such as dental, optical, chiropractic, physiotherapy, and podiatry, for the Social Service Recipient group, as well as for medical services. In June 1967, this group, which included the physically disabled, came under the new Alberta Health Plan which had been derived from the newly legislated federal Medical Care Act (1967, p. 49). The Alberta Health Plan replaced the program under the Treatment Services Act consisting of The Alberta Medical Plan and the Alberta Extended Health Benefits Plan. Under this Act, the federal government contributed to the province(s) approximately one-half of the national cost of insured medical services. The new Alberta Health Plan Division described the benefits.

> By authority of the Alberta Health Plan Act assented to April 11th, 1967, the Alberta Health Plan commenced July 1st, 1967.... The purposes of the Alberta Health Plan are to afford to all residents of Alberta, regardless of income level, the opportunity to obtain for themselves and their dependents basic health services and optional health services under a voluntary plan to provide prepaid or insurance coverage for those services and to provide financial assistance to residents in low income groups, where required and requested, by way of subsidies paid by public moneys of the Province.(1968, p. 84)
>
> Basic Health Services were defined as: "(i) medical services provided by a physician, (ii) oral surgery provided by a dental surgeon, (iii) services provided by an optometrist in respect of the refraction of the eyes for the fitting of glasses, (iv) services and appliances provided by a podiatrist, and (v) services provided by an osteopathic practitioner, subject to the limitations and exclusions prescribed in the regulations. This established a minimum level of health insurance coverage to be offered by the Government agency and approved carriers throughout the Province. Optional Health Services offered

> under a standard contract by the Alberta Health Plan and which can be purchased only as an addition to Basic Health Services, are divided into three categories.
>
> A. Hospital and Ambulance Services
> B. Drugs and Prosthetic Appliances
> C. Chiropractic and Naturopathy
>
> ... Social Service Recipients as authorized by the Department of Public Welfare are provided with coverage for Basic Health Services and certain Optional Health Services free of charge. (p. 84)[10]

The introduction of the Alberta Health Plan (operated by the Alberta Health Care Insurance Commission) into the province had a major consequence for the Division of Arthritis Services. Effective March 31st, 1969, it became government policy to discontinue the program. The economic contextual constraint was identified as the main reason for the change made in the following statement by the Division of Arthritis Services.

> While there appeared to be a continued interest on the part of families and patients for follow-up at the clinic, there was not an increase in the number of new cases seen. This is in contrast to former years and probably reflects the pattern of the more affluent society and the advent of total medicare. Under these circumstances, referral for consultation to full-time rheumatologists has been the pattern and less assistance has been asked for through the clinics. With the ready availability of rheumatology consultants throughout the province, and a decrease in the number of patients seen in at the clinics, it was considered that closing of the Arthritis Clinics was a good economy measure. There is the possibility that a certain number of people might suffer through not being able to purchase the rather expensive drugs which are sometimes used in the treatment of arthritics, but in order to take care of this contingency arrangements have been made within the Department of Health so that certain drugs can be provided as necessary through the Division of Medical Services. (1969, p. 69)

Consequences, similar to those that occurred in the Department of Public Welfare, were the result of these particular

federal government policy inputs. Firstly, certain of the physically disabled who once were categorized according to pathology, were recategorized to fit a much broader category. Secondly, the department itself made certain organizational alterations to adapt itself to the new policies. The data identified that sufferers of arthritis were recategorized when medicare was introduced and the provincial program became discontinued.

Although evidence was not provided in the annual reports that could account for the similar fate of the cerebral palsy program, it too lost its separate identity. The "coalescence of the Edmonton Cerebral Palsy Clinic with the multiple Handicapped Children's Unit at the Glenrose" Provincial Hospital occurred in 1963. The Division of Cerebral Palsy Clinics noted then that "one large problem,... is going to be the continued supervision of the Calgary Cerebral Palsy Clinic through the Edmonton Cerebral Palsy Clinic (now Glenrose) unless the Calgary Clinic, too, is absorbed into the Glenrose situation" (p. 108).

In 1964, the responsibility for the clinical program at the Edmonton clinic was transferred to the Glenrose Provincial General hospital. Children with defects other than cerebral palsy were included where no alternative facilities for their medical care and education were available. In 1965, the Division stated that,

> This will be the last annual report of the Edmonton Cerebral Palsy Clinic as at present constituted. The functions of this clinic have been expanded to include any handicapped child who cannot by other means obtain a suitable education, assuming

> of course that the child is educable. The physical facilities for patients attending daily will be transferred to the new building at the Glenrose Provincial Hospital in June, 1966, and there should be an active program catering for 120 children by the beginning of September, 1966.(p. 122).

Establishing Similarities and Differences with the Data from the Social Welfare Branch in British Columbia

The analysis of the data for the Social Welfare Branch verified the existence of a conceptual category of contextual constraints. However only the socioeconomic type of constraint emerged to explain the process of policy development for the physically disabled.

Like Alberta, the Social Welfare Branch also reacted to the availability of federal funds. For example in 1954, the Branch stated that "the Act to provide for allowances to Disabled Persons will enable the Provincial Government to take immediate advantage of the Federal legislation" (British Columbia, Department of Health and Welfare, Social Welfare Branch, Annual Report for the Year Ended March 31st, 1954, p. 11).

> In March, 1955, an agreement was finalized between the Provincial Government and the Federal Government to provide allowances to totally and permanently disabled persons, 18 years of age or over,...This Federal "Disabled Persons Act" and also the Provincial enabling "Disabled persons' Allowances Act" provides for an allowance up to a maximum of $40 a month, payment of which is shared equally between the Federal and Provincial Governments. The primary purpose of the Act is to provide a measure of income maintenance for those permanently and totally disabled persons for whom rehabilitation or other forms of therapy offer no solution.(p. 62).

During that year "payment of a cost-of-living- bonus and health services to Disabled Persons' Allowance recipients on

a similar basis to old-age recipients were provided" (1955, p. 11) by the province.

Pursuant to this, the Old Age Assistance and Blind Persons' and Disabled Persons' Allowances Board was constituted to administer the respective Federal and Provincial Acts and Regulations, including the consideration of applications and the payment of assistance (1959, p. 53).

The Canada Assistance Plan, introduced by the Federal Government became effective on April 1st, 1967. The Branch stated that,

> two important principles that were included in the plan were the acceptance of child welfare as a shareable service under the plan and the recognition that many grants do not solve all problems. Rehabilitation, counselling, and other services should be available to persons in need and to persons who are likely to become persons in need. Over a period of time the general effect of the plan should be to raise standards of financial assistance and welfare services in all Provinces and result in a more uniform level of service for all Canadians. (p. 9)[6]

In the Alberta Department of Public Welfare, the introduction of this program had two important consequences. It had caused the physically disabled to be recategorised, and had caused the Department to make certain structural adaptations to the organizational units wherein the rehabilitation and pension policies for the disabled were located. In the Social Welfare Branch of B.C. the physically disabled were not recategorised because they were already included within a consolidated program of social assistance and rehabilitation - the Social Assistance and Rehabilitation Division. (Prior to 1963, this had been the Family Division). However a certain latent consequence emerged.

When the Canada Pension Plan was brought into effect in 1966 (along with C.A.P. which was to replace the Old Age Assistance and other pension programs), the age of eligibility for Old Age Security (a federal program) was lowered from seventy to sixty-five. This group also qualified for the new guaranteed income supplement offered by the federal government that tended to replace the provincial supplementary social allowance offered to the aged. In 1967, the Board stated,

> By January, 1970, persons reaching 65 years of age will all be eligible for Old Age Security and the Old-age Assistance case load will be non-existent. With the Old-age Assistance case load non-existent and relatively few numbers of Old Age Security recipients eligible for Supplementary Social Allowance, who then will qualify for the services to the aged provided by the district and municipal offices? Also, what services will be provided in the future? In the past, the prerequisite for availability of service was eligibility for any of these allowances and a fair percentage of the aged population qualified. In the future, the aged population will not be economically disadvantaged, but will be needing services nevertheless. When large numbers of people need services, the problem becomes one in which government at all levels must concern themselves. (p. 26)

The result of this concern was the creation of a Division on Aging that was responsible for "developing services and resources for the aged in the Province" (1967, p. 26).

Thus the new federal legislation had the latent consequence of creating a new priority for the branch. While the Division on Aging continued to administer the Disabled Persons' Act (as well as Blind Persons' Act, Old-Age Assistance Act where applicable and supplementary social allowances), its concerns for the physically disabled were displaced by specific issues concerning the elderly.

In 1969, the Medical Division announced another development.

> With the introduction of "medicare" came the sharing of costs by the Federal Government in physicians' services. At the same time the Social Assistance Medical Services plan developed and operated for many years by the physicians of British Columbia for social assistance recipients was incorporated in the British Columbia Medical Plan. This new plan provided for optometric examinations previously provided by this Division, and also added limited chiropractic, nursing, physiotherapy, and podiatric services.(p. 25).

In addition the free health benefits that were available under the Pensions were incorporated into the British Columbia Medical Plan. The Plan was administered and operated under the supervision of the Medical Services Commission.

The particular attention that had once been directed towards the physically disabled and other unemployables/ed was altered at the end of 1967 when "responsibility for adult occupational retraining was assumed by the new Federal Department of Manpower and the focus was enlarged from retraining of unemployed to retraining the labour force" (p. 14). The Social Assistance and Rehabilitation Division stated that,

> The impact would appear to be to reduce the opportunity for the social assistance recipient in gaining access to vocational training. To compensate for this special arrangements are being worked out between the Department of Education and the Department of Welfare to ensure continuance of opportunity.(1967, p. 14).

And in 1970,

> In recent years the emphasis has had to change as public assistance has been required to fill an unemployment-assistance role. One of the characteristics of unemployment assistance has been fluctuation in need. Changing economic factors require sudden

> adaptation of services to provide for suddenly escalating numbers. As the economy improves, the emphasis changes to one requiring a rapid gearing of services to assist in reabsorption. Complicating this are large-scale changes in the manner and nature of goods produced, requiring workers to acquire new skills and adapt to changes of role and community.
>
> In addition, there has been a slow absorption of youth into the labour force,...
>
> Welfare programmes were not designed to cope with unemployment assistance of this kind, and as a result have been distorted and inundated by the volume of the problem and efforts to cope with the entirely different nature of services required... It is evident that a programme of unemployment assistance is needed that is separate and apart from the public welfare system.(p. 16)

Establishing Similarities and Differences from with the Data from the Health Branch in British Columbia

Comparison of the data from these annual reports verified the existence of the conceptual category of contextual constraints. The main socioeconomic constraint that impacted on the development of policies for the physically disabled was, again, the availability of federal funds. In May 1948, the Branch's Deputy Minister of Health announced that "the Federal Government would provide the Provinces with money to assist in the promotion of health services... The grants are made available only if the projects involved represent new services or extensions of present services..." (pp. 11,12) (In Alberta, although the allocation of federal funds from these grants was acknowledged, their allocation by the Department of Public Health to specific areas was not identified.)

In 1949, the Assistant Provincial Health Officer who

was responsible for the general administration and over-all control of the grants stated that,

> every endeavour has been made this year to utilize to the fullest extent the money available, but there are various factors which influence the allocation of funds. The amount of possible expenditure may be limited until a Provincial programme is finalized, as in the crippled children's and hospital construction grants. On the other hand, where the Provincial programme is well developed, such as in tuberculosis control and mental health, difficulty may be experienced in meeting the requirements that expenditures must be for new and extended services... The Federal health grants have not only made possible new developments in health in British Columbia but have also accelerated expansion of present policies. (British Columbia, Department of Health and Welfare, Health Branch, Annual Report, 1949, p. 27).

In 1949, the Health Branch announced that "a programme for the investigation and treatment of persons suffering from arthritis was inaugurated in 1948, with Federal and Provincial funds, and is being continued..." (p.33). The General Public Health Grant continued to provide financing for the Canadian Arthritic and Rheumatism Society in succeeding years.

Funds from the Tuberculosis Control Grant were made available to the Division of Tuberculosis Control. In 1949, the Division stated that,

> the rehabilitation programme which was initiated by the British Columbia Tuberculosis Society was transferred during the year to the division, using funds from the Federal health grant... A full-time rehabilitation officer and a full-time occupational therapist were appointed. A home-making service for tuberculosis patients was established, and at the end of the year there were seven full-time home-makers and four part-time home-makers in patient's homes.(p. 23)[7]

In 1953, the Division stated that,

> a breakdown of the expenditures for tuberculosis under National health grants will show that $91,008, about 25% of the total, is allocated to staff and

> equipment in the various units of the Division, which does not include a further $27,900 for a rehabilitation programme. The latter makes provision for extra rehabilitation services and the training of the existing staff. It is hoped that these new positions will be filled in the near future so that the rehabilitation programme may be properly developed in all of the institutions.(p. 107)[8]

In 1954, and ensuing years, the Division made it clear that,

> it will be seen that the Tuberculosis Control Grant plays an important part in case-finding, treatment, and rehabilitation. In actual expenditure, vocational rehabilitation represents less than 10 per cent of the total grant, but it has enabled us to build up an effective service, and the total project is supported by these funds.(p. 123)[9]

In the same year, the Federal Hospital Construction Grant was used "to assist in the construction of...the Poliomyelitis Pavilion" (p. 15).

In 1949, the following criterion was set by the Federal government for the allocation of funds under the Crippled Children's Grant to the provinces. The Health Branch reported that, "for the purposes of this grant, a "crippled child is one under the age of 21 years who, because of disease, accident, or defect, is restricted in his normal muscular movements" (p. 29). The Branch stated their concern that,

> this definition restricts planning and makes it necessary to separate this phase of child health from the remaining phases, such as blindness, deafness, rheumatic heart-disease, and mental defectiveness, which must, therefore, be included in the planning under other grants...it has not been possible to broaden the definition due to the limitations of the grant.(p. 29)

The most important development under that grant was "the survey of crippling disease in children...to include all phases of child health in accordance with the decision of the

Health Survey Committee". This survey was to "provide the basic information necessary for the formulation of a Provincial programme for crippled children in B.C." (p.30). The Branch also stated that,

> expenditures under this grant have been almost entirely for orthopaedic and other equipment for hospitals and institutions in order not to encumber this grant for future years until the Provincial programme for crippled children is finalized. A new development, which is being financed this year but which will easily become an integral part of any Provincial programme, is the provision of staff and facilities whereby patients under the age of twenty-one will receive the necessary investigation, retraining, and rehabilitation following an attack of poliomyelitis.(1949, p. 30)[10]

"Assistance to the Western Society for Physical Rehabilitation, Vancouver...for the retraining and rehabilitation of poliomyelitis patients" (1951, p. 30) was initiated under the Crippled Children's Grant. In 1951 "an essential service" was "added in the establishment of a brace-shop" (p. 30) for the manufacture and fitting of orthopaedic appliances to patients.

In 1952, another development under the Crippled Children's Grant was the "provision of assistance for the programme for cerebral-palsied children,...worked out under the auspices of the Cerebral Palsy Association of British Columbia" (p. 92).[11] The Grant provided assistance to the three branches of the Association in 1957 and to the cerebral palsy unit at the Children's Hospital in Vancouver (1957, p. 34).[12]

In 1953, a new grant established by the federal government, was announced by the Health Branch that would contribute to the further development of policies for the physically disabled.

> The Medical Rehabilitation Grant makes available to British Columbia $43,000 per annum. Although certain portions...are governed by a matching principle and can be utilized only if the Provincial Government spends at least equal amounts in financing the enterprises, it is understood that Provincial moneys already being expended in the...fields of endeavour will be viewed as the required matching funds. It is fortunate that these are sufficiently large to preclude the necessity of providing additional Provincial funds.(1953, p. 18)

Financing for the operations of the Western Society for Rehabilitation was re-allocated under this new grant. In 1955, the Assistant Provincial Health Officer noted that, "assistance is also being given to the Western Society for Rehabilitation to provide staff to enable them to extend their services to include trainees requiring some nursing care. As a result it will be possible for cases to be accepted earlier for training" (p. 117).[13] In 1957, "...the grant enabled the Centre to increase the services provided to disabled homemakers...to provide funds for medical rehabilitation and associated services for indigent persons referred to the Rehabilitation Service of the Health Branch...for the purchase of prostheses and other medical aids, as well as maintenances for those who temporarily must live away from their homes to receive rehabilitation service" (p. 37).[14] The funds in the latter project for indigent persons were used only when no other means of financial assistance was available.

In 1957 the name of the Crippled Children's Registry was changed to the "Registry for Handicapped Children" and the funding was re-allocated under the Child and Maternal Health Grant (1957, p. 34).

In 1959, the provision of assistance under the latter

grant was extended to include patients in the Pearson Poliomyelitis Pavilion who required prosthetic equipment and other medical aids (1959, p. 37).

In 1960, the Crippled Children's Grant and the Medical Rehabilitation Grant were combined into the Medical Rehabilitation and Crippled Children's Grant. From this grant funds were allocated to the "G.F. Strong Rehabilitation Centre and the Cerebral Palsy Association of British Columbia" for "support towards their staff" (1960, p. 41). The Registry for Handicapped Children and Adults (as of 1960) and the Health Branch's rehabilitation service for adults also received support from this grant.

Provision was also "made toward the medical rehabilitation services supplied by the British Columbia Division of the Canadian Arthritis and Rheumatism Society. The home care programme of the association also received matching funds..." (1962, p. 75).[15]

In 1963, under this grant "funds were supplied for the care of thalidomide babies in the Province, including medical care, travel for consultations, and purchase of prosthetic equipment" (p. 69).

In 1954, the appointment of a Provincial Co-ordinator of Rehabilitation "was the result of an agreement between the Province and the Federal Department of Labour, which" shared "in paying the salary and expenses of the Co-ordinator". The Health Branch stated that,

> the recent appointment of a Provincial Co-ordinator of Rehabilitation under the provisions of the agreement between the Federal and Provincial Departments of Labour will materially assist in the development of a

> rehabilitation programme for the Province, including the most effective use of funds available under this grant.(p. 107).

In addition to paying the salary and expenses of the Co-ordinator, the annual grant of $15,000 was "to cover certain other expenses attendant on the organization and administration of a rehabilitation co-ordination service" (p. 126).

Prior to this policy being adopted, the Health Branch had formed the Division of Environmental Management in 1951, based upon the findings of the 1948 survey of the health services and facilities in B.C. The Division in its first annual report described its origins.

> Originally it was the intention of the Health Branch to form a Division of Industrial Hygiene to meet the growing need for a service that could deal with the many health problems related to the occupations of people in the Province. However, as the time approached when the Health Branch found itself in a position to establish this service, the concept of industrial hygiene was changing.
>
> The trend was away from concentrating on the problems of the worker in solely the place of his employment. Specialists in the field of industrial hygiene were recognizing the fact that it was not enough to deal with the individual adult, at work, to the exclusion of all his other activities and interests. All the factors of his total environment at work, at home, and at play were equally important and needed to be taken into consideration. To continue dealing with these factors in an unrelated and separate manner was to follow the dangers of over-specialization.
>
> Recognizing this trend, the Health Branch took steps to form a division which would have responsibilities across the whole scope of adult health, dealing with nutrition, sanitation, occupational health, chronic care, rehabilitation, public safety, problems of addiction, and the development of civil-defense health services. In order to avoid the impression that industrial hygiene alone would come within the division, the name of "Environmental Management" was adopted....Rehabilitation and care of the chronically ill are two problems which are now being dealt with

> on the basis of study and discussion by organizations and persons throughout...British Columbia...When definite plans are agreed upon to deal with these problems, they will be included in the programme of environmental management.(1952, p. 46).

However in the 1953, annual report, the Division, which was renamed the Division of Environmental Engineering, stated that,

> the other phases of environmental management are largely in the early developmental stage therefore it is found in the field of rehabilitation that plans are still in the process of being discussed among senior staff members of the Provincial and Federal Governments for the purpose of establishing a sound basis on which the programme can be developed and methods of financing the employment of a suitable Rehabilitation Co-ordination Officer.(p. 43)

This attempt at structuring a rehabilitation policy for the disabled within a different organizational framework was displaced, as noted, by the introduction by the federal government of a cost-shared program.

In 1961, "the Federal Government's Act for the Vocational Rehabilitation of Disabled Persons" made "provision for the Federal Government to share equally with the Provincial Government expenditures on vocational rehabilitation" (p. 13). This source of funds supplemented those already available under the Medical Rehabilitation and Crippled Children's Grant of the National Health Grants programme.

The rehabilitation surveys were also inaugurated as a "joint inter-departmental undertaking by the Health Branch and the Department of Social Welfare, using funds from the National Health Grants" (1962, p. 33). In 1963, the Health Branch reported that the development of local community rehabilitation services "has been given impetus by the signing of the Federal-

Provincial agreement which provides financial assistance for the vocational rehabilitation of disabled persons". (p. 95).

In 1958, as a result of the Hospital Insurance and Diagnostic Services Act which the federal government had introduced and which became effective on July 1st, "in-patient services in hospitals previously supported under the grants were discontinued and became subject to assistance under the new Act, ... administered through the British Columbia Hospital Insurance Service" (p. 30).

Prior to 1960, the costs of hospitalization for poliomyelitis patients were covered by the B.C. Hospital Insurance Service (with Social Welfare covering the costs for social service recipients) as long as the patient was in the acute phase of the disease. After this stage, the cost of hospital care became the responsibility of the individual. Rehabilitation which was available at the Western Society for Rehabilitation, Vancouver General Hospital in Vancouver, and the Royal Jubilee in Victoria or privately through the Canadian Arthritis Society's physiotherapists, was expected to be paid for by the patient. (1953, p. 32).

In September, 1960, after the introduction of the federally cost-shared Hospital Insurance and Diagnostic Services Act, hospital insurance was extended to "include a coverage programme for rehabilitation, chronic treatment and convalescent care in certain approved hospitals". (1961, p. 88). The institutions that received funding for operating costs for this programme through the new plan were designated as the Gorge Road hospital, Holy Family, Children's Hospital, the Queen

Alexandra Solarium, Vancouver Preventorium, the Western Rehabilitation Society (later G.F. Strong) and the Poliomyelitis Pavilion. Excluded from coverage of the federal program were patients of the bedridden, aged or infirm type who required expert nursing care but who would not likely benefit by rehabilitation measures and who could not receive adequate care in private nursing homes. Participation in the program was limited to approved active treatment chronic hospitals or chronic units that intended to provide a full treatment service. Items such as wheelchairs, braces, artificial limbs, and self-help devices were not included under the plan. If patients could not pay the $1 co-insurance charge or out-patient fee or were unable to pay for prescribed appliances (those who were not social service recipients) had the cost of their requirements reviewed by the sponsorship social worker for possible referral to an appropriate voluntary or government agency for sponsorship (1962, p. 66).

Although the existence of a federally funded pattern of resource availability was the major constraint that the Branch reacted to, in its development of policies for the physically disabled, other constraints also existed.

In 1960, "a new section called the "Registry and Rehabilitation Services" was created. The integration principle was identified as underpinning the change.

> ...it reflects an integration of the rehabilitation and crippled children's registry services which had previously operated as relatively independent entities. The registry function was extended to include provision for registration of handicapped adult cases.(p. 35)
> ...and a Director of Registry and Rehabilitation

> Services was appointed (p. 12) ... The Children's Registry concerned itself with persons under 21 years of age. It was realized, however, that many of those originally registered, though having passed beyond the age-limit, still required some type of rehabilitation service as adults. Moreover, since a general programme of adult rehabilitation is being developed, it was felt that the services of the Registry should be extended to include handicapped adults, thus automatically taking care of those previously registered as children.(p. 110)

In 1963, the director of the Registry and Rehabilitation Services reported that,

> the Registry and the Rehabilitation Services, although basically serving different functions, are in fact becoming ever more closely integrated in their activities. Both are concerned with services to the handicapped. Both are concerned with detection and location of persons with health problems....Both services have benefited from this. The Registry, besides collecting data, has been able to expand its fields for service. The Rehabilitation Services have derived benefit from the case-finding facilities of the Registry.

Summary

In 1945, Cassidy, an experienced observer of Canadian social services noted that there had been a "haphazard piling up of measures...leading each province to its own system or lack of system" (p. 11). Later in 1961, Morgan (1980) noted that "it is difficult...to trace any orderly development of social services provided by the various levels and types of government..." (p. 95). Mallory (1971) in his discussion of the structure of Canadian government said that "the executive departments are carved out on no coherent principle of organization" (p. 121). Still more recently, Agranoff (1977), an observer of the American federal scene, has said that the "debates that occur over the nature of public organization form, the loci of decisions, and how policies

are to be implemented suggest that political actors care about the design of public organizations because their structure and operation effect policy" (p. 15).

The preceding analysis has argued and presented evidence for the proposition that the development of policies concerning the physically disabled did not occur randomly without any implicit order. Rather, it has been demonstrated that two different types of contextual constraints often precipitated or influenced the development of certain policies by the provinces, and that the concepts of labelling, boundary decisions, and valuation provide adequate analytic tools for an understanding of the principles that underpinned the choices that the provinces then made, from 1945 to 1972.

The following chapters examine the annual reports for Alberta and British Columbia from 1972 to 1980 for changes that may have occurred in the organization of policies for the physically disabled that were well established in one form or another by the early seventies.

Notes to Chapter 8

[1]Alberta, Department of Public Welfare, Annual Report for the Fiscal Year Ending 31st, March 1962, p. 14; 1963, p. 11.

[2]Idem, 1966, p. 27.

[3]Idem, 1966, p. 48; 1947, p. 48; 1968, p. 44.

[4]Idem, 1968, p. 18; 1969, p. 17.

[5]Alberta, Department of Public Health, Annual Report, 1967, p. 91; 1969, p. 72.

[6]British Columbia, Department of Health and Welfare, Social Welfare Branch, Annual Report for the Year Ended March 31st, 1968, p. 10.

[7]British Columbia, Department of Health and Welfare, Health Branch, Annual Report, 1950, p. 88; 1951, p. 106; 1952, pp. 98, 114.

[8]Idem, 1952, p. 114; 1954, p. 123; 1956, p. 105.

[9]Idem, 1958, p. 31; 1959, p. 135; 1960, p. 44; 1961, p. 38; 1962, p. 71; 1963, p. 64.

[10]Idem, 1950, pp. 22,24.

[11]Idem, 1955, p. 112; 1956, p. 103.

[12]Idem, 1958, p. 30; 1959, p. 34.

[13]Idem, 1956, p. 108; 1957, p. 37; 1958, p. 31.

[14]Idem, 1956, p. 108; 1958, p. 31; 1959, p. 35.

[15]Idem, 1963, p. 69.

CHAPTER NINE

COMPARISON WITH THE DATA FROM ALBERTA AND BRITISH COLUMBIA FOR 1972 TO 1980

Preamble

Smith's (1976) statement "that there can be many movements and ceaseless activity, but no real change within or between units" (p. 5) aptly reflects the state of policy development between 1972 and 1980 for the physically disabled in both Alberta and British Columbia. Many policies/programs remained unchanged under the new governments of both provinces. These were taken to be established and were not analysed any further. Due to the economic constraints within which the provinces' costs of major programs such as hospital and medical care insurance were shared by the federal government, these programs were, of course, retained. Within the welfare components of Alberta and British Columbia, a number of new policies were developed into programs because of the availability of federal funding through the Canada Assistance Plan (CAP). These programs, although different in content in both provinces, were residual in nature as they were designed for those in need - a classification that included the physically disabled.

The analysis of the annual reports also demonstrated

that most new policy decisions had their antecedents in programs that had been started before 1972 on a limited basis, or they were duplications of policies, including organizational structures, that had existed before.

A significant trend in both provinces was the emphasis that continued to be placed on the funding role of departments while responsibility for operations was delegated to the community - their voluntary sector. The latent outcome of this negative structural selective type of decision-making was that rationing of services became dependent on the priorities and interests of community organizations, not all of which were concerned with the needs of the physically disabled. One particular example of this for which data was available was the Activity Centres Program for Handicapped Persons in British Columbia. Since these centres were started in 1971 by the former Social Credit government, and retained by both the NDP and then the Social Credit again, they were not included in the specific analysis for the province. However a particular point is of interest here. To be eligible for financial support from the Department, and later, the Ministry of Human Resources, centres had to agree to "serve physically or mentally handicapped persons over school-leaving age, regardless of the handicapping condition" (British Columbia, Department of Human Resources, Annual Report, 1974, p. 82). While funding was allocated to non-profit societies that met this and other criteria, the distribution of services to the physically disabled was entirely dependent upon the nature of the society that had applied for funding. As an examination of the reports revealed, the

majority of funds were allocated to work activity centres for the mentally retarded.[1]

Similarly in Alberta, funding was also increased to voluntary organizations who provided residential, vocational and child development services, according to their own priorities.

The results of the analysis on new policies that were taken for the disabled indicated that, even with three different political parties governing from 1972 to 1980, all relied upon economic criteria to legitimate their decisions. In addition, most of these were also bounded by the contextual constraints of financing available from the federal government.

The following three sections describe the status of policy development for the physically disabled according to the presence of indicators that verified the existence of the conceptual categories and properties of the theoretical framework.

Comparison with the Data from Alberta for 1972 to 1980

Introduction

By the early seventies, a number of policies specific to the physically disabled had become assimilated into the structure of three major social programs that the provincial government cost-shared with the federal government. These were hospital insurance and diagnostic services, medical care insurance, and the Canada Assistance Plan.

Hospitalization for the physically disabled who were social service recipients was included within the Alberta Hospitalization Benefits Plan. The federal Hospital Insurance

and Diagnostic Services Act was based on the assumption of universal coverage of all citizens on uniform terms and conditions regardless of age, sex, physical or economic condition.

In December 1966, the Medical Care Act was passed by the federal government and Alberta introduced its Alberta Health Care Plan in July 1967. The latter provided the disabled who were within the social services/pension recipients groups, along with the rest of the population, coverage for basic health services with certain optional health services provided free of charge to the former group.

The introduction of the Canada Assistance Plan (CAP) in 1966, saw specific pension and rehabilitation policies for the physically disabled absorbed within one common administrative framework. Social assistance to anyone in need, whatever the age and whatever the reason for the inadequacy of income, was shared by the federal and provincial governments as were the costs of health and welfare services for this group. Depending on the policy decisions of the provincial governments, federal contributions were designated specifically to include a broad range of health services, assessment and referral services, home-maker and day care services, costs of care of persons in institutions such as homes for the aged, nursing homes, and welfare institutions for children, prescribed items incidental to carrying on a trade or other employment, work activity programs, and other special needs of any kind, including special care necessary for the safety, well-being or rehabilitation of a handicapped person in need.

Although not related to provincial policy making, it

is important to note that one year prior to the implementation of CAP, the Canada Pension Plan was introduced by the federal government. It was designed to be a comprehensive social security measure enabling contributors to provide for retirement, disability and survivors' pensions. The compulsory plan covers all employees between the ages of 18 and 70, with payments made according to a wage related scale with a basic minimum contribution, adjusted annually, at which coverage begins. Excluded from this coverage are employees and the self-employed who earn less than the minimum requirement, casuals, family workers, some migratory workers and housewives. To be eligible however, contributions must have been made for a minimum of five calendar years. Disability benefits became payable under the Plan in 1970.

Within the Department of Health at the beginning of 1971, only a few programs specific to a pathologically defined sub-group of the disabled remained. Thus in the analysis of the data for 1972 to 1980, these programs have been listed as established and were not analyzed. Any changes in these policy arrangements were analyzed according to the methodology of grounded theory for conceptual categories that could elaborate on policy development for the physically disabled during the seventies.

This analysis began with the annual report that ended in the 1972 fiscal year for the Department of Health and Social Development. In that year, two significant governmental changes occurred. On March 31, 1971, the Health and Social

Development Act was passed and the two departments of Health and of Social Development were merged. However before the Social Credit government could actually operate their policies within this new structure, a Provincial General Election held during that summer, brought a new Conservative government into power for the seventies, that subsequently changed the name of the Department from Health and Social Development to Social Services and Community Health in 1975. Thus the analysis took place within the context of a shift in political ideology.

Relevance of the Central Integrated Theoretical Framework to the Analysis of the Data

The conceptual categories and their properties that explained the development of policies for the physically disabled from 1945 to 1971 had emerged quickly and easily. In contrast as the annual reports from 1972 to 1980 were examined, data required to verify the existence of those categories did not readily emerge.

I had noted earlier that several policies/programs concerning the physically disabled had been carried over from the original two departments. These were as follows. From the Department of Health came the Special (Multiple) Handicapped Children's Program at the Glenrose Provincial Hospital. The Calgary Cerebral Palsy Program that was operated directly under the Department's jurisdiction until April 1, 1972 was transferred to the hospital board of the Alberta Children's Hospital in Calgary that the government had purchased. The Department provided additional funds to the hospital board for the develop-

ment of services necessary to support the program. The role of the Alberta Children's Hospital was to expand the provincial program for multiple handicapped children. The auxiliary hospital program was also carried over to the new department. These programs operated within the jurisdiction of the Hospital Services Commission (previously Hospitals Division until 1967, then the Hospital Services Section).

Several policies that operated within the Medical Services Division were also maintained. These were the Cystic Fibrosis, Rheumatic Fever, Poliomyelitis Treatment, and Tuberculosis Control programs. The Registry for Handicapped Children and Adults operated until 1975, after which no further mention was made of it in subsequent annual reports.

From the Department of Social Development was transferred the Social Allowance program in which category the physically disabled were included. This included the administration of the Disabled Persons' Pensions Program and Allowances for those pensioners who had continued to receive pensions prior to the discontinuance of applications for it in 1968.

However with respect to eliciting from the annual reports criteria that underpinned alterations in the boundary arrangements of these policies, and the taking of new policies, the data was ambiguous. As the annual reports were examined again and again for clues to the reasons for the organizational arrangements of the policies, their ambiguous nature continued to emerge. Gradually facts were accumulated that verified that a property of ambiguity underpinned some of the boundary decisions made with respect to the physically disabled. At the

same time, the taking of positive allocative and negative structural selective boundary decisions also emerged, although less clearly.

A category of labelling contexts did not emerge because of the pervasiveness of this ambiguity. Similarly, the valuation contexts and contextual constraints that underpinned the taking of new policies were not as strongly evident as they were prior to 1972.

In order to present the analysis as clearly as possible, the data that verified the existence of a property of ambiguity within the conceptual category of boundary decisions has been presented first, followed by data on the positive allocative and negative structural selective nature of other boundary decisions.

Boundary Decisions

The data was coded into two types of ambiguity - ambiguity of intention, and ambiguity of organization. Ambiguity of intention was determined when facts indicated that policies were characterized by ill-defined or unclear objectives. Ambiguity of organization was indicated when particular organizational designs were detected that facilitated the misinterpretation and thus the ambiguousness of a policy's intentions.

The following examples verified the existence of the property of ambiguity of intention.

The 1972 annual report of the Department of Health and Social Development (Alberta) announced that, "following a Provincial General Election in the summer of 1972, the new

government carried out a further organizational change. Effective January 1, 1972, as part of the priorities established by the Progressive Conservative Government, two new areas were created: Mental Health and Services for the Handicapped" (p. 2).

Handicapped has usually described a "disadvantage that is consequent upon impairment and disability" (Wood 1975, p. 15) of any type. Understood in this sense then, the expectation would be that Services for the Handicapped was designed to implement policies for persons who suffered from a variety of disabilities.

Upon further examination of the data, it emerged that this initial statement and subsequent ones, were characterized by an ambiguity of intention. Policy objectives that appeared to concern the physically disabled were unclear and ill-defined. The following examples demonstrated that, in fact, the physically disabled occupied a very indeterminate place in the services administered through the Branch, since most went to the mentally retarded.

For example, in 1973, the Services for the Handicapped Branch stated that,

> a division of services for the handicapped was established in April, 1972, to emphasize the importance the government placed in developing additional services for handicapped persons in Alberta. (p. 17)[2]

This statement appeared to describe the straightforward intention of the Division to concern itself with all handicapped persons. Its completion illustrated, however, that the government's intentions towards the physically disabled were quite ambiguous, in contrast to their intentions towards the

mentally retarded.

> The division was made responsible for administering institutions for the mentally retarded in Calgary and Red Deer and for establishing new services at the community level. This includes administering government grants to a number of established community agencies which provide services for handicapped persons...nine community service workers...are responsible for ensuring handicapped persons obtain services at the community level wherever possible, and for assisting communities in determining local needs and establishing necessary services. The workers are also an integral part of the government's commitment to return mentally retarded persons back to the community from the institution.... On April 1, 1972, a new policy for assistance with capital and operational costs of sheltered workshops was established...Grants totalling $285,753 were made to community agencies for operation of workshops which have a total of 348 spaces for retarded adults. Community residences for handicapped persons received operating grants of $173,486...(p.17)

In 1974, references to the handicapped again illustrated an ambiguity of intention towards the physically disabled. Services for the Handicapped stated that,

> ...Grants to community-based agencies providing services for handicapped persons increased from $1.3 million in 1972-73 to more than $2.4 million this year. The majority was provided for expansion of existing workshop and residence programs. A total of $1,179,000 was provided in grants to nine rehabilitation agencies in Alberta to assist with operating costs of programs offering training in personal services to physically and mentally handicapped persons...a total of 277 spaces were funded in community residences for handicapped persons throughout the province.
>
> One hundred and fifty-five spaces for day training of handicapped children are being funded. These facilities, in Edmonton and Calgary, offer a specialized program primarily for retarded and multiple-handicapped children. (p. 20)

In the 1976 annual report from the Division, the disabled were distinguished from the first time from the mentally retarded and a commitment to the former expressed.

> An important responsibility of the Services for the Handicapped division is to ensure that child development services are available to disabled or mentally retarded children and their families. These services have two basic aims: to help the handicapped child develop to his maximum potential and to provide support to the child's family.(p. 25).

Integrated Day Care and Specialized Day Programs were developed for the handicapped child. Their specific target population was not always specified in the 1976 annual report. However as the data was examined further, it emerged that the majority of these programs were directed towards the mentally retarded. For example, a specialized day program was operated by Goodwill Rehabilitation Services in Edmonton. During 1975/76, this organization was granted $497,000 "to assist in the construction of a new centre which allowed expansion of its program for handicapped children. Called the Elves Memorial Child Development Centre, the new facility" would "provide a development program for 50 children who are mentally retarded and have other disabilities" (p. 26).

Similarly, in Edmonton, a Behaviour Management Service "was established to help retarded children, three years and older, who" had "serious behaviour problems...To achieve this purpose, two distinct co-ordinated programs were established - the home program and the centre program" (1976, p. 26).[3]

The following statement made by the Division in the same year, also separated out the physically disabled from the mentally retarded, and for the first time, identified the carrying out of some action specific to the former.

> Services for the Handicapped finances or operates a wide range of residential facilities designed to provide accommodation to mentally retarded and/or

> physically handicapped people in their own community... During the year, the division provided its first operating grant to a community residence for physically disabled young adults. The residence opened in April, 1975 in Edmonton and was constructed by the Alberta Rehabilitation Council for the Disabled to test the idea of group homes for physically handicapped adults who require assistance in daily living...it is specially designed to meet the needs of the nine handicapped residents. A similar facility is under development in Calgary.(1976, p. 26)

The Fourth Dimension, a community residential facility for young adult paraplegics and quadraplegics, became operational during 1977 with financial assistance from Services for the Handicapped (1977, p. 13). Many more community residential facilities had been funded for the mentally retarded.

The ambiguity of intention towards the physically disabled reappeared in the annual report for 1977, concerning Services for the Handicapped.

> Located within the Health and Social Development Department, the division was charged with planning and developing programs and resources to meet the special health and social service needs of the handicapped. The division began operating on April 1, 1972, and was granted an additional one million dollars of new monies for the development of new programs. Prior to 1972, health and social services for the mentally handicapped consisted primarily of institutions operated under the authority of the Mental Health Act. Under the legislation, there was little differentiation between the needs of and services for the mentally retarded and the mentally ill. Subsequently, the Blair Report on Mental Health in Alberta (Volume 1, 1969) advocated a greater thrust in developing services for the mentally retarded, particularly at the community level. Accordingly, the Services for the Handicapped division has placed its emphasis on developing community-based and regional services and opportunities for the mentally retarded. (p. 9)

Even though this annual report stressed services for the mentally retarded, the physically disabled were given some recognition in the following three objectives of the development

of community services for the handicapped.

> -to assist mentally retarded persons in the maximum development of their individual abilities; - to make it possible for the mentally retarded to function in the community rather than in isolation from it; - to assist physically handicapped persons to lead lives as normal as possible within their own communities. (pp. 9,10)

When the Vocational Rehabilitation Branch was established on March 1, 1976, it described how it supported "vocational training centres, where spaces are available for physically or mentally handicapped who meet certain entrance requirements" (1977, p. 15). Capital funding during that year, however, was allocated only to those agencies who served the mentally retarded.

> Capital grants totalling $157,500 were approved during the year for the construction of training centres in St. Paul and Bonnyville. The grants comprised 50 per cent of the projected capital costs with the remaining funds raised by the communities. The Bonnyville Association for the Mentally Retarded was granted $105,000 to construct the Dove Centre, a vocational training centre providing training for 30 handicapped adults. Habitat Enterprises, operated by the St. Paul Association for the Mentally Retarded, was granted $52,500 to build a workshop accommodating 15 trainees. Additional funding in the amount of $210,000 will be available to private agencies in the coming year to provide 50 per cent of the capital costs for construction of vocational training centres for mentally retarded persons. (p. 15)

In 1980, the Services for the Handicapped stated that,

> The three major program components offered by the ...Branch include:
>
> 1) the development of specialized programs for handicapped infants and children;
> 2) the development of residential or group home facilities for handicapped persons; and
> 3) the operation and development of institutional residences and programs for mentally retarded persons. (p. 45)

Although the distinction made here between the mentally retarded and the handicapped suggested that the physically disabled were included in the latter group, the regional reports for Edmonton, Calgary, Grande Prairie, Lethbridge, Medicine Hat and Red Deer, verified again that the emphasis was placed on services to the mentally retarded (1980, pp. 46-48).

An interview that was conducted with the Director of Rehabilitation Services (responsible for both Services for the Handicapped and Vocational Rehabilitation as of 1976) confirmed the ambiguity of the department's intentions towards the physically disabled when the Services for the Handicapped was established in 1972.

The Newsletter asked:

> The title of your Division would indicate that it was created to serve all handicapped people, but its first efforts were geared almost entirely towards the mentally retarded. Why was this particular group of handicapped people selected as needing more services than they were previously getting and why did the Government not follow the direction of some other provinces in creating a separate Division, solely for the mentally retarded? (p. 4)

The Director responded:

> The Blair Report had devoted one chapter exclusively to the needs of the mentally retarded so when I was approached about taking the Director's position, it was suggested to me, by the Government, that I create a Division for the mentally retarded similar to the Ontario Government's program. I basically recommended against that direction, since through my previous involvement in the social services area with other handicapped people, I really couldn't see, from a management point of view or from a service development point of view, how the community residential, educational or vocational needs of the physically handicapped people differed that much from those of the mentally handicapped. My suggestion was that whatever services this department was involved in should be brought together

> for all handicapped people and not exclusively for the mentally retarded. The reasons for particular attention being paid to the needs of the mentally retarded were largely that the greatest service component, to physically handicapped people, existed in another part of the Department under the Hospital Services Commission and also because we had inherited the Institutions at Alberta School Hospital, Deerhome and Baker Sanatorium, in Calgary, which were totally concerned with a mentally retarded population. We focused on the mentally retarded simply because of the sheer numbers that were living in our large and overcrowded Institutions, that were waiting on their waiting lists and because of the various local associations who were operating pretty much in isolation in attempting to develop community services for their children. (Parent School Organization Letter, p. 4).

Even though the Director claimed that the greatest service component to the physically disabled existed under the Hospital Services Commission, the previous data has indicated that the range of these services was limited to multiply handicapped children who required treatment and, physically disabled adults who required institutional care. The ambiguity of the intentions of the Services of the Handicapped Branch suggests that the physically disabled were not considered to be a priority by the Department.

Data that verified the existence of the ambiguous nature of the Department with respect to the organization of its policies for the physically disabled also emerged.

Although Weick (1977) has suggested that organizational designs "are important because they clarify circumstances" (p. 36), Kaufman (1978) has recognized that organizational arrangements are "all too often...misconstrued, so the architects of administration would be mistaken to let the symbolic considerations dominate their designs..." (p. 223).

The organization of the jurisdictional responsibility for policies for the physically disabled became ambiguous when The Services to Handicapped Children's program was implemented early in 1974 under the Child Welfare Branch. This program met "the special needs of physically, mentally, and emotionally handicapped children" (1974, p. 17). Services were provided through an agreement between the director of Child Welfare and the parents or guardian of the child. "The initial agreements were taken to cover those children in institutional settings throughout the province, but in the latter part of the year the program began taking agreements for children who were still in the community and in their parents' care" (1975, p. 16). Parents of handicapped children were entitled to receive "counselling, support services or financial help to cover the extra costs imposed by a child's disability" (1976, p. 17). The annual reports from 1979 to 1980 reported that "services available include life supports and aids to daily living, specialized diagnostic and therapeutic services, transportation, counselling and training, parental relief, and specialized residential accommodation" (1979, p. 5).[4]

The ambiguity of jurisdiction with respect to handicapped children emerged in the following statement made by Handicapped Children's Services in 1978. It stated that "the program endeavours to assist in providing a prescribed rehabilitative process which may be necessary for a disabled child to attain his or her maximum potential" (p. 78). How this organizational ambiguity came about was suggested in the minutes from the Department's Policy Planning Committee for

March 6, 1981. The following statement was made by one of the committee members.

> I agree with the recommendations that the issue of organization placement of the H.C.S. program has not been resolved and that future planning for handicapped children should include all handicapped children regardless of status on an integrated basis. In considering the former, we must keep in mind that the H.C.S. program was established in the Child Welfare Branch in view of the need to ensure that the children served by this program were "children in need" as defined by the Canada Assistance Plan. Since we continue to share the H.C.S. costs under C.A.P., any transfer of this program out of Child Welfare will require a modification to the Child Welfare Act, and possibly the creation of a second Director of Child Welfare for handicapped children, if we are interested in continued cost sharing.(p. 2).

The implication in this statement was that the contextual constraint created by the availability of federal funds under the Canada Assistance Plan was responsible for the organizational design that the Department chose for implementing this policy. It does not entirely answer the question, however, of why Handicapped Children's Services could not have been transferred to Services for the Handicapped.

The positive allocative boundary decisions that were taken by the Department resembled those taken prior to 1971. Before then, vocational rehabilitation services were delivered within the framework of the Social Allowance program. However when the Services for the Handicapped was established as a division in late 1971, a vocational training section was later stated to have operated in that division prior to the establishment of the Vocational Rehabilitation Branch in March, 1976 (1977, p. 13). The first specific description of this service was reported in 1976 as follows: "Services for the Handicapped

finances a range of vocational training programs for the mentally retarded and physically handicapped" (p. 27). These programs, aside from the Activity Centres, were based upon achieving an economic return by preparing the individual for employment. Vocational Rehabilitation Centres assessed work skills, provided training and offered placement and follow-up services. Vocational Training Centres provided practical work experience and taught the skills needed to obtain and hold jobs in the community. In 1980, it was reported that work activity programs provided "a complete continuum of training for mentally retarded and physically disabled Albertans" (p. 49).

When the Vocational Rehabilitation Branch was established, its purpose was to "reduce the dependence of individuals on supportive services from the Department" (1977, p. 15). Clients who failed "to attain sufficient skills" were "not dropped but referred to services appropriate to their needs" (p. 15). The 1977 annual report for Vocational Rehabilitation also clarified that "vocational rehabilitation services...differ from manpower services. Although employment is a goal for clients, job placement is not necessarily the major activity for branch staff" (p. 15). In April 1977, the Employment Opportunities Program was moved from public assistance to the jurisdiction of Vocational Rehabilitation. This program offered "pre-employment preparation, counselling, placement and follow-up services..aimed at directing the client towards financial independence" (1978, p. 32). Handicapped placements were made through this program in jobs which were available (1977, p. 16). The 1980 annual report stated that "the

Vocational Rehabilitation Branch delivers a variety of rehabilitative services designed to assist handicapped and disadvantaged Albertans to move towards independence" (p. 48).

Boundary spanning mechanism, similar to those developed prior to 1971, were implemented to limit the scope of the rehabilitation policies for the disabled to that of financial assistance (negative structural selection boundary decisions). The exchange of (or bargaining for) services between voluntary agencies and the Department was described in several annual reports.

For example the 1974 annual report stated that "grants were increased substantially this fiscal year to voluntary organizations providing residential, vocational and child development services to handicapped individuals" (p. 3). The two group homes for the physically disabled that were previously described were operated by a voluntary society. Most of the vocational training programs for the mentally handicapped or physically disabled were "managed and directed by local, non-profit organizations. The Vocational Rehabilitation Branch's input was "to provide funding for operational and consultative services which assist private organizations to deliver vocational training of high quality" (1980, p. 49).

In 1976, the Alberta Rehabilitation Council for the Disabled operated the Community Enrichment Program funded through Services for the Handicapped. It was designed to "teach social skills and the use of community resources to severely physically handicapped adults" (p. 28).

The following quote provided an example of how

organizational structures, embedded in the history of an organization, tend to reoccur. In November 1977,

> a provincial inter-departmental committee for the physically handicapped was formed...with representation from eight government departments whose programs have some involvement with the physically handicapped. The committee will look for province-wide implications of issues and coordinate the collection and distribution of information through its membership. Where appropriate, the committee will prepare joint submissions for presentation to member departments.
>
> Voluntary agencies serving physically handicapped persons have been encouraged to establish a similar coordinating mechanism.(1978, p. 31)

This co-ordinating mechanism was remarkably similar to the Provincial Advisory Committee that had functioned in the late fifties and sixties, and served the same purpose.

Up until 1979, the boundaries of the Employment Opportunities Program were coded by restricting admittance to it to those clients of the Department who were also in receipt of another service.

Two new positive allocative boundary decisions were taken during the seventies. The first was the introduction of a province-wide renal program in 1972 for Albertans suffering from chronic renal failure. This program was under the jurisdiction of the Hospital Services Commission up until 1975 when it then went under the new Department of Hospitals and Medical Care. The Commission stated the

> program is cost-effective and further cost benefits are expected through central purchasing of equipment and supplies in bulk quantities for the entire province...Ongoing cost studies have been initiated to insure the most economic mechanism for the provision of this form of health care. Two major regional dialysis centers have been established for the purpose of consolidating present patient care facilities,...and to initiate a home dialysis program,

> thus achieving optimal treatment at the lowest cost. The regional dialysis programs are established at the University of Alberta Hospital in Edmonton and at the Foothills Provincial General Hospital in Calgary" (Alberta, Hospital Services Commission Annual Report. 1972, p. 6)

This program was implemented after the Task Force on the Cost of Health Services in Canada, 1969, recommended that renal programs be introduced in all of the provinces.

The other new program was the implementation of Alberta's Coordinated Home Care Program in 1978. Prior to this, both Calgary and Edmonton had received approval from the government to establish budgets for their own local home care services. The Department stated that the program

> was established to allow Albertans of all ages to receive health and support services while living at home. Its main objective is to reduce the need for institutional care on a temporary or permanent basis ...the program primarily will serve the elderly, the chronically ill, and the handicapped, although other potential users would be those discharged early from acute treatment hospitals. (1978, p. 9)

The expectation that this program would reduce expensive institutional costs emerged in the following quote.

> Based on the evidence available, home care will add to health costs in the short run. It will require perhaps three to five years to counteract the current trend toward high hospital and nursing home utilization, by alleviating the need for admissions, and by encouraging earlier discharge when hospitalization is unavoidable. Thereafter, it is expected that the CHCP will reduce the demand for new institutional beds, and thus allow a reduction in the construction and operating costs of new facilities. (p. 10)

However this program was not without its restrictions as well, since its boundaries were coded with a fairly stringent set of criteria as follows.

> Patients must require a medical service to be eligible for admission to the program....The last criterion for eligibility requires the person to be under the care of a physician who corroborated the need for medical services, as all treatments provided by the home care program are under the direction of the patient's personal physician.

Thus "people requiring support services only" were "not eligible for admission to home care, but" would "be referred by the home care coordinator to appropriate agencies for the type of assistance needed" (p. 9). Support services included homemaker, home-help, meals-on-wheels, handyman and volunteer services such as friendly visiting. Most of these services were provided through voluntary agencies thus limiting access to them to those areas of the province that were covered. Although this information was not recovered from the annual reports, it is relevant to note that home care was included in the provisions of the 1977 Established Programs Financing agreement between federal and provincial levels of government that broadened the former's base of its coverage of health by incorporating a per capita grant for provincial extended health care, designed to cover nursing homes, intermediate care, adult residential care, converted mental hospitals and ambulatory health care.

Finally, within the residual category of policies taken for the physically disabled a new financial maintenance program that singled out the severely handicapped from the Social Allowance caseload was introduced. The 1980 annual report stated that the objective of the Alberta Income for the Severely Handicapped (AISH) was,

> to enhance the living conditions of Albertans with severe handicaps. The program provides a level of

> income approximately equivalent to that available to Alberta's senior citizens. When the program commenced (p. 4)...handicapped people now become eligible for one of three types of AISH:
>
> 1) An income-tested regular AISH benefit of up to $370 per month payable to clients living in the community. An earning exemption is allowed: $100 for single persons and $333 for couples. Each dollar of additional earnings reduces the benefit by 75 cents.
> 2) A modified AISH benefit of $35 payable to handicapped persons residing in nursing homes, auxiliary hospitals and designated social care facilities. This is in addition to the cost of care which is provided through AISH and other programs.
> 3) For severely handicapped people receiving Social Allowance, a supplement to regular AISH benefits of $370 provides $35 in excess of Social Allowance needs. This is a group whose financial needs could not be met by regular AISH benefits, largely due to having dependents.(p. 21)

The annual reports did not state how severely handicapped was defined for purposes of admission criteria.

In the next section the data from British Columbia has been analyzed with the same intention of determining whether the process of policy development concerning the physically disabled was explained by the theoretical framework.

Comparison with the Data from British Columbia for 1972 to 1980

Preamble

Even though from 1972 to 1980, British Columbia was governed by first, the New Democratic Party until 1975, and then again by the Social Credit, for purposes of comparison with Alberta this time period has been regarded as one unit. However, a distinction has been made between the annual reports of each. Before proceeding with the analysis, changes in nomenclature of the departments have been described.

When the NDP took office in September 1972, the two departments of health and of welfare remained as separate entities. The Health Branch retained its separate status as part of the Department of Health Services and Hospital Insurance until 1974 when the latter became the Department of Health, and the Branch was renamed Community Health Programs. After the Social Credit resumed office late in 1975, the Department of Health was renamed the Ministry of Health in 1976.

In 1973, first under the NDP, the Department of Rehabilitation and Social Improvement became the Department of Human Resources, and then the Ministry of Human Resources in 1976 under the Social Credit.

The analysis of the seventies data for British Columbia followed the approach that was used for Alberta in the previous section. Like Alberta's analysis, any policies/programs that were carried over into the departmental structure of the NDP government without change were not analysed since they were taken to be established. The data were subsequently examined, according to the methodology of grounded theory, for indicators, of change in the content of and boundary arrangements of established policies, and of new policies which may have developed after 1972.

In comparison to Alberta the data bearing on the development of policies for the physically disabled in the annual reports for both the Department of Human Resources (welfare) and the Department of Health were not ambiguous when each department was examined separately. It must be mentioned here however, that the welfare annual reports did not provide adequate

data on the boundary arrangements of established and new policies due to reorganization of their presentation. Policies/programs were not described in relationship to the organizational sub-units within which they were located until 1978. Since the data were available predominantly by program type, changes in boundary arrangements that could have occurred did not emerge.

Health

Introduction

By the late sixties, British Columbia had, like Alberta, established hospital insurance and medical care insurance plans, within the boundaries of the previously described federal acts, for the total population. From 1972 to late 1975 when the Social Credit resumed power, the former was administered by the British Columbia Hospital Insurance Service of the Department of Health Services and Hospital Insurance (Department of Health in 1973), later renamed Hospital Programs in 1974. Late in 1972, the Medical Services Commission responsible for the administration of the Medical Care Act was transferred from the jurisdiction of the Department of the Provincial Secretary to the Department of Health Services and Hospital Insurance.

Other established programs concerning the physically disabled that were not altered significantly were tuberculosis, rheumatic fever, kidney failure correction, public health nursing, and home care. The extended care program under the administration of the province's Pearson Hospital continued its two patient-care programmes. (In December, 1975, this program

was transferred from the Division of In-patient Care and placed under the newly appointed Director of Government Health Institutions).

The central administrative and decentralized community structure of the Division for Aid to Handicapped was also retained. Interestingly, even though the NDP philosophy eschews the profit-making motives of the capitalist system, the following statement made by the Division in 1974 indicated very clearly that economic values continued to underpin and legitimate the policy decisions that the NDP carried over from the Social Credit.

> During the year a cost benefit analysis of the programme in the Upper Island Health Unit was undertaken. The purpose of the study, primarily, was to obtain some information about whether a monetary benefit could be demonstrated as a result of the provision of appropriate rehabilitation services to disabled persons. It has long been a contention of those in the rehabilitation field that properly applied rehabilitation services result in dividends related to relieving the community of certain financial burdens entailed in the support of the disabled. Also, that such services assist the disabled toward a more satisfactory and independent, personal adjustment in the community. The work entailed in the study was undertaken by a private firm of management consultants. The study took 10 months to complete and encompassed the total period of the eight years that the programme for the Division for Aid to Handicapped has been in operation in that particular area of the Province and the results are available for review.
>
> Calculation showed that the average annual expenditure on the disabled in that particular area of the Province was $57,000. The study report states: "The benefit cost ratio of $175,000 over $57,000 annually, i.e. about 3 to 1 is the minimal benefit of this programme. In fact the level of annual administration expense is sufficient to allow for the intake of additional clients, while the annual disbursements postulated at $16,000 a year are not required into perpetuity. From an investment standpoint, the investment in the programme to date is probably in the order of $200,000. Present worth of the recurring

> annual benefit of $175,000 is probably in the order of $1.75 million. On this investor's viewpoint, the benefit cost ratio would be over 8 to 1.
>
> The above study applied only to the work of one of the Aid to Handicapped Committees in the Province. At the end of 1974 there were 50 such committees. It is fair to speculate that if a similar study could be made in the case of every committee, the results would vary somewhat from the above-quoted study but, in general, a positive and favourable result would be demonstrated. Such being the case, a substantial fiscal return to the community and to the Province is being achieved through the rehabilitation programme of the Division.(Department of Health, Health Branch Annual Report, 1974, p. 43).

The NDP also retained the philosophy that the "handicapped should be served wherever possible in their own community, with their own community resources and with their own community personnel" (1973, p. 38).[5] In 1975, a similar statement was made by the Division for Aid to Handicapped.

> The year was one of consolidation rather than expansion. Many new programs aimed at providing more and better services for the handicapped and those who have been described as "disadvantaged" have been developed under various Federal and Provincial auspices. A major part of the responsibilities of Aid to Handicapped Consultants in the Province has been the promotion and development of means by which services within a community can be co-ordinated to the advantage of disabled people who are served by the Aid to Handicapped Programs. (p. 56).

Within the renal care program, humanitarian values were displaced by requirements for a demonstrated saving of dollars when it was indicated that a better type of home dialyser was too expensive to use for the renal patients. In 1974, the Branch stated that,

> patients are able to live a relatively normal life on home dialysis, but it is a very time-consuming procedure. Most patients require three dialysis runs a week, consuming 30 to 35 hours, including

> the time spent on dialysis and machine preparation. A new disposable type of dialyser has been developed which will reduce each run from the present eight to ten hours to a standard period of five hours. This method will cost an additional $50 a month for each patient, so that it is not possible to abandon the present equipment at this time.(p. 21)

While the new much more efficient method was too expensive to implement, an investment in the future of children on dialysis was made, as indicated in the following statement.

> Another programme added in 1974 was the supply of nutritional supplements to growing children on dialysis. These high-calorie, low-potassium, and low-sodium beverages and food products are supplied in the belief that extra calories may present the stunting of growth.(p. 21)

In late 1974, the Registry of Handicapped Children and Adults was renamed the Health Surveillance Registry to provide "a name which more fittingly reflects the present nature and scope of its activities" (p. 39). This new name emphasized that the Registry's function had shifted from co-ordination of resources for the disabled as well as registration to that of an information system.

Similarly, when the Social Credit resumed office in December 1975, the programs/policies that have just been identified were retained without any significant alteration of function.

During 1977, the shifting of total responsibility for rehabilitation to the community was to become effective. The Division for Aid to the Handicapped stated that,

> this year has been one of re-evaluation for the Division of Aid to the Handicapped. One outcome has been a decision to introduce greater decentralization in the division's programs.

Thus, effective December 1, 1977, Regional

> Consultants and local Aid to Handicapped Committees will make the final decision in terms of selection and training of clients for their particular regions on a trial basis and full decentralization will follow on April 1, 1978, if the experiment works satisfactority.
>
> In the future, Aid to Handicapped hopes to localize programs further and to develop community-based rehabilitation through the use of information obtained from summer survey projects in every region....(p. 51).

In contradistinction to this intended aim to decnetralize, the Division also announced that "the total number of local Aid to Handicapped Committees that have been established throughout the Province by the division declined over the past year from a peak number of 53 to a low of 39" (p. 51). This statement carries with it the implicit suggestion that the determination of priority to be allocated to the provision of services to the disabled (handicapped) was also being shifted over to the community.

The implementation of pre-referral interviews by some field staff also functioned as a gate-keeping mechanism to increase the selectivity of the intake process for rehabilitation services. As the Division stated, "at these sessions, the prospects of vocational rehabilitation are discussed with the client prior to a referral being made in writing. At present, this is being done in Vancouver, Burnaby, New Westminster, Port Coquitlam, Mission, and Maple Ridge" (1977, p. 51). In 1978, the Division stated that "this system led to better and more efficient help to those clients accepted for service" (p. 64).

An example of the exchange of services that continued to be carried out between this Division and other public and private agencies has been stated below.

> In New Westminster the division has worked closely with Ministry of Human Resources, Public Health, and Mental Health personnel to establish the Howard Chadwick Residence at the New Westminster YW/YMCA. The Howard Chadwick Residence has been licensed under the Boarding-home Program and is authorized to allow 20 physically or mentally handicapped adults to partake in a social and life skills program. The intended result is to allow each individual to gain sufficient skills or support to undertake independent living in a community. The program is unique to the division in that clients may now be referred to the Lower Mainland area from other parts of the Province for specialized programs. The ongoing programs at the "Y" and individual counselling by special "Y" staff have added to the rehabilitation alternatives available to the Aid to Handicapped Committees and their clients.

Other community programs supported by the Division for Aid to Handicapped included the following:

> ...(3) Vocational Orientation Program for patients at the Vancouver General Hospital - extension for one year; (4) Goodwill Enterprises for the Handicapped - salary subsidy for professional rehabilitation staff and fees for Aid to Handicapped clients continued; (5) Opportunity Rehabilitation Workshop - through new management, has changed its function to primarily a vocational assessment centre with financial support for professional staff and a fee for service to cover the cost of daily operations continued; (6) advances have been made to Community Colleges to assist with the creation and running of community-based programs for the disabled.(pp. 51,52)

It will be recalled that in 1971, the Social Credit government then stated that the name 'Division of Aid to Handicapped' reflected the intent to provide services to the handicapped without reference to a vocational settlement. In 1979, the name of the Division was again changed to that of the Division of Community Vocational Rehabilitation Services because "it was felt that the new name more accurately reflected the objectives of the program". The Division stated further that,

> the philosophy of C.V.R.S. is based on the practical application of the idea that those persons handicapped

> by a physical or mental disability require a wide range of services from a variety of disciplines present in the community. To be effective, these services must be applied in a co-ordinated manner, and in the appropriate sequence, to assist the handicapped person along the road to greater economic independence.(p. 72)

This statement made it quite clear that vocational rehabilitation was again the prime objective of the program, although as had been suggested previously, this basic intent had never changed.

The financial feasibility provided by the federal government for the development of new programs by the Division was illustrated in the following statement.

> A significant development during the year was in the job placement aspect of vocational rehabilitation. "Project BreakThru", a pilot project funded through an agreement with the Government of Canada-Youth Job Core Program and Community Vocational Rehabilitation Services, was established. The mandate of "Project Breakthru" was to assist those handicapped persons considered to be "job ready", to find suitable employment. It was gratifying to note that the response from the business community was extremely positive.(1979, p. 72).

Relevance of the Central Integrated Theoretical Framework to the Analysis of New Data

Contrary to the ambiguity of decision making concerning policies for the physically disabled and their boundary arrangements in Alberta, the review of the annual reports up to this point has indicated that for the most part, boundary decisions taken prior to 1973 were maintained by both the New Democratic and Social Credit governments with little functional adaptation. The analysis of the reports indicated that from 1972 to 1980 only two new significant boundary decisions were made that

concerned the physically disabled. The first was the opening of "an exemplary spinal cord injury unit...At Shaughnessy Hospital to act as the referral centre for the Province" (p. 15) in 1975 under the NDP government. Additional facts to determine whether this decision was underpinned by any of the four conceptual categories were not available.

The second major boundary decision was taken by the Social Credit in 1978 when it was announced that the introduction of a new long-term care program would commence on January 1 of that year. The scope of the program has been described below.

> The comprehensive program would provide coverage for intermediate and personal care levels, as well as extensive benefits for care in the home. It was estimated that as many as 17,000 people would be entitled to receive coverage in care facilities at a cost to them of $6.50 per day for ward accommodation. The charges to patients for services in the home would be scaled on the basis of income. For the more than 5,000 extended-care beds, which are already part of the hospital system, the co-insurance charge was to be raised to $6.50 per day, effective January 1, 1978. (1977, p. 15).

The introduction of this program was within the contextual constraint of financial feasibility that was offered by the federal government. It was stated that,

> the introduction of programs such as the one for long-term care were assisted by an agreement between the Province and the Federal Government in 1977. Consistent with the Federal Government's general trend to move from shared-cost programs to block funding, the Federal Government would provide block payments for certain low-cost alternatives to high-cost care. Services such as personal care, intermediate, health aspects of home care, and some ambulatory services were considered appropriate uses for these funds. The sum was set at $20 per capita per year. Allocation of the funds is left to the decision of the Province. (1977, p. 15).

The Long-term Care Program was also called a "positive approach to the needs of that segment of the population who cannot

live without help, because of health-related problems which do not warrant care in an adult care hospital." The primary aim of the program was "to permit those who qualify for benefits to remain in their own homes, among their own families, for as long as is desirable and practicable to do so" (1978, p. 29). Placement in an approved community care facility, or admission to an extended care hospital, was provided when this was not longer possible. An economic value however underpinned the taking of this positive allocative boundary decision as the next statement has illustrated.

> ...attention was given to the expected effect of improving and increasing other services which are appropriate, and less-expensive alternatives to in-patient care in acute hospitals. These include ambulatory programs, as well as the new long-term care program.(1977, pp. 15,16).

Homemaker societies continued to provide the homemaker services that were provided by this program.

Effective April 1979, the Long Term Care Program assumed responsibility for funding eligible Long Term Care clients living in Co-operative Independent Living Homes. Although the operation of these homes came within the auspices of private agencies, Long Term Care extended itself to provide the cost of the direct care component of these homes. As of October 1979, the shelter costs of these homes were subsidized by the Ministry of Lands, Parks and Housing.

When this analysis was compared with the ensuing one for the welfare department it became apparent that a certain ambiguity of organization continued to exist between the two departments with respect to the distribution of 'rehabilitation'

functions related to the physically disabled. The responsibility for this group in this area continued to be diffused through two separate organizational departments whose efforts seemed to overlap, without evidence of co-ordination.

Welfare

Introduction

By mid 1972, when the NDP won office in British Columbia for the first time, the consolidated type of administrative structure within which both social assistance and rehabilitative functions had been combined had operated without any marked organizational change since 1945. Thus the introduction of the Canada Assistance Plan and the Canada Pension Plan had not affected the type of boundary decisions made by the welfare branch nor their organizational arrangement, as had occurred in Alberta's Department of Public Welfare.

However when the New Democratic Party came into power, the Deputy Minister for the new Department of Human Resources announced that,

> when governments change from one political philosophy they do so abruptly....the process of improving government services is a long one because it requires changing people's attitudes and abilities to operate in new directions.
>
> In 1973, these new directions became evident in the Department of Human Resources. We have initiated a significant number of new programmes...In the humanistic tradition it is the Department's goal to provide services in a manner which honours the individual's integrity and takes into consideration the needs of the society at large.(British Columbia, Department of Human Resources, Annual Report, 1973, p. 8)

In contradistinction to this statement, an examination of the annual reports revealed that whereas the previous Rehabilitation and Social Assistance Division was restructured with the reorganization of all of the programs under Social Services and Income Security Programmes, the majority of the boundary decisions that had been taken by the previous government were not changed.

Those policies/programs previously allocated through Rehabilitation and Social Assistance that were carried over included social allowance payments for special services such as: boarding homes, rest homes, nursing homes and private hospitals for those elderly and handicapped who required either of these types of care but who did have the resources to meet the need; meals-on-wheels, homemaker and housekeeper fees for services charged to recipients of public assistance and other low income families; subsidization of educational upgrading and vocational costs for social allowance recipients when these could not be obtained from other sources such as Canada Manpower, the Department of Education and Aid to the Handicapped who Human Resources identified as being "primarily concerned with educational upgrading and vocational training" (1975, p. 86);[6] the Opportunities Allowance Program; and community grants to agencies that provided services directed towards special problems or situations, including funding for the activity centre program for the handicapped (it has been noted that a majority of these centres provided services for the mentally retarded. The Health Care Division continued to cover the health care and related needs (such as medical appliances) of recipients of social

allowance, pensions, as well as of children in care.

Relevance of the Central Integrated Theoretical Framework to the Analysis of New Data

The analysis of the annual reports for new policies/programs indicated that three new developments occurred as outgrowths of the residual type of boundary decisions taken before 1972. The first involved an alteration in the residual income maintenance program for the disabled. Due to the availability of financing for persons in need under the Canada Assistance Plan (an economic contextual constraint), the Handicapped Persons Income Allowance Programme for those 18 and over, if handicapped, was introduced in December 1972. It combined the former means-tested Blind and Disabled Persons's Allowances. The intent of the new allowance programme remained residual in nature in that the guaranteed minimum monthly payment provided the income "essential for handicapped persons to meet their everyday living requirements" (1973, p. 47). In June 1973, the incorporation of the statistics for this program into Mincome, the minimum income program for senior citizens, amalgamated all previously separately administered pension programs. As of December 31, 1973, all handicapped persons were guaranteed a minimum monthly income of $213.85, as long as liquid asset exemption levels did not exceed $1,000 for a single person and $1,500 for a couple.

The nature of the economic contextual constraint under which the Mincome program operated has been illustrated in the following statement.

> By far the most significant amount of money involved is with the Mincome program. The Federal Government will share only up to $200 per person per month, increasing to $215, effective January 1, 1975, whereas the Mincome guarantee, as of January 1, 1975, is $234.13. Also, the Federal Government will share only in payments to persons with very low asset levels and is not willing to share beyond Social Allowance levels ($160 for a single person) for those aged 60-64 years. The Provincial Government believes that the Federal levels are at present far too low and will continue to press for additional sharing.(1974, p. 12).

The Department stated that "although a guaranteed income through Mincome may be seen as a first and very important step in the direction of improving opportunities for handicapped people, it is recognized that much more must be done if handicapped people are to participate fully in our communities" (1973, p. 47). The concluding statement to this remark illustrated, however, that their response to this apparent need was the implementation of another boundary spanning mechanism. A co-ordination position was created to control input from the environment of the Department. Human Resources went on to say that

> in response to this realization, a Special Consultant to the Minister on the Needs of the Physically Disabled was appointed to co-ordinate efforts and make recommendations.
>
> Further, in order to involve the disabled in identifying needs and required services, a Conference for the Physically Disabled was sponsored by the Department of Human Resources on October 31 and November 1, 1973. Handicapped persons and representatives of various agencies and organizations attended and made recommendations to all levels of governments.
>
> As a result of the conference an advisory committee was formed for the purpose of meeting with Government to follow up implementation of the recommendations that resulted from the conference.

> Recommendations concerned
>
> (1) architectural barriers;
> (2) education, employment, and recreation opportunities;
> (3) income security and health-care benefits;
> (4) personal attendant care (in-home);
> (5) transportation facilities.
>
> These new recommendations point to new directions in 1974.(p. 46)

In the annual report for 1974, it was stated that,

> the Advisory Committee on the Needs of the Physically Handicapped held 22 meetings in 1974 to work on following up and refining recommendations on the needs of the handicapped made earlier to the Minister at a conference held in the fall of 1973...The final recommendations of the Advisory Committee will be made to the Cabinet early in 1975.(p. 81)

Recommendations were not described in the annual report for 1975. This Provincial Advisory Committee resembled the committee that Alberta set up later in 1977 as a mechanism to delay decision-making concerning that province's physically disabled.

The second development that occurred was the introduction of Pharmacare in 1974 for particular groups among which included the physically disabled. Prior to this program, payment for drugs and supplies was made via the Pharmacy section of health care services to holders of B.C. Medical Plan "W" cards issued to unemployable social assistance recipients. The program was introduced to provide free prescription drugs to senior citizens aged 65 and over, as well as to those persons in receipt of financial assistance from Human Resources or those with little or no taxable income. The Department stated that,

> Plan C is designed to provide eligible persons (exclusive of senior citizens) in receipt of financial assistance from the Department of Human Resources

> because of inability to work or, in the case of single parents, those persons who must stay home to care for their young children. The person who is able to work, but who is temporarily in receipt of financial assistance because of employment, is not eligible for these benefits.(1974, p. 111)

The Provincial Government received cost-sharing from the Federal Government for Plan C (Plans A and B for senior citizens and persons without taxable income) were not cost shared.

Within the residual scope of services, costs for handicapped children attending specialized private kindergardens where public kindergardens were not yet available were also subsidized, as well as if they attended group day care. Parents were "eligible for subsidies determined on a sliding scale, based on parents' net income" (1973, p. 20). While funding was made available for these services, their operation was the responsibility of communities. Thus "non-profit societies" were "eligible for grants of up to $20,000 to meet capital costs, and up to $2,500 for equipment. Money" was "extended on a matching basis to the society" which was frequently accomplished "by the community by a land donation or a long-term lease at nominal rental" and "donations by parents of hard work, time, materials, and skills..." (1973, p. 20). This program was subject as well to the selective needs criteria of the Canada Assistance Plan. In 1973, Human Resources stated,

> in order to take full advantage of Federal funding, the focus of the Day-care Programme would have to be changed from that of a preventive social service to a service for families who are already experiencing serious social problems. Low income is not considered a sufficient reason in itself to establish "social need".(p. 21)

In 1974, it was announced that the Federal Government

agreed to share in day care costs to the percentage point of capital costs that equalled the percentage of children on subsidies. Human Resources stated that,

> we are disappointed with this approach. We believe group day care should not develop as a program only for the poor. We would like to see a variety of day care facilities which can be used by all children in the community and which would encourage the participation and enrichment of children of mixed economic backgrounds.(p. 36)

In 1975, a decision was taken to restrict the Incentive Opportunities Program by coding its boundaries with criteria "to limit participation more strictly to instances where job training was leading to a definite job at the end of the six months period on the program" (p. 89). Previously, social assistance recipients had often been able to remain on the Incentive Program for longer than the six months.

The only other positive allocative boundary decision that was made was a decision to expand the use of the Children's Rehabilitation Services program "to serve younger children who" were "physically and(or) mentally handicapped". The Department stated that "this has resulted in the inclusion of significant numbers of children who have been excluded from school and the concomitant socializing experiences" (1975, p. 97). The Department's function was described as being,

> largely a facilitating one in making it possible for these children and young people to continue to participate in an educational experience. In addition, there are very definite steps taken in most of the programs to deal with family difficulties, acquisition of acceptable social skills, and an orientation to the world of work. The Department's involvement in the program is through the provision of child care workers to the 94 programs.

> Close to half of the programs have some kind of work activity component which is similar in its objectives to the Federally funded work activity programs for adults. There is also a very significant life-skills component to most of the programs which includes budgeting, job finding, cooking, and house-keeping, etc. (p. 97).

The programs were actually operated by groups or societies with the exchange of funding provided by the Departments of Education and Human Resources on a regularized basis.

When the Social Credit resumed power in December 1975, the policies programs that had been maintained by the NDP remained the same with the main exceptions being the Mincome Program, the child day care program. In addition, a major structural change occurred within the Department when, with the implementation of the Long Term Care Program, the responsibilities of Human Resources for assisting the elderly and handicapped who were unable to afford long-term residential care were transferred to Health. New programs for employment and infant development were the only new positive allocative boundary decisions that were taken.

In 1976, the Ministry of Human Resources stated that "to assist in the administrative process of determining eligibility for income assistance and associated health care and other benefits, the previous Social Assistance Act and the Guaranteed Minimum Income Assistance Act were all incorporated into a new Guaranteed Available Income for Need Act (GAIN)", and that these "regulations to the new GAIN Act were introduced to comply with requirements of the Canada Assistance Plan" (p. 17). The economic contextual constraint offered by CAP, in addition

to the desire to facilitate administrative simplicity, effected the combination of programs for specific need groups into one general administrative category of need. The Ministry stated that the goal of GAIN for handicapped persons was "to provide the income essential for disabled persons to meet their every-day living requirements and maintain their sense of independence and dignity" (1976, p. 79). Thus the basic goals of this program had not changed, and the Federal Government continued to participate "in the cost of GAIN for handicapped persons in those cases where assets" did "not exceed $1,500 (single) or $2,500 (couple)" (p. 79).

In June 1976 a Special Needs Day Care Program was offered "to enable children with physical, social, and (or emotional) problems to receive assistance through available day care programs in both regular and specialized centres" (p. 33). Applications were also required to meet social need criteria established by the Federal Government for cost sharing purposes. Human Resources stated that,

> where it is possible to document aspects of physical, social, or emotional problem seriously detrimental to the development of the child, a non-profit group day care centre, nursery school, afternoon centre, with an enrolment of 50 per cent or more children requiring very specialized care, may be designated as a specialized pre-school service.
>
> Placement is made on an individual basis, related to the developmental needs of the child.(p. 33).

As of July 1, 1978, special needs children enrolled in integrated centres on a half day basis were fully subsidized. Parents were expected to pay one half of a regular fee for children enrolled for a full day program with Human Resources accepting

responsibility for the additional costs incurred as a result of the special needs of the children. The basic residual nature of these programs remained the same.

In 1976, "to assist income assistance recipients, the handicapped, and other marginally employable persons find work and independence, a province-wide job-finding program was established" (p. 11). The Provincial Rehabilitation and Employment Program (PREP) worked closely with Canada Manpower, employers and Human Resources. This program was underpinned by strong economic criteria identified as follows in 1976.

> In May of this year the Minister of Human Resources announced a major plan to reduce welfare costs and simultaneously assist recipients to gain or regain a useful work place in the work force. Previously there had been a number of more or less successful efforts to achieve similar goals. However, these were largely of a local or regional nature, although Provincial sanction was accorded to some by way of grants or sponsorship.
>
> The scope of the present Provincial Rehabilitation and Employment Program (PREP), as it has become known, is Province-wide. It is the intention that the services of the program shall be brought within reach of everyone in need of them.(p. 56).

Whereas the handicapped were identified as a target group, the following statement indicated that placement of the handicapped was not a priority of the program. Human Resources stated that, "PREP not only seeks to serve the readily employable, but as the staff situation and facilities permit, the severely handicapped, drop-out youths, single parents, and other special needs categories (1976, p. 57). This supposedly new program actually reflected some of the characteristics of the Social Credit's Provincial Alliance of Businessmen program that existed prior to 1972.

Then, an Infant Development Program based on the expectation of future gains was implemented in 1977. Its objective was "to assist families in caring for infants aged 0 to 3 years who are exhibiting developmental delay". Goals were to "optimize the infants' development and to assist their families in responding to their infants in a positive, therapeutic manner" (p. 39). Human Resources stated that,

> a delay in providing the kinds of activities and experiences that the infant needs can result in more pronounced physical development delay which becomes more difficult to remedy in later years. In addition, secondary handicapping conditions, such as speech problems, poor gait, or abnormal behaviour patterns can develop that further hinder the infant's development.(pp. 39,40).

Again these programs were funded by Human Resources in exchange for their operation by local sponsoring societies.

In 1978, the Community Projects Division was implemented whose specific purpose was to "provide integration and coordination of community-based preventive and rehabilitative social services delivered by non-profit societies and volunteers to special needs groups, handicapped adults and senior citizens" (p. 61). With respect to the physically disabled, the Community Grants and Activity (Achievement) Centres Programs were within the Division's purview. The implementation of this boundary spanning mechanism reflected Human Resources's firm intention to displace the rationing of services to the disabled, including the physically disabled, onto the community sector.

Notes to Chapter 9

[1]British Columbia, Department of Human Resources, Annual Report, 1975, pp. 84-86; 1976, pp. 81-83; 1977, pp. 76,78; 1978, pp. 70,71; 1979, pp. 73-75.

[2]Alberta, Department of Health and Social Development, Annual Report for the Fiscal Year Ending March 31, 1974, p. 20; 1975, p. 20; 1977, p. 9.

[3]Idem, 1977, p. 12; 1979, pp. 39,40.

[4]Idem, 1980, p. 6.

[5]British Columbia, Department of Health, Annual Report, 1974, p. 42.

[6]British Columbia, Department of Human Resources, Annual Report, 1973, p. 49; 1977, p. 64; 1978, p. 52; 1979, p. 55.

[7]Idem, 1975, p. 113.

CHAPTER TEN

CONCLUSION

The Theoretical Framework - Understanding the Totality of Policy Making for the Physically Disabled

The search for meanings that underpinned the development of policies for the physically disabled and their interaction with the organizational structuring of departments within which they were located, led to the emergence of four inter-related conceptual categories and their properties - the theoretical framework. While the framework is built upon the evidence of specific facts that emerged as indicators of valuation contexts, boundary decisions, labelling contexts, and contextual constraints, its relevance and utility exists not in those details of policy and organizational arrangements, but in having made explicit those latent bases upon which decision-making for the physically disabled rested in Alberta and British Columbia.

Over the years, a number of authors have decried the limitations and lack of over all comprehensiveness of policies constructed for the disabled and their administration. While the functional and dysfunctional aspects of these policies have received extensive documentation (Dunlop, 1958; Royal Commission on Health Services, Volume 2, 1965; Brown, 1977; and Canada, House of Commons, 1981), the more fundamental question of why

policy development for the physically disabled has not become an issue of priority for either the provincial or the federal levels of government has not been addressed.

Like the categorisation of policies according to artificial boundaries that are inimical to the idea of relatedness between needs of the physically disabled, the descriptive functionally based commentaries noted above have not gone beyond the tradition of analyzing policies as they fall into these arbitrarily defined categories. This study has endeavoured to cut across traditional methods that analyse policies as discrete entities and has examined the policy making process for the physically disabled as a totality.

The theoretical framework was constructed from conceptualizations of empirical phenomena that emerged consistently from the description of events in the annual reports. They are sufficiently generalized that they help to make thirty-five years of policy formulation and reformulation for this group understandable at an adequate level of meaning. Thus while limitations of the analysis may have resulted from not having been able to examine policy content and delivery in detail from the annual reports, the intent of the study has been to provide a paradigm within which detail could be organized and understood according to how:

1) decision-makers structured their perception of reality along certain values;
2) decision-makers' perceptions of reality became organized and interpreted through different labelling contexts that were applied to the physically disabled;

3) valuation and labelling contexts were integrated into criteria for the taking of certain types of boundary decisions and;

4) the determinant of external contextual constraints acted upon provincial decision-makers.

Conceptually, each category is distinct and denotes a particular meaning of the policy process. More importantly, however, all the categories are linked by properties that have an utilitarian or economic rationale as their basis. This singular characteristic is central to the ensuing discussion since it is critical to making appropriate recommendations for future policy making for the physically disabled. Before the implications of this principle are discussed and policy recommendations are made in conjunction with them, a brief summary of the status of policy development for the physically disabled, with respect to change, is required.

Maintenance of the Status Quo - A Characteristic of Policy Development for the Physically Disabled from 1945 to 1980

Recall Smith's (1976) admonition that change must not be confused with simple variation of forms and of structures. Throughout the analysis of the annual reports, as facts emerged and were synthesized into conceptual categories of explanation, it became increasingly clear that progress towards a clearly defined goal for all of the physically disabled (who did not have work related injuries or other forms of compensation for accidents) was not a priority of either British Columbia's or Alberta's government.

Specifically, policies conceived with the intent of rehabilitating the disabled into employment utilized a variety of boundary spanning mechanisms that restricted the availability of these services to those disabled who had the potential for definite job prospects, that displaced the acceptance of responsibility for job placement onto other jurisdictions, both public and private, and that utilized co-ordinative committee structures as buffers between the decision-makers of both provinces and the physically disabled group.

With the structuring of programs of hospital and medical care insurance according to the tenets of universality and accessibility and the development of standard operating procedures for them, the value that health is a right has become indoctrinated into Canadian society. The history of rehabilitation policies and their programs has, in contrast, been marked by a degree of discontinuity as policies gradually lost their visibility only to reappear later under the guise of a new program title and administrative structure. Often the availability of rehabilitation services was dependent upon the existence of community facilities. The existence of the cost-shared Vocational Rehabilitation of Disabled Persons Act was not a guarantee that the needs of the physically disabled would be accorded priority - that decision was left to the provinces.

Similarly, financial maintenance policies for the physically disabled, that also included subsidization towards other health and social services, were formulated first as public assistance, then as specific disabled persons' pensions and allowances, and later as social allowances and guaranteed income

programs. Even through British Columbia's Guaranteed Available Income for Need program for the handicapped, and Alberta's Assured Income for the Severely Handicapped carry with them the suggestion that the establishment of reasonable levels of income security had become a priority, within the amount of financial assets allowed and the monthly income obtained from employment that could be kept before deductions, for 1982 the maximum monthly incomes available are $533.69 (single) for the former and $575.00 (single) for the latter. Revised poverty guidelines for 1982 (Canada, Department of Health and Welfare, National Council of Welfare, 1982) locate an annual income of $8,970.00 (single) to be the low income cut off point based on a population of 500,000 people. Thus, the provision of income security continues to be residual in nature.

While the intent of these financial measures is to provide some baseline for equality of condition, the issue that intrudes into arguments that legitimize these minimum levels of incomes, is that of equity. When monthly income security figures are also examined within the context of the work place where groups within both the public and private sector have claimed catch up wage increases that have been greater than 10% in the past few years, and where average weekly earnings range, for example, from $258.20 in the service sector (based on averaged January to April weekly wages) to $387.88 in the industrial composite sector (based on the month of April) for 1982 (Statistics Canada, 1982), their adequacy must surely be questioned.

The transitory nature of these policies and their ability to be so easily uprooted and replaced by a new program according to federal funding initiatives is indicative of the

unwillingness of both levels of government to enact these policies into more comprehensive and obligatory types of legislation.

While institutional placements were available in both provinces for the physically disabled (in Alberta and British Columbia first through welfare subsidization and then respectively through the Auxilliary Hospital Program and then the Long Term Care Program), commitments toward facilitating the independent living of the disabled in the community were weakened by restrictions placed on the availability of home support services that were not medical in nature. Gradually during the late seventies in both provinces, allocations began to be made for the provision of group homes for the physically disabled as an alternative to institutional placement, although operational responsibility for these homes came within the purview of interested community groups.

Programs directed towards the prevention of further disability in children were accorded higher priority in both provinces, although in many of the examples cited, other needs fail to the community sector to be provided.

Although this information did not emerge from the annual reports, legislation protecting the rights of the disabled is not uniform between the two provinces. In Alberta headway was made with the amendment to the Individual's Right Protection Act proclaimed on August 1, 1980 (Bill 56, 1980). This Act now recognizes the physically disabled as a group whose rights must be protected. The Preamble states that,

whereas it is recognized in Alberta as a fundamental

> principle and as a matter of policy that all persons are equal in dignity, and rights without regard to race, religious beliefs, colour, sex, physical characteristics, age, ancestry or place of origin.

Provision for protection against the denial of any accommodation, service or facilities customarily available to the public was made at that time for the physically disabled. The Human Rights Code of British Columbia (1973) which was consolidated for convenience only in January 1978, does not make any reference to the need for protection against discrimination due to physical characteristics/handicap.

These major deficits in policy development for the physically disabled were recognized in the official Report of the Special Committee on the Disabled and the Handicapped (Canada, House of Commons, 1981). The Committee reviewed over six hundred briefs and listened to over five hundred witnesses during the International Year of Disabled Persons, 1980. In the introduction to their report it was stated that,

> in comparison with efforts being made in other countries, Canada shows poor progress in assisting disabled persons in the areas of employment opportunities, income security, community support services, and technical aids. The Members can find little reason for this situation other than lack of direction and coordination on the part of government, institutional, and community leaders who have the power to make changes. There are no insurmountable obstacles to prevent Canada from taking a world leadership role in providing disabled persons with the practical means for greater independence (p. 6).

In addition to recognizing deficiencies, this quote unwittingly strikes at the very root cause of why the problem of physical disability has not received the kind of priority, over the time period in question, that could be translated into

dollars. It implies the existence of a dangerous complacency towards, or lack of awareness of how, choices concerning resource allocations come to be made in Canadian society, and of the mechanisms that prevent the taking of other policy options. Whereas the recommendations made in the Committee's report were notable and identified Ottawa as the key to the provision of adequate funding, they were based on the assumption that the only obstacles to the lack of definitive policy objectives and their accomplishment for the physically disabled were a lack in direction and coordination between different levels of bureaucratic administration. While this study also identified the exclusive, as well as the inclusive, features of policy-making for the physically disabled, it has gone beyond a descriptive effort to eliciting from the data the existence of obstacles more fundamental and elusive than the lack of coordination between government bodies.

The Obstacles

The Immutability of the Economic Function to Produce and Consume

This analysis demonstrated that reasons for the underdevelopment of policies for the physically disabled, far from being due to the vagaries of political whim or differences in political ideology, are deeply imbedded in utilitarian values. These sustain the operation of an economic system dependent upon the production of goods and services and their consumption for its survival. The entrenchment of this value was alluded to in the analysis of contextual constraints that identified a new trend in

welfare department functioning. Traditionally these departments dealt primarily with the needs of an unemployable indigent population. By the late sixties however, they were more involved in offsetting the effects of unemployment due to inflation, advances in technology, changing mores and in making employment available for those whose joblessness was not due to reasons of disability.

The belief that benefits must ideally exceed or at least equal costs sabotages the very relevance of a humanitarian ideal. As the examples for valuation contexts had shown for British Columbia, although the latter was often juxtaposed with economic values, the bottom line was always fiscal.

The allegiance of both levels of government as well as of different political ideologies within these levels, to the principle of economic rationality is a frightening, if not lamentable, commentary on a society that presumes to organize itself according to democratic principles. The legitimacy and feasibility of departments taking or developing other than residual policies for the physically disabled within their boundaries was dependent upon their ability to meet well-defined economic criteria. This suggests that the philosophical tension maintained between values of equality, justice, liberty, and opportunity that have historically guided the development of the free western world is gradually being eroded away and supplanted by an ever increasing subserviance to an industrialized system. The latter demands increased gross national and provincial products while it also insists that all social costs attributable to special need groups have a dollar value assigned to them.

I am not contending that the maintenance of a high standard of living through the production of goods and services is not commendable, but that when economic growth becomes an end in itself instead of a means to redistribute income to special need groups, such as the physically disabled, who through no fault of their own in most cases are fated to live on subsistence levels of income, how can this be justified? Is this evidence of governments' ability to turn a blind eye to the needs of the physically disabled justifiable at a time when the Canadian standard of living has never been higher?

Although the analysis verified the existence of this economic value, it did not clarify to what extent it was consciously selected by the decision-makers after other conceptualized and rationally argued alternatives had been weighed, or whether the acceptance of this value has been so insidious that decision-makers have taken it on its own grounds without questioning its moral implications.

Part of the service to be provided by the analyst of social provision is to increase the visibility of those values upon which decisions are based, to government officials and public alike who may not be cognizant of their long run implications for society in general. With this in mind, the following general and preliminary policy recommendations have been made:

(1) that decision-makers within federal and provincial levels of government recognize and then reassess the validity of developing policies for the physically disabled according only to the value of economic rationality;
(2) that the problem of physical disability be evaluated on the basis of objective documentations of that population's current status (i.e. income, employment, place of

residence, years of obtainable education) rather than according to generalized perceptions of their status as employable or unemployable.

The entrenchment of this value has been perpetuated by developing different levels of rationing for the physically disabled within the delivery of health and social services according to whether or not economic criteria were met by different policies.

Rationing Service Delivery Within the System

The Canadian economy may rightly be called a mixed economy in which decisions concerning resource allocation are made by both the public and private sectors, and are underpinned by the antagonistic values of economic individualism/independence and collectivism. However within the context of Canadian government, when it comes down to determining who will look after the needs of the physically disabled, the tension that maintains a balance between these values is disrupted so that the former value seems to prevail. While evidence of governmental regulation (albeit indirect) of the free market exists not only in the health and social service areas of hospital and medical care insurance, Family Allowances and the Canada Pension Plan, but as well in resource industry - Petro Canada - and in service industries (for better or worse) such as Canada Post, Canadian Broadcasting Corporation, Canadian National Railways, the opposite trend seems to have taken place with respect to the physically disabled. Both provincial governments have been content to let community (non-profit voluntary) delivered services develop to offset the pull of market forces for this group in areas outside of income

security and health. The private sector in the community has been identified and allocated responsibility by the taking of negative structural selective boundary decisions as the final arbitrator of who shall get what services. As the examples that illustrated this type of boundary decision indicated, while funding was allocated to this sector by the provincial departments, their criteria were often set so broadly that it was ultimately within the discretion of the mandate of the sponsoring community group as to who in particular would be served.

The existence of a double edged sword that differentiates the responsibility for delivery of services to the physically disabled group according to whether or not economic criteria are met, raises fundamental questions concerning government intervention. How can governments justify intervention that is directed towards only those who are creamed off as having the most potential to contribute, while others may not have services available to them or must be left to be picked up by the philanthropic actions of voluntary groups?

Voluntarism - An Opportunity to Demonstrate Philanthropy or a Political Buffer?

The importance of the non-profit voluntary sector's actions in supplementing the availability of a range of services to the physically disabled that would otherwise have been difficult or impossible to obtain through official channels cannot be overlooked. Voluntary agencies are not bounded by departmental guidelines as to whom they must serve and as to what services they must provide (unless they apply for funding that is earmarked for

particular services). This is decided independently by their boards. While these agencies and their members are given the opportunity to meet needs that they perceive will improve the overall welfare of the recipient, there is no inter-coordination between services offered by various groups. By virtue of having a disease-specific clientele some voluntary agencies compartmentalize services offered even more, thereby promoting duplication of programs that have similar basic objectives. The question becomes not so much whether voluntary organizations can provide a better service than one operated by government but whether the proliferation of more and more voluntary based groups (a trend that is not discouraged) which require some sources of funding, effectively services the physically disabled group if accessibility becomes channelled through increasing numbers of selective channels rather than through organizations that are structured along functional lines according to major needs, such as transportation, recreation, income, rehabilitation, and support services to name a few. The costs of maintaining the administrative structures of these organizations must also not be neglected. Although many also receive support through donations from the private purse, would not public money be just as well spent in maintaining the income of those physically disabled who were not being accepted into the employment stream at an adequate rather than at a minimum level? The fact that governments choose to support the existence of voluntary groups suggests that change directed towards enhancing the independence of the physically disabled does not occur at a faster pace because of the contribution that disability makes to the maintenance of service

industries, both public and private. In addition, while the governments expect financial accountability from the voluntary groups that it funds, the former are usually not held accountable for the quality of the service that they are providing indirectly through funding. With respect to these comments it is recommended that:

(1) the mechanism of delivery via voluntarily operated organizations be reviewed by provincial levels of government in order to evaluate where resources are being channelled through organizations that duplicate functions, and whether they could be more effectively offered directly by government or through a different more coordinated structure of voluntary groups;
(2) that government be held more accountable for the quality of service provision that is provided through the purchase of services from voluntary organizations.

Who Shall Live...Well?

While in the United States, Fuchs (1974) has asked the important question of who shall live, with respect to the need to make choices concerning the allocation of resources for health care in a system that has been built upon the free market approach, in Canada the answer to this appears to have been the institutionalization of universal and comprehensive systems of hospital and medical care insurance. Health, for many consumers, has become an immutable right, and this of course includes the physically disabled. However once the latter's health has been established and cared for, what then? How should the question of 'who shall live well' be answered by Canadian governments? In contrast to Canada, some countries have initiated legislation that ensures the provision of more comprehensive levels of service provision and

income supplementation to the physically disabled. Sweden's compulsory health insurance scheme for all residents aged sixteen years and over provides protection against loss of income because of illness, injury or disability and is financed 85 per cent by employers' contributions and 15 percent by State grants (WHO, Regional Office for Europe, Copenhagen, 1981, p. 177). Britain's passage of the Chronically Sick and Disabled Persons Act in 1970 obliged local authorities to discover the number of disabled people living in their areas and to provide them with social services (Central Office of Information for British Information Services, 1975, p. 4).

Canadian politicians and their bureaucrats (at federal, and at the provincial levels analysed in this report) appear to perceive responsibility for the provision of services to the physically disabled in terms of laissez-faire. However while the invisible hand of Adam Smith's classical economic theory allowed demand to meet supply through the mechanism of price, the physically disabled in most cases have not been in a financial position to pay for services required at the supply side price. Thus the governments have accepted responsibility for a minimum level of intervention in policy making either of a residual nature or that was demonstrated to have some potential economic gain, while other aspects of policy making were negotiated into the private sector.

As long as these values and the attitudes that they inculcate exist among senior decision-makers, change directed towards more comprehensive policies for the disabled as recommended in the House of Commons Report (1981) will be

difficult to bring about.

While voluntary groups press for the maintenance of the availability of services for their own specific clientele, their demands are not representative of the needs of the entire population of disabled consumers of service. Advocacy for the needs of the physically disabled that cuts across all jurisidctional lines has gained more impetus from consumer groups of the disabled that were set up across Canada during the seventies. COPOH, the Coalition of Provincial Organizations of the Handicapped, provides its divisions with national leadership. These groups bring forward the views of their constituents to the government in briefs and by lobbying. Since they address the needs of this group as a whole, these consumer groups appear to be the best advocates of change for the physically disabled. With respect to the need for co-ordinated action to be taken on behalf of the physically disabled population, it is recommended that:

(1) consumer groups of the disabled continue to press for change for the physically disabled by increasing the public's awareness of this group's needs and by exposing the value bases of decision-makers that hinder more adequate policy development.

Organizational Design

Armitage (1975) has stated that,

> frequently, in the development of social services there has not been a conscious, conceptualized, and rationally argued choice of service design. Nevertheless the absence of conscious choice does not mean the absence of choice - there may be implicit choice (p. 91).

The analysis demonstrated that choices, whether consciously or unconsciously premeditated not being determined,

were indeed made with respect to the structuring of the organizational sub-units within which policy making for the physically disabled occurred. The various changes in boundary arrangements that were made had the latent consequence of indirectly facilitating a shift in priority from one type of policy to another. The organization of the government departments seemed to have implications for determining the priority that a policy would receive. However, these implications were subsidiary to the effects of values that delineated the boundaries within which policy making occurred and the contextual constraints that put observable limitations on the actions that could be taken.

The organization of the provincial departments for delivery of policies to the physically disabled also contributes to an understanding of how policy making developed. During thirty-five years there was never any continuity maintained between different boundary arrangements nor was there ever delegation of the responsibility for the administration of all services to the physically disabled to one organizational arrangement. While reacting with similar sets of values, over the time period in question, each province accommodated its departmental organizations in different ways to the contextual constraints imposed upon them.

The need for a distinct organizational apparatus for the disabled was recognized however by the Royal Commission on Health Services (Volume 2, 1965). The Commission stated that,

> ... we make it clear that we would like to see all rehabilitation resulting from health defects co-ordinated by one agency without limiting it to certain population groups (such as the employable) or to certain types of health defects (such as either physical or psychiatric). We are equally

> anxious to ensure that the administering agency cover all services--health, welfare, education, employment--which can possibly aid the impaired. This is basically a matter of legislation as well as of the spirit, knowledge and intentions of those called upon to administer it, no matter what department of government they are administratively associated with.
>
> As long as the aforementioned requirements are met, it matters less which department is responsible for co-ordinating rehabilitation services, but in view of existing problems we conclude that the most satisfactory solution would be an independent agency on which the various departmental interests are represented, under a chairman to be appointed because of his personal qualifications rather than his affiliation with a particular department.
>
> Whatever the structure of this agency, it should be responsible for rehabilitation services of all kinds for all types of health problems, including psychiatric disorders and mental retardation. The corresponding organization at the provincial and local level may follow similar patterns, integrated with the organization of health services outlined in this and the previous chapter. (pp. 254,255)

Unlike Sweden who has a separate Health and Welfare Services Department for the Aged, the Handicapped and the Mentally Retarded with separate administrative divisions for each group and Britain where there has been a government minister with special responsibility for disabled people since March 1974, both federal and provincial levels of Canadian government studied here have not seen fit to legitimize the needs of the disabled by developing this kind of structures.

Thus, while the organizational structures of the four departments studied, played a major role in mitigating against comprehensive planning for the physically disabled, it is clear that values, which act through these structures, would have to be changed first.

With respect to the provincial government departments

studied, it is recommended that:

(1) Alberta and British Columbia reconsider the organization of their centrally administered services for the physically disabled in the areas of health and of welfare with the intent of determining a more effective administrative mechanism.

Summary

Throughout this discussion I have argued that the pervasiveness of the economic values of the capitalist system and its institutions have dictated social policy making for the physically disabled. The intent has not been to denigrate the capitalist system but to point out that the value of economic rationality has rather insidiously gained accession over other values that have been traditionally important to mankind. As long as policy making for the physically disabled accepts these values as the final arbitrator of legitimacy and feasibility, this group will be denied the justice of equitable treatment. In order to circumvent this outcome it is recommended:

(1) that the provincial governments (in this case Alberta and British Columbia) must develop and externalise a commitment to the physically disabled that encourages the development of policies to meet their stated needs and whose main bases are not solely economic in nature.

APPENDIX A

Objectives and Functions of Voluntary Organizations Concerned with Physical Disability

In 1966, Govan's report to the Royal Commission on Health Services was a comprehensive examination of the development, support and activity of voluntary health organizations in Canada up to 1962. It included a discussion of their organizational structure as units in relation to each other and other official agencies, their financial position, motivation and their philosophy of voluntary action. The organizations that were examined were defined as non-profit operating under voluntarily organized boards with the primary or major objective being the promotion of health, the prevention of illness or disability, and the discovery, treatment or rehabilitation of persons suffering from disease or disability.

The objectives of twenty-four nationally incorporated organizations, their provincial divisions or affiliates, local units and other local autonomous agencies were analysed according to whether they were citizen member (philanthropic) groups or patient member (mutual aid) groups. Govan stated that,

> the direct services to patients provided by the voluntary health organizations are, generally speaking, those which are not available through other public or voluntary organizations. They must therefore be taken to represent the points in community services in

which citizen-member and patient-member organizations are aware that obtaining service presents difficulties to the patient.(p. 172)

She gave the following examples of activities in which voluntary health organizations were then presently engaged in delivering.

1. The organization of direct services related to medical and health care, which in some parts of the country and even in the same community are also provided by government - rehabilitation centres, bedside nursing, school health services.

2. The organization and provision of services as auxiliary to ones which the government is providing - lodges for out-patients attending hospitals, transportation.

3. The payment of the costs of services for all patients, or for patients on the basis of need, which in some places the government undertakes - schools for the retarded, prosthetic appliances, transportation.

4. The provision of services for groups of patients for whom the government has assumed responsibility, with government paying full cost, or sometimes a grant, for the services provided - services to the war-blinded, to the indigent.

5. The administration of institutions at the request of government, with all, or practically all, costs borne by government - outpost hospitals, sanatoria.

6. Demonstrations of services for which government has not yet assumed responsibility, with the objective that the public will be convinced that government should - Red Cross dental cars, schools for the retarded.

7. The provision of services supplementary to those of government through the provision of money or of volunteer activity - equipment for government hospitals, White Cross activities in mental hospitals.

8. The organization of pressure upon government to provide or improve certain services - Briefs to the Royal Commission on Health Services.

9. Education of the public on health questions which require action on the part of the individual -

nutrition, immunization, mass tuberculosis surveys.

10. Education of the public in attitudes to illness and disability, to provide greater opportunities for the sufferers and to encourage early diagnosis - mental health, epilepsy.

11. Pressure and education of the medical profession to enlist their interest in and increase their knowledge of specific diseases, or to obtain specialized services - arthritis, hemophilia.

12. Provision of bursaries, fellowships and training centres for the increase or improvement in personnel in certain professions - public health nursing, physiotherapy, medical specialties.

13. The development of high standards of professional service through demonstration and training courses - visiting nurses, mental health.

14. The provision of money for and the participation in research both basic and clinical - heart, cancer.(pp. 172,173)

The following were examples of the wide range of medical and related services which the voluntary organizations provided or paid the costs of for their clientele.

1. Provision of specialized diagnostic and treatment clinics, either stationary or travelling and including casefinding surveys

2. Provision of medical specialists for treatment, including surgery

3. Fees for out-patient care in Rehabilitation Centres

4. "Halfway homes" for discharged patients

5. Payment of insurance for medical care

6. Dental care, including orthodontia

7. Transportation to medical centres for diagnosis and treatment by public facilities and ambulances, for patients and their escorts where necessary

8. Local transportation for frequent attendance at clinics, rehabilitation centres or schools for handicapped or seriously ill patients

9. Accommodation for patients and escorts at the medical centre, while receiving service as out-patients, awaiting admission, or, on discharge, pending transportation home

10. Accommodation for relatives in lodges during critical illnesses

11. Blood transfusion service and the Eye Bank

12. Surgical dressings, particularly for cancer

13. Drugs, including pain-killers

14. Milk, cod liver oil, etc., for children

15. Prosthetic appliances of all kinds

16. Equipment needed by the sick or handicapped - wheelchairs, crutches, colostomy bags, hoists, hospital beds, insulin injection and testing equipment, inhalation tents

17. Home nursing - both professional and practical

18. Homemakers, housekeepers, and home helps

19. Physiotherapy and occupational therapy at centre or at home

20. Social work

21. Dietary counselling

22. Speech therapy

23. Construction costs of hospitals and community health centres

24. Nursing stations in remote areas

25. Education and training

26. Vocational assessment

27. Workshops for work adjustment, vocational training and terminal employment

28. Placement in employment, and education of employers

29. Work for the homebound, including sales outlets

30. Housing

31. Residential care for particular groups - the blind, the mentally retarded, the crippled

32. Equipment designed for particular handicapped groups, such as the blind and paraplegic

33. Social adjustment activities, including group activities, day centres, camps

34. Recreation (pp. 173,174)

These lists provide a fairly complete over-all view of the gaps in service delivery to the disabled (including others than the physically disabled) that voluntary health organizations met during the sixties.

By 1980 a plethora of local voluntary non-profit organizations along with the traditional nationally organized groups had sprung up to serve the interests of the physically disabled. For the purposes of this Appendix, however, a sample of the roles and objectives of those voluntary organizations that provide services to the physically disabled has been prepared from directories and annual reports in order to illustrate the range and diversity of services that continue to be provided by the voluntary sector. A more complete review of the extent of the availability of these kinds of services may be found in community directories such as the Directory of Services for Greater Vancouver, the Canadian Rehabilitation Council for the Disabled Resource Manual for Canadian Information Services for the Physically Disabled, and Health and Welfare Directories of Rehabilitation and Related Agencies. The following have been classified according to their orientation as philanthropic (general), citizen-member, patient-member-disease-specific, or as consumer groups of the disabled. Organizations similar to both

Alberta and British Columbia have been selected to provide some comparison of the problems addressed.

Alberta

1. Citizen-member:

Alberta Rehabilitation Council for the Disabled - is comprised of over sixty independent volunteer groups, agencies and service clubs, striving in various aspects of rehabilitation in Alberta. ARCD provides a wide range of personal assistance to physically disabled individuals and their families, as well as economic and consultative support to its affiliates. Serves all ages and disabled groups.(Canadian Rehabilitation Council for the Disabled, 1980, p. 4)

Community Enrichment Program-is designed to bridge the gap between special rehabilitative services directed to those over 18 and the mainstream of adult community life in Edmonton. The program offers one to one counselling, skill development and group lessons in home management, food management and community awareness. Clients range from individuals with very mild disabilities who require only minimal guidance to severely disabled people. Specialized information is available in dealing with special rehabilitative services for adults, utilizing the transitional normalization phase of the rehabilitative process. As this is a program that serves to bridge the gap between institutional living and independence, much of the information available would be on lifeskill rehabilitative techniques. (Ibid, p. 10)

Alberta Lung Association-focusses on the Christmas Seal Campaign, health education such as the Smoking Cessation Program, and other seminars such as asthma workshops for professionals, and parents of asthmatic pre-school children. (Alberta Lung Association, 41st Annual Report, 1979-80)

Rehabilitation Society of Calgary-operates workshops for the physically disabled, as well as social clubs for the young handicapped. (Rehabilitation Society of Calgary for the Handicapped, Annual Report, 1977-78)

2. Patient-member, disease-specific:

Canadian Paraplegic Association, Alberta Division-serves those with spinal cord injuries primarily between the ages of fifteen and sixty-five. Information is readily available concerning problems associated with physical disability. As a consumer group, the association searches actively to answer any request within its mandate of service. (Canadian Rehabilitation Council for the Disabled, 1980, p. 8)

The Alberta Division of the Cerebral Palsy Association-provides information on cerebral palsy, guidance and referral to appropriate resources when necessary. An employment senimar, and a public awareness program have been developed for primary to grade-school levels. The Association serves the cerebral palsied of all ages. (Ibid., p. 9)

3. Consumer Groups of the Disabled:

The Handicapped Housing Society of Alberta's-objectives are that all future housing for handicapped persons maximize their independence, and optimize integration; that all future housing for handicapped persons include the disabled in their planning, design, construction and management. The Society has developed 37 accessible units within a 13-storey, 79 unit apartment building, Sir Douglas Bader Towers. (Ibid., p. 14)

The Alberta Committee of Action Groups of the Disabled-is a provincial alliance of disabled persons and their organizations that is dedicated towards the qualitative improvement in the lifestyles of persons with physical disabilities through legislative and positive policy changes at all levels of government. The Committee has made many presentations on Human Rights coverage and disabled persons, barriers to employment, job adaptations, independent living, vocational integration, the consumer movement in Alberta, Home Adaptation for homeowners and renters, Dependent Adult Act, and attendant care/comprehensive care. Membership into the Alberta Committee is on the basis of having a physical disability and desiring to effect an improvement in the lifestyles of disabled persons through legislative and positive policy changes on a provincial level. (Alberta Committee of Action Groups of the Disabled, 1980, p. 1)

4. Philanthropic (general):

The Victorian Order of Nurses (Edmonton Branch) operate a Home Health Aid program and a Meals-on-Wheels program. (Victorian Order of Nurses, Edmonton Branch, Annual Reports, 1980)

British Columbia

1. Citizen-member:

The British Columbia Lion Society for Crippled Children-provides services to disabled children living in B.C. and the Yukon. There are more than 120 Easter Seal buses travelling throughout the province, three Easter Seal camps, accommodation at Easter Seal House, and direct Patient Care services such as air fares for diagnosis or treatment,

wheelchair or prosthesis purchase, or other monetary help in this field. (Canadian Rehabilitation Council for the Disabled, 1980, p. 23; Canada, Health and Welfare, 1981, p. 217)

The Kinsmen Rehabilitation Foundation of British Columbia-provides the following: patient care, equipment loan program, technical aids program, information services program, the Kinsmen Mother's March. Services also include travel assistance, electronic aids for the severely disabled and communication aids to the non-verbal. Provides services to both children and adults. (Canadian Rehabilitation Council for the Disabled, 1980, p. 39)

The British Columbia Lung Association is active in funding and conducting research, education and community programs concerned with all aspects of respiratory diseases, including asthma, emphysema, chronic bronchitis, pneumonia, lung cancer and tuberculosis. (Greater Vancouver, Information and Referral Service, 1982, p. 46)

2. Patient-member, disease-specific:

The Canadian Paraplegic Association, British Columbia Division-provides mainly a counselling service for those with recent spinal injuries; however the services of this division are available to all disabled individuals. The Association has programs for wheelchair living research, medical treatment facilities, acute spinal cord injury unit, physical re-training, counselling shelter and accommodation, the paraplegic lodge, educational vocational training, sports and recreation, public education re paraplegia, elimination of architectural barriers, community support through the regional consultants program, legislative planning for the physically disabled, and demonstrating the ability of the spinal cord injured in becoming contributing citizens. (Op. cit., p. 29, Canada, Health and Welfare, 1981, p. 220)

The Cerebral Palsy Association of British Columbia-is a parent organization of Cerebral Palsy Associations around British Columbia, providing consultation and information services to these member agencies. It also helps develop new and existing programs, administers a Health Grant to Child Development Centres on behalf of the Ministry of Health and provides direct aid for the purchase of equipment and transportation.

Other services include the publication of a quarterly newsletter and community and staff education. The Association services children, youth, and adults who have cerebral palsy, and other developmental disorders where resources permit (p. 32). (Canadian Council of Rehabilitation for the Disabled, 1980, p. 32)

The B.C. Division of the Multiple Sclerosis Society of Canada-is one of five area offices across Canada. The main aims of the Society are to provide patient services, to increase public awareness of MS and its inherent problems, and to raise money for research. Patient and family counselling, referral and other support services are provided through nurse co-ordinators in the field. The Society services primarily adults with MS. (Greater Vancouver Information and Referral Services, 1982, p. 49)

3. Consumer Groups of the Disabled:

The B.C. Coalition of the Disabled-is an advocacy group of disabled people which represent the interests of disabled people and provides liaison between disabled people and government bodies on issues of concern to disabled people. (Ibid., p. 287)

The Garth Homer Society for the Handicapped in Victoria-offers disabled clients the possibility of a full life in the community in cooperation and union with others. An attempt is made to tailor tasks to fit capabilities and to enrich the life of the individual. The Society will help persons who cannot face the competitive environment of the world, and also those who are about to launch into it. Programs are developed in response to separate needs, wants, hopes, and aspirations in order to help the individual in achieving his optimum level of vocational and personal independence. (Canadian Council of Rehabilitation for Disabled, 1980, p. 35.)

The Lower Mainland Society for Residences for the Physically Handicapped-has a mandate that includes research into problems of the physically handicapped person in relation to housing. It is also involved in the encouragement of housing developments appropriate to the needs of handicapped people, in the most normalized societal environment possible. The objective of the Society is to provide for the housiong needs of the physically disabled. The Society operates one 24-bed residence for the physically disabled. (Ibid., p. 40)

4. Philanthropic (general):

The Canadian Red Cross is an international society working for the improvement of health, prevention of disease and the relief of human suffering. National free blood transfusion service, water safety program, Red Cross Youth in schools, outpost hospitals, disaster service, tracing and reunion of families, free sick room equipment loan service, family health services, veteran's services and serving for international relief. (Greater Vancouver Information and Referral Service, 1982, p. 47)

The Victoria Order of Nurses (VON)-provides a day program for adults with some degree of disability living in the Vancouver-

Richmond area as well as Meals-on-Wheels. (Ibid., p. 345)

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