A COMPARATIVE REVIEW OF THE MEDICAL SERVICES PROGRAMME FOR PUBLIC ASSISTANCE RECIPIENTS IN BRITISH COLUMBIA

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ABSTRACT

This thesis has reviewed the medical care programme for public assistance recipients in British Columbia. It has been concerned with eligibility qualifications, the extent of services provided, and the administration and financing of these services.

As background material, recent developments in social assistance medical care in Canada were summarized. Particular attention was given to an analysis of the Saskatchewan programme, as its philosophy of public assistance is similar to that of British Columbia.

Eligibility for medical services is not a complex subject in British Columbia because it simply extends to all categories of public assistance. The same may be said of the actual provision of services. British Columbia does not have the usual administrative tangles usually surrounding the kinds of services offered because of the fact that it has chosen to provide comprehensive care.

The administration and financing of the programme offers plenty of material for discussion by the student of public administration. It is evident that the provincial role is predominant, as is true of many aspects of provincial-municipal relations in British Columbia. The contribution of the municipalities is largely confined to a share in the financing of the scheme, and this is not large.

The Director of the Medical Services Division carries administrative responsibility for the programme, but the Canadian Medical Association (B.C. Division) through its Social Assistance Medical Service is responsible for remuneration to the individual physician from a pooled fund provided by the provincial government. The administration of public funds by a private body is a much-discussed issue in the extension of public medical care, but it suffices here to state that the plan seems to be working satisfactorily in British Columbia.

Probably the distinctive contribution of the programme is the integration of the physician and the social worker in the planning of the physical and social rehabilitation of the individual. The relatively comprehensive nature of services, both medical and of a social work nature, contribute to the integration.

The extension of medical care is now a lively issue in Canada, and has become a focal point in federal-provincial relations. British Columbia has prepared itself for an inclusive programme through the introduction of hospital insurance, but its pioneering in medical care for the needy may also be of aid in the planning of the larger programme which must inevitably come.

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CHAPTER I

THE PROBLEM OF MEDICAL CARE IN PUBLIC ASSISTANCE PROGRAMMES

The term "public assistance" denotes the various forms of financial aid granted from public funds to those who, for one or more of many reasons, prove they are unable themselves to provide the necessities to maintain life. The purpose of public assistance is two-fold. First, it is provided to meet the immediate needs of people threatened by destitution. Second, it is so administered as to assist them to gain or regain a status of self-dependence. Hence public assistance may be regarded as an attempt to remedy rather than merely relieve the problem of destitution.

Among the chief causes of destitution are ill health and physical incapacitation. Illness, malnutrition, and the lowering of physical stamina may be among the effects of destitution. Obviously the provision of adequate medical care should be an integral part of any public assistance programme.

Medical care for persons receiving public assistance should be the same as that available to anyone in the community at large. This means the provision of curative services which are adequate and appropriate to individual need, which are given at the proper time and carried on for the period required to be effective, and which are administered in accordance with the highest standards of medical knowledge and practice. The objective is the restoration of sick or disabled children, men and women to a state of health which permits them to occupy a useful, satisfying, and when possible self-dependent place in the community. Humanitarian concepts underly this

programme, and are the basis for providing treatment to alleviate pain for those suffering from chronic diseases, and for whom rehabilitation may not be possible.

Besides these curative services, the public health or preventive services provided by government departments play a large part in inducing and maintaining good health. They should include pre-natal and post-natal clinics, school health services, dental care for children; immunization programmes, the control of communicable diseases, sanitation, food and water inspection, consultation on nutrition and public health education.

Health and welfare are inseparable concepts and must be considered so in public assistance programme planning. To be of maximum effectiveness these programmes should be closely coordinated in their administration and financing. Constitutionally health and welfare services are the responsibility of the provinces in Canada and, through provincial legislation relating to municipalities, of the local areas. The federal government has, however, shared the financial burden of most categories of destitution and public health within recent years.

The social security measures introduced in the past twenty years by the Government of Canada provide against destitution caused by unemployment, old age, blindness, physical and mental disabilities and the effect of war services. Remaining as the responsibility of provincial governments are the programmes of financial support and remedial services for those who may become destitute by reason of individual breakdown. Workmen's compensation provides for those who are temporarily rendered unemployable by industrial

accident. Mothers' Allowances provides for dependent women with children. Foster home care is provided under provincial child welfare legislation for children in need of support.

Besides these categorical statutes, some provinces have enacted social assistance legislation of one kind or another to meet the needs of those who do not qualify for any of the above benefits. This legislation usually makes it possible for the provincial government to share the costs with the municipalities. Otherwise, the local area is required to assume the whole cost. Whether costs are shared or not, the municipality usually administers the social assistance programme. At the present time agreements are being worked out by which the federal government will assume a share of the financing of social assistance.

In none of the above social security and public assistance programmes does the federal government share the costs of medical services. Both the preventive and curative health programmes are the responsibility of the provinces and municipalities. However, since 1948, the federal government has made substantial amounts of money available on a matching-grant basis for the purpose of laying the foundation for a nation-wide health service. The grants made have been used to bring hospital, clinical, technical, administrative, research and professional facilities and services up to minimum standards in those provinces with serious deficiencies in their total health planning, and to broaden and strengthen existing services generally.

The federal government is constitutionally responsible for health services to Indians, Eskimos, and to sick mariners. Since the creation of

the Department of Veterans' Affairs in 1944, certain health services are provided for ex-servicemen and women of any war since the Boer War. Previously only veterans who saw action in a theatre of war in World War I were given such treatment. On a shared basis with the province, federal money is available for assistance to indigent immigrants and their families who have been in Canada less than one year and for remedial care to persons in receipt of blind allowances.

Characteristics of Medical Care in Canadian Social Assistance

General problems of medical care in social assistance programmes in Canada have recently been reviewed by Dr. Malcolm G. Taylor.[1] He examined in considerable detail organized programmes in five Canadian provinces to meet the medical care needs of welfare groups.

Dr. Taylor states that Ontario and Nova Scotia offer the limited benefits of physicians in office or home, certain laboratory procedures and emergency drugs. The three comprehensive public medical care programmes are those of the westernmost provinces - Saskatchewan, Alberta and British Columbia. These are the provinces that have established government-sponsored hospital care programmes for the general population. Their all-inclusive schemes are practically identical in range of benefits which include medical, surgical and obstetrical services, in office, home, or hospital; dental care in Alberta and Saskatchewan; all necessary drugs in Saskatchewan and British Columbia; and ancillary services of optometrists, physiotherapists, and private duty nurses.

In each of the five provinces Dr. Taylor describes the beneficiaries

[1] Taylor, Malcom G., "Social Assistance Medical Care Programs in Canada", American Journal of Public Health, Vol. 44, No. 6, pp. 750-759, June, 1954.

as typically the following: (1) recipients of Old Age Security who pass a means test, (2) recipients of Old Age Assistance, (3) recipients of Blind Pensions, (4) recipients of Mothers' Allowances, and (5) recipients of public assistance to unemployables. In Nova Scotia the programme originally (1950) included those in receipt of Old Age Pensions, but in 1952 when the federal government introduced the universal pension for this group, the provincial government withdrew the benefits from it, leaving in the programme only those receiving Mothers' Allowances and Blind Pensions. Mileage payments for physicians' home calls to rural patients has been a consideration in four of the provinces. One of the main reasons for the discontinuance of services to Old Age Security recipients appears to be due to the high mileage accounts associated chiefly with home calls to the aged.

Administrative Agency

Dr. Taylor states that the pattern established in 1935 by the Ontario government for the administration of physicians' services has been followed by other provinces excepting Saskatchewan. The Ontario government entered into a contract with the provincial medical association for the provision of medical care to qualified beneficiaries for a stipulated sum of money, to be administered by the association or its agent. In Alberta the medical association office administers the medical benefits as a side line to its other activities. In Ontario and British Columbia, the associations have set up separate administrative agencies with boards composed solely of representatives of the profession. In Nova Scotia the programme is administered by the physician-sponsored medical care plan.

In Alberta the government entered into a similar contract with the

dental association for the provision and the administration of limited dental benefits, a consistent extension of the principle. If the principle of delegating the administration to the association of the profession providing services were to be extended to its logical conclusion, drug benefits would be administered by the pharmaceutical association, nursing benefits by the nurses association, physiotherapy benefits by the physiotherapists, and so on. The high cost of such repetitive administration would be a colossal one.

In Saskatchewan the attitude is that this is a programme to be administered by the health department as part of its total programme. However, aware of the important role of the profession in its successful administration, it relies for policy guidance and assessment of accounts on a three-member Central Medical Assessment Board nominated by the Association, and appointed and paid by the government.

The practice of permitting a private agency to distribute government funds among its own members without direct government participation in or supervision of administration is a departure from accepted government procedure. Dr. Taylor states he discussed this question in each of the four provinces following this practice, and they maintain the profession can administer the programme better because the association has the power to discipline its members more effectively than a government agency. The associations have added that they administer the programmes inexpensively and their costs have proved this.

The soundness of administration by the medical profession has been further backed by the fact that complaints from the receivers of the service

are practically non-existent. However, it must be remembered that beneficiaries of these programmes are probably the most inarticulate group of the population and, as the services they receive are free they perhaps do not consider they are in the same position to complain as persons who are paying for the services. The professional bodies have apparently merited the confidence governments have placed in them.

In three provinces - Ontario, British Columbia and Nova Scotia - it is the welfare department that negotiates the contract with the medical association; in Alberta, the health department makes these arrangements, and in Saskatchewan, the health department administers the programme. Opinion is therefore fairly evenly divided as to whether administration of the programme is one for health or welfare.

Method of Payment

According to Dr. Taylor, there is uniformity in the payment for physicians' services. Each government agrees to pay a fixed annual per capita sum for all its eligible beneficiaries. Each medical association agrees to accept this amount as payment in full for all accounts submitted in accordance with the official fee schedule. Since this amount is, with one exception (Nova Scotia since 1952), inadequate to pay all accounts at 100 per cent of the fee schedule, prorating is used. Per capita payments have been increased from time to time in keeping with the steady increases in demand for service and increases in fee schedules, which have tended to reduce the percentage payment of physicians fees.

In Alberta this method of negotiating a fixed per capita amount for the payment of an indeterminate number of services is utilized in the

provision of dental care.

Ontario has added the formula of assessing each physician's accounts in accordance with the patterns of practice established by his confreres with due allowance for individual difference. In the programmes of the western provinces in all other professional services - for example, dental services, physiotherapy - payment is made in accordance with professional fee schedules negotiated specifically for these programmes.

Utilization and Costs

Dr. Taylor points out that the recipients of these programmes are characterized by either low income or old age, or both, and since the programmes remove the economic barrier, and do not require a recurring means test, high rates of utilization are to be expected.

With respect to hospital services Dr. Taylor has found that the utilization of these is high. The combination of high admission rates and prolonged stay may be explained by the presence of a fairly adequate supply of hospital beds, a shortage of doctors in rural areas, a probable lack of nursing and boarding home facilities for alternative suitable care.

Pharmaceutical Services

Dr. Taylor's findings indicated that the utilization of drugs in the British Columbia and Saskatchewan programmes follows the pattern of drug programmes everywhere - a persistent increase in the annual number of prescriptions, and a higher increase in drug expenditures.

In 1952 the total per capita costs of all services were given as follows:[1]

Nova Scotia	-	$ 9.96
Ontario	-	10.84
Saskatchewan	-	77.44
Alberta	-	53.76
British Columbia	-	76.89

While medical care programmes are expensive their provision is an acceptance by society that medical services are today another of the basic needs along with food, clothing and shelter. Established medical care programmes for social assistance recipients are of an exceptionally high standard. One criticism may be that they are available too late. If people had such medical resources available earlier, they might not have been obliged to seek public assistance.

While the above presents a general picture of social assistance medical care in Canada, it is appropriate before describing British Columbia's programme to provide a background of information on Saskatchewan. It is a province of somewhat comparable size and social welfare philosphy.

The Saskatchewan Plan[2 & 3]

On January 1, 1945, Saskatchewan inaugurated a tax-supported programme of virtually complete medical services for persons receiving public assistance. To keep administration and expenditures manageable, certain groups - constituting 85 per cent of the total - were defined as provincial

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[1] Taylor, Malcolm G., "Social Assistance Medical Care Programs in Canada", American Journal of Public Health. Vol. 44, No. 6, pp. 758, June, 1954.

[2] Province of Saskatchewan. "Medical Services Division". Public Health Annual Report. Report of the Department of Public Health for the fiscal year April 1, 1953 to March 31, 1954. pp.114-136.

[3] Roemer, Milton I.; Feader, Carman P.; and Acker, Murray S. "Medical Care for the Indigent in Saskatchewan". Presented before the First Canadian Medical Care Conference in Association with the Forty-second Annual Meeting of the Canadian Public Health Association, Quebec City, May 31st to June 2nd, 1954.

responsibilities, with the remainder continuing to secure their health services from local governments. The purpose was to ensure that the aged, the handicapped and others in need would reeeive comprehensive health services on a uniform basis, the programme being but one part of the general welfare programme. In addition, the municipalities of responsibility were relieved of considerable portion of health costs.

The medical care programme is administered by the Medical Services Division under authority of the Health Services Act. Through administrative necessity, the benefits are provided under two sub-programmes. The first provides benefits to persons receiving regular and long-term public assistance in the form of pensions or mothers' allowances. A health service card, issued to the head of the family, entitles the holder and his dependents to health care as required.

The second programme provides benefits mainly to recipients of social aid who are certified by either the department of Social Welfare or Municipal Affairs (Local Improvement District Branch) as being in need of health services. Most of these are short-term cases. Health service cards are issued only when benefits are provided over an extended period.

The two certifying departments determine who will receive pensions, allowances, or social aid. The health department arranges for the provision of essential health services for these beneficiaries and determines the manner in which the services will be provided.

Health Services for Long-Term Beneficiaries (Programme 1)

The beneficiaries of this programme include the following group:

recipients of old age security who qualify for the provincial supplemental allowance on a means test basis, together with their spouses and dependents; recipients of blind persons' allowance, their spouses and dependents; recipients of mothers' allowance including incapacitated husbands and dependents, child welfare cases and certain children assigned to guardians.

The annual report of the Medical Services Division of the Department of Public Health for the fiscal year April 1, 1953 to March 31, 1954 states that since 1945 there has been a gradual, though somewhat irregular, increase in the number of beneficiaries under this programme. The noticeable decline in the last two years appears to be associated with the upward swing in economic conditions and the national universal benefit for those reaching 70 years. There is no doubt, however, that the long time trend in numbers of eligible persons is upward. Excluding local government beneficiaries, both programmes served approximately 4 per cent of the 1953 population of 861,000 in Saskatchewan. Of all persons 65 years and over, 27 per cent were public assistance beneficiaries.

All beneficiaries are eligible for a wide range of services. Medical care includes the services of physicians and surgeons in home, office, or hospital. Comprehensive hospital care includes all benefits of the Hospital Services Plan together with certain additional benefits excluded under this Plan such as out-patient services and extra drugs. In addition, dental services, drugs and appliances, optical services, nursing, physiotherapy, and chiropody may be obtained when required.

Health services are not available outside Saskatchewan except in

emergencies, unless prior approval is granted. Reciprocal agreements exist with the governments of Alberta and British Columbia whereby health services are provided to those pensioners who transferred between provinces on or prior to December 31, 1952. Pensioners moving after that date must establish residence in the province in which they are residing before qualifying for medical services.

Medical and Surgical Services

Under an agreement with the College of Physicians and Surgeons of Saskatchewan, the per capita payment of $15.00 was applicable for fiscal years 1952-1955. As of April 1, 1955 the per capita was increased to $16.50. The physicians' rate of payment for those eligible in Programme 1 in 1953-1954 amounted to 52.61 per cent of the schedule of fees. Transportation costs are paid physicians on a mileage basis for any rural home visits. Saskatchewan reports that with time and experience, there tends to be a gradually increased utilization of physicians' services. A central medical assessment board, nominated by the College of Physicians and Surgeons and appointed by the Minister of Public Health, assisted in the authorization and assessment of medical accounts and functioned as an advisory board concerning the operation and administration of the medical care portion of the programme.

Drug Services

Recipients are responsible for 20 per cent of the cost of most drugs. However, the entire cost of insulin, parenteral liver extract, vitamin B12 concentrate, and appliances are covered. On the recommendation of a physician, the entire cost of drugs is paid where a real hardship is

shown to exist. Drugs represent a major expenditure for the public assistance group. According to the report of the fiscal year April 1, 1953 to March 31, 1954, the average prescription price across Canada was 13.7 per cent higher in 1953 than in 1952 and a similar situation prevailed in the United States.

Dental Services

Recipients are permitted to select the dentist of their choice but are not allowed to change dentists during the course of any one treatment. The regulations are designed to encourage preventive work. Research has shown that this service is under-utilized for the children under the age of 14 years, due possibly to the lack of knowledge and conviction regarding the need for dental care for children, who are not suffering pain; poor distribution and shortage of dentists in the province; and difficulties around travel to areas where dental services are available.

Fillings and extractions present few administrative problems but prosthetic dental service in Saskatchewan as elsewhere, requires certain limitations. Since 1951 the government pays $50.00 towards the cost of all complete upper and lower dentures, leaving the recipient responsible to negotiate the balance with the dentist. Second sets of dentures are provided, if necessary, five years after the first set. Prior approval by the dental director of the Department of Public Health is required for complete dental X-rays, oral surgery, gold inlays, dentures, complete or partial, and denture relines.

Hospital Services

Each beneficiary is entitled to coverage of the Saskatchewan

Hospital Services Plan, which provides hospitalization in any Saskatchewan hospital as long as medically necessary. The Plan simply estimates the funds required to cover the long-term beneficiaries and obtains it from the general revenues of the provincial government. Out-patient services, a portion of emergency hospitalized illness outside the province, and certain drugs excluded from the benefits of the Hospital Services Plan are also provided. The increased out-of-province payment by the Saskatchewan Hospital Services Plan of $7.50 per day beginning in 1954 had the effect of reducing the share of the payments for these beneficiaries paid by the Medical Services Division. In 1953, Saskatchewan Hospital Services Plan expenditures for the group of long-term beneficiaries amounted to $1,817,224.76[1] or approximately $62.58 per capita.

Nursing Services

Special private duty nurses are provided, on the request of the attending physician. Home nursing care through the Victorian Order of Nurses is also financed, when prior approval is obtained. The per capita cost for this service increased from 33 cents in 1952-53 to 48 cents in 1953-54.

Optical Services

Eye glasses are obtained directly on prescription from a physician or an optometrist. Prior approval is required only if a second pair of eye glasses is sought within two years. Saskatchewan reports that the wholesale cost of optical supplies increased during the fiscal year 1953-54, although the refraction fee remained constant.

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1. Based on discharges for the calendar year 1953.

Other Services

Services by physiotherapists in private offices or in hospital out-patient departments are provided, when prescribed by a physician and approved by the Medical Services Division. Chiropody services and appliances for foot ailments are provided directly on application by the patient and without prior authorization. Expenditures for physiotherapy services provided by other than physicians increased from 4 cents per capita in 1952-53 to 6 cents in 1953-54. Per capita expenditures for chiropody increased from 15 to 17 cents.

Health Services for Short-Term Beneficiaries (Programme Two)

The Department of Social Welfare certifies those individuals or groups of persons who are entitled to health services under this programme. In general, they are persons receiving social aid on a short-term basis: single homeless, and transient persons; transient families; Metis; civilian rehabilitation cases; wards; gaol inmates; juvenile delinquents; indigent immigrants and indigent poliomyelitis cases. Persons receiving social aid and medical indigents residing in local improvement districts are certified by the Local Improvement Districts Branch of the Department of Municipal Affairs. Paraplegic cases may receive benefits in regard to special care given at certain centres outside the province by the Department of Veterans' Affairs. Excluding immigrants, medical indigents in local improvement districts and indigent polio cases, there was an average increase of 46 social aid cases in 1953-54 over the previous year.

With certain exceptions, the health services for this group are similar to those provided for long-term beneficiaries (Programme One). They

include medical, dental, hospital, optical and nursing services, drugs, physiotherapy, and chiropody. Indigent immigrants have been provided health services under a separate agreement with the federal government which contributes 50 per cent of the cost. This agreement provides health services for a period of one year for all indigent immigrants who enter Canada with the intention of requiring Canadian domicile. Under a reciprocal agreement with the British Columbia government each province provides health services for wards living in the other province.

Transportation

The Saskatchewan government has operated an Air Ambulance Service for approximately nine years and is giving consideration to expanding this service. Patients with emergency conditions are flown to outside hospitals through the service of the Saskatchewan Government Airways, which makes emergency flights throughout the entire northern area when required. Most patients, however, are brought in and returned on scheduled flights. The northern outpost area is served by a two-way radio service operated by the Department of Natural Resources so that no district is completely isolated as far as communications are concerned.

Administration

The entire programme is administered by a staff of thirty-four persons constituting the Medical Services Division of the Provincial Department of Public Health. All activities are centralized in one office in the provincial capital. The Regional Health Offices established throughout the province for public health services do not at present carry any direct responsibilities in this programme. The Division is composed of a Medical Director

and Assistant Director, a Technical Advisory Section, Eligibility Checking Section, Assessing and Coding Section, Accounting Section, and Office Management Section. The Medical Services Division works closely with the Saskatchewan Department of Social Welfare. Field workers of this Department stationed throughout the province interpret benefits available to the needy persons. In addition, all the long-term and some of the social aid beneficiaries are mailed a descriptive pamphlet on the whole programme.

Municipal Medical Care Programmes

Saskatchewan's municipal medical care programmes, commonly known as municipal doctor plans, play an important role in the rural life of the province. They originated about 40 years ago and, while not as significant as in the early years in the total organization of medical care, they still provide an important measure of protection for about 170,000 persons. The plans are financed and controlled by the municipalities under contract with physician or group of physicians. Their purposes are primarily to attract and hold doctors in rural areas and to ease the burden of medical bills by spreading medical costs over many families and over a period of time.

They are financed through taxation on land or a combination of land and personal taxes. The programmes receive some support through provincial government grants which are made available on an equalization formula designed to provide the maximum amount of aid to the municipalities with the lowest assessment.[1] Receipt of grant aid is contingent upon the

[1] Municipalities operating prepaid medical care programmes and fulfilling the requirements of medical care grant regulations receive a flat grant of 25 cents per capita plus an equalization grant if the per capita land assessment is under $900. The equalization grant ranged from 20 cents per capita per year, where the per capita assessment was $800. to $2. where the assessment fell below $299.

contract between the participating parties being in accordance with a "model contract" designed to protect the interests both of physicians and of the persons paying for and receiving the services. In addition, the health department provides a full time consultative service available to any municipal unit operating or intending to operate a programme.

Not all programmes are "approved". A few operate without health department supervision and, of course, without provincial grant assistance. The department encourages municipalities, in their negotiations with physicians, to enter into agreements which will ensure complete coverage of all residents, a wide range of benefits, an equitable taxation load, and a volume of service fair both to the practitioner and to the beneficiaries. Beneficiaries should expect to have prior claim over private patients to the services of the physicians, and the physician is expected (where health regions have not yet been organized) to undertake a certain amount of public health work.

Issues in Medical Care in the United States

That there is a good deal of similarity in the problems of medical care confronting public assistance agencies in the United States is shown in a recent article by Pearl Bierman in the Social Service Review.[1]

Increase in Medical Requirements and Costs

In discussing this subject Miss Bierman points out that twenty

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[1] Bierman, Pearl. "Medical Assistance Programs". The Social Service Review, June 1954, Volume XXVIII, number two. The University of Chicago Press, Chicago, Illinois, U.S.A.

years ago persons in receipt of public assistance were employable. Today, persons benefiting from such financial aid are likely to be unemployable and to have heavy medical needs. The need for public assistance itself often arises from illness.

Miss Bierman states that information available for one three-year period indicates that about one-fourth of all new aid to dependent children families were in need because of the illness or disability of the father, and that about one-fourth of all Aid to Dependent Children families during one year of this period were in need because of the premature death of the father. At times during this period as many as one-third of the general assistance recipients were destitute because of the illness or disability of the family head.

Large numbers of old age assistance recipients are unable to work because of chronic illness or impairment. By definition all recipients of aid to the blind and aid to the permanently and totally disabled are dependent because of disability. When there is provision to assist for the medically indigent - those who are otherwise self-supporting but cannot meet medical needs - such help is generally limited to the "catastrophic illness" in which costs are high.

According to Miss Bierman, differences in the family unit and in housing have made it necessary for agencies to meet many of the service needs of public assistance recipients. Also, the gradual aging of the population, and changes in standards and advances in practice of medical care have increased costs. A change in philosophy, on the part of both the providers

of medical care and public assistance agencies, has further added to the costs. More and more agencies are expected to pay the usual rates or the full cost of care.

Status of Medical Assistance Programmes in 1953

It is Miss Bierman's opinion that, while much progress has been made with respect to medical care programmes, much more can be achieved. Reports submitted to the American Public Welfare Association in March, 1953, by the forty-eight states, plus District of Columbia, Alaska, Hawaii, Virgin Islands, and Puerto Rico, indicated a wide variation in adequacy and scope.

Sixteen states reported that no state public assistance funds were available for general medical care; two indicated a complete medical programme for public assistance recipients administered and financed by the state departments of public health and fourteen states reported their source of finances to be local funds but only six of these were considered adequate. A number of states reported health departments administering state-wide programmes, which appeared to be the only states permitting all public assistance recipients the means of obtaining the same scope of services.

According to Miss Bierman the lack of state financial participation in medical care does not necessarily mean that localities do not sometimes provide sufficient care. Without the leadership of the state agency, however, local administration of medical assistance programmes may not provide for the same scope of services and for equitable treatment of recipients throughout the state.

Miss Bierman considers that limited and inadequate medical assistance programmes, and lack of provision for the medically indigent, all keep public assistance agencies from accomplishing their major job; that of restoring people to the highest degree of self-sufficiency. Facilities for the medically indigent are generally inadequate and outside the large cities provision for treating them is generally lacking. Miss Bierman stresses the need for full cooperation on utilization of health and welfare services.

State Agency Responsibilities

In this thesis, which reviews the programmes of medical services, the question of State Agency responsibility is of particular interest. In Miss Bierman's opinion local units, in the main, cannot afford the kind of professional health personnel necessary to administer medical assistance programmes properly. State agency consultation and supervision is essential. As the American Public Welfare Association stated in 1939, "the function of the Federal authority should be to assist with financial aid and with the maintenance of standards rather than to administer the service. The state authority should either be responsible for enough assistance to and supervision of local administration to insure sufficient service and good standards, or for administration on a state-wide basis".[1]

The state public assistance agency also should be responsible for guiding the localities in establishing effective and efficient methods and in controlling the cost of medical assistance.

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[1]American Public Welfare Association. "Organization and Administration of Tax-Supported Medical Care" (unpublished policy statement, 1939) p. 5.

CHAPTER 2

DEVELOPMENT OF PUBLIC MEDICAL CARE IN BRITISH COLUMBIA

British Columbia, unlike Nova Scotia and New Brunswick and nearly all the American states, has never had a poor law. However, there has been the equivalent of this in a simple provision of the "Municipal Act" which was one of the first Acts to be passed after the entry of British Columbia into Canadian Confederation in 1871.

This Act set out the areas of jurisdiction over which the municipal governments would have autonomy. One of these was "the relief to the poor". Amended many times since then, the "Municipal Act" has continuously placed the responsibility for health and welfare of the indigent upon the local organized areas. The section referred to in the present Act states that "it shall be the duty of every city and district municipality... to make suitable provision for its poor and destitute".[1]

This duty did not make heavy demands in the early days of municipal history, because requests for aid were small and there was no machinery to see that the municipalities took the legislation seriously. The population was often too sparse to make local organization possible. The province on account of its administrative jurisdiction over unorganized territory, was compelled to assist its own destitute, particularly the aged and the sick, and to provide for burial of indigents. To aid the occasional case that came to the attention of the local representative in the

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[1] R.S.B.C. 1936. Chap. 109, Sec. 501.

in the Provincial Legislature, a Destitute Poor and Sick Fund was set up in the Provincial Treasury in 1880.

The Provincial Home at Kamloops which offers institutional care to older men was opened in 1893. The Marpole Infirmary (formerly known as Home for Incurables) was established in 1922. Grants to resident physicians in outlying districts, to compensate them in some measure for service to the poor and to encourage them to remain in remote communities, began before 1886.

The municipal costs of destitution grew due to population increase and change of social and economic conditions. Not until the onset of the depression of the 1930's did the problem become a grave one to the municipalities and the provincial government. At this time an Unemployment Relief Branch under the Provincial Department of Labour was created. It was charged with the duty of administering successive Federal Acts passed to relieve the distress of the thousands of unemployed.

It created policies and regulations to provide needed relief on an impartial basis according to funds at its disposal. It attempted to bring a measure of uniformity in municipal practice, and extended assistance to the local governments through a sharing of costs. Through cooperation of the federal government, and other provincial departments, work projects were instigated. It maintained a staff of investigators who served throughout the province, and insofar as numbers would allow, made an attempt to include positive rehabilitation services.

With the depression, families and individuals moved their place of residence. These movements created problems which resulted in the passing in 1935 of the "Residence and Responsibility Act". This Act stated legal residence could be established in a local area after one year's continuous residence on a self-supporting basis, or three years' residence if in receipt of relief. Thus the responsible area was now obligated to pay the cost of relief given until the recipient had established residence elsewhere.

With this programme for financial assistance, many municipalities were forced into bankruptcy and the treasuries of both provincial and municipal governments were depleted. Although it had no direct responsibility to do so, the federal government was forced to enter the situation with a grant-in-aid programme to the province.

In 1935, all existing social welfare administration was placed under a Director of Social Welfare, within the Provincial Secretary's Department. Under this new administration, the field service was expanded in the rural parts of the province and social workers were assigned to various areas. This staff gave a generalized service which included mothers' pension, the destitute, poor and sick relief, child welfare, tuberculosis control, mental hospital, and industrial schools services, and took care of inquiries from collector of institutional revenue and other agencies. Because of problems created by long stay patients in acute general hospitals, hospital clearance was instituted in January, 1938.

In 1941 the provincial government assumed 80 per cent of the cost

of direct relief to unemployable persons residing in organized areas, paying 100 per cent of this cost in the large unorganized territory of the province. The policy established toward the end of the depression of granting such financial aid on a basis of need yet within a set maximum scale was continued. Individual consideration was given to individual situations, with the focus of rehabilitation.

In October, 1942 was seen the beginning of amalgamation of the separately administered services. To begin with, the Unemployment Relief Branch, the Mothers' Allowance administration, and the Child Welfare Branch were brought together under the Department of the Provincial Secretary. The new office was named the Social Assistance Branch. The field staff of the Unemployment Relief Branch and of the Welfare Field Service were brought under it. The chief executive of the Branch was given the title of Assistant Deputy Provincial Secretary.

Early History of Medical Care[1]

The Unemployment Relief Branch appointed a medical doctor in the early 1930's to give partial service to the work project camps. This consisted of supervising the medical care in the camps given by the local doctors in the area where the camps were situated. These doctors were paid a small monthly retaining fee of $50.00 to $75.00 a month.

This was a categorical service designed to be a precautionary measure to guard against epidemics in the camps. No service was given to the municipalities or to the public generally. A treatment clinic for

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[1] Interview with Mr. E.W. Griffith, former Deputy Minister of Welfare for British Columbia, July, 1955.

single men, mainly transients, was established in Vancouver and the chief function of the Branch doctor became supervision of this Clinic.

About this time, the provincial government decided to pay for medical services in unorganized territory on a tax fee basis ($1.00 a visit). From 1934-1936 the government contributed to the municipal medical care on the basis of 25 cents per capita of the relief population monthly and the municipality had to put up the equivalent amount. Some municipalities did not take advantage of this arrangement because they had difficulties in reaching agreements with the local doctors. During the depression years, the efforts of the general administration were steered toward finance; that is, of obtaining money to maintain the men in work camps. In the peak period of the depression there were 11,000 in about 200 road camps. At the same time there were also 133,000 in receipt of financial aid and this would be about 20 per cent of the population. There was always consciousness of the need for medical services and this was born out by provision of medical services for the indigent whenever finances were available. In the 1930's those in receipt of financial aid were in normal health, but due to the work situation were unable to provide for themselves. Therefore, a health problem was not a pressing one.

The difficulties encountered in negotiating any type of medical care programme with some municipalities stemmed mainly from the interpretation placed on the "Municipal Act" dealing with the provision for medical care. Many municipalities contended that provision for the poor and destitute

covered food, clothing, shelter but not medical services. The Administrator who later became Deputy Minister of Welfare contended that suitable provision for the care of these people should cover all the needs of the individual including hospital and medical care. Grants were not made to hospitals refusing to care for patients who were indigent. The Attorney General's Department supported the interpretation of the Clause in the Municipal Act that medical services were to be provided.

Until the Medical Services Branch of the Provincial Secretary's Department was organized in 1935, the provision of medical relief continued to be a municipal responsibility. When the Branch was first organized, it was contemplated that responsibility for medical services for the indigent would be assumed completely by the Provincial Secretary's Department, but in practice this did not take place, and funds for the Medical Services Branch were provided by the Unemployment Relief Branch of the Department of Labour. In effect, therefore, the Medical Services Branch was simply one section of the Unemployment Relief Branch.

This Branch arranged medical services (general practitioner service, necessary drugs and a few extras) for recipients of unemployment relief in unorganized territory and made grants (essentially on a 50-50 basis) to municipalities which desired to provide organized services (general practitioner and drugs) to those on unemployment relief within their boundaries. The first medical director was appointed in December 1934. By 1935 agreements were in effect with most of the municipalities including all the larger

ones. The municipalities in turn made their own arrangements for remuneration of physicians, agreements with the medical profession for lump sum payments being most common.

In Vancouver, a full time doctor, nurses, and a nutritionist were members of the City relief staff. A plan to provide maternity services for unemployed families was started in August, 1933, with wider provision, including all basic medical services, following in January, 1934. The general principle was accepted of a monthly grant to the local medical association which was disbursed pro rata to the doctors submitting accounts. Fifty per cent of the total grant ($5,000.00 a month) was paid by the City, the remainder by the Province.

The contract with the Vancouver Medical Association provided for both general practitioner and specialist service. All essential operations were covered, and hospital charges were met jointly by City and Province. Dental treatment was limited to extractions and glasses were supplied free if recommended on grounds of health. While the relief office had a standard pharmacopeia, it arranged directly for the supply of medicines and met this particular cost as a 100 per cent city charge. The fees of a doctor and nurse at agreed standard rates were paid for home confinements, while one inclusive charge was made for hospital confinements.

Recent Administration of Medical Care

In 1940 the situation regarding medical services and drugs was as follows: The provincial government paid for medical services to social allowance

cases in provincial areas on a tax fee basis. It should be noted that medical services were granted only to the Social Allowance Group and not to Old Age Pensioners or Mothers' Allowance cases. It can be said, however, that limited services were extended to Old Age Pension and Mothers' Allowance cases where extreme urgency was shown. Drugs were supplied free and the Government was granted a 10 per cent discount by druggists. Hospitalization was available and the Government paid to the hospital a specified daily rate in addition to the daily per capita grant.

The granting of medical services and drugs to municipal social allowance cases was entirely the responsibility of the municipality. Here again no ancillary service was granted to Old Age Pensioners or Mothers' Allowance cases except under extreme conditions of urgency.

In the fall of 1940 the city of Vancouver concluded an arrangement with the Vancouver Medical Association on the following basis. The City was to pay a per capita rate to the Medical Association, viz;

TABLE I

1940 SCHEDULE OF PAYMENTS
BY THE CITY OF VANCOUVER TO THE VANCOUVER MEDICAL ASSOCIATION

No. of Persons in Receipt of Allowance	Payment per Month to Vancouver Medical Assoc.
20,000 and over	.30
17,500 to 20,000	.31
15,000 to 17,500	.32
15,000 and less	.33

Source: Departmental Comptroller, Department Health and Welfare, Victoria.

This was the first agreement based on a per capita payment established by a municipality and a Medical Association for the provision of medical services to Social Allowance cases.

Effective November 1st, 1942, a new agreement relating to medical services for Social Allowance cases only was drawn up between the city of Vancouver, the Vancouver Medical Association and the Province. The Province agreed to pay 50 per cent of the cost. The following is the schedule of payments:

TABLE 2

1942 SCHEDULE OF PAYMENTS
BY THE CITY OF VANCOUVER TO THE VANCOUVER MEDICAL ASSOCIATION

No. of Persons in Receipt of Allowance	Payment per Month to Vancouver Medical Assoc.
12,500 to 15,000	.34
10,000 to 12,500	.35
7,500 to 10,000	.36
5,000 to 7,500	.37
2,500 to 5,000	.38
2,500 and under	.39

Source: Departmental Comptroller, Department of Health and Welfare, Victoria.

In addition to the above payments it was also agreed that where the number covered by the agreement was 10,000 or less the per capita payment would be supplemented by a flat $100.00 per month.

In a circular letter dated January 21st, 1943 the Provincial Government offered to share with any municipality on a 50-50 basis the cost of medical services up to a maximum of 33 cents per person per month. A municipality could make arrangements with the local medical association to this effect. The agreement was to include recipients of Social Allowance, Old Age Pension and Mothers' Allowance. The provincial government would also pay 50 per cent of the cost of drugs to these cases. The agreement, however, did not cover optical or dental services which were a 100 per cent municipal charge. The same service was extended to all social assistance cases in unorganized territory where the provincial government was 100 per cent responsible for the cost.

For some years the Unemployment Relief Branch had supplied medical services to destitute persons from unorganized territory and, when it was necessary for them to be hospitalized, the Medical Services Branch had paid a specified daily rate varying from $1.00 to $2.00, to the hospitals in addition to the daily per capita statutory grant. On March 31st, 1953 such additional payments were terminated.

In March, 1943 the government decided to increase the maximum per capita rate previously set at 33 cents to 40 cents; thus a municipality could enter into an agreement with a medical association offering a maximum per capita payment of 40 cents. Payments for medical services in unorganized territory were still on a tax fee basis and drugs were free to social assistance recipients, the government receiving a 10 per cent discount from

druggists. The medical services offered to both organized and unorganized cases included operations and specialists services. About the same time it was further agreed by the provincial government, that because of the small number of cases in municipalities with a population of 1,000 or less, these cases would be regarded as being in unorganized territory for the purpose of granting medical services and drugs.

In September, 1944, services were arranged whereby a recipient of social assistance who, although a municipal responsibility, was residing in unorganized territory would receive medical services from the Provincial Government. However, if the municipality responsible for the case was one which had accepted the general medical and drug scheme the municipality would be billed for 50 per cent of the cost. If the municipality was one which had not accepted the scheme the municipality would be billed 100 per cent of cost. At this time the city of Vancouver provided a certain limited dental and optical service. Regulations pertaining to medical services and drugs were extended to provide these services to a spouse of an Old Age Pensioner, Blind Pensioner or Social Assistance recipient.

On April 1st, 1947 the province agreed to share costs on a 80-20 basis with municipalities, making the necessary arrangements with local physicians for the provision of medical services. The province would also share on an 80-20 basis the cost of prescribed drugs, based on the B.C. Formulary. At the same time the Social Welfare Branch agreed to pay $3.00 per day to any hospital receiving statutory grants under the Hospital Act

in respect of every genuine in-patient who was in receipt of social assistance.

An administrative review of the medical programme by the Director of Medical Services Division in July, 1947 indicated the necessity for a uniform scheme of medical care. The services being rendered throughout the municipalities showed alarming variations. Emergency medical care was being given payment or no payment. Lack of uniformity led to considerable inconvenience and embarrassment and perhaps emotional disturbance on the part of the client, and financial embarrassment to those rendering the service. There was no provision for remedial work and no means for an individual to obtain service outside his local area. In unorganized areas coverage was given by the doctors on a fee for service basis. In organized areas there were almost as many schemes as there were municipalities. As an example of the discrepancies which existed it was noted that the per capita rate varied from 40 cents to 66 cents.

As a result of this review, the problem of medical care received much attention and the ensuing negotiations culminated in the agreement of March 1st, 1949 with the medical professional. This provided complete medical, surgical and obstetrical care to all clients regardless of their place of residency. This subject will be expanded in Chapter 4.

In the interim, January 1st, 1949 with the introduction of the Hospital Insurance Service all social assistance cases were covered for hospitalization premiums, being paid 100 per cent by the provincial government.

On January 1st, 1950 Drug and Optical services came under the equalization plan as Medical Services. Glasses were supplied to recipients of social assistance at no cost to them individually. However, in the case of breakage, or loss, the patient would be expected to replace them if it could be done without too great a financial burden.

The provision of dental services remain under the supervision of the municipalities although maximum rates of payment are set by the Medical Services Division.

On April 1st, 1952 hospitalization of Social Assistance cases was charged at cost by the Hospital Insurance Service, whereas previously premiums were paid by the Welfare Branch.

CHAPTER 3

ELIGIBILITY AND SERVICES IN MEDICAL CARE IN BRITISH COLUMBIA

Eligibility.

Eligibility for medical care in public assistance in British Columbia has a good deal of simplicity about it. In the main, all people in receipt of public assistance and their dependents are eligible. Specifically, care is provided for recipients of Old Age Security who qualify for the bonus provided by British Columbia on a means' test basis, recipients of Old Age Assistance, Social Allowance to unemployables, Mothers' Allowance, Blind Persons' Allowance, and Disabled Persons' Allowance who qualify for the provincial bonus. In all the above categories dependents who are the sole responsibility of the head of the family also receive full medical coverage. All these beneficiaries receive a "Medical Identity Card", issued to the head of the family and on which dependents and those entitled to medical services are indicated. In addition, services are given to the children in the care of the Superintendent of Child Welfare. Those who receive temporary financial assistance from time to time are not granted coverage for medical services.

Persons in low income groups are not eligible for medical services as provided by the Department of Health and Welfare. However, some hospitals have out-patients departments for the medically indigent, the Vancouver General Hospital providing particularly comprehensive service.

Referrals are made by doctors or social workers.

Table 3 indicates the relative numbers in each of the eligible categories and their percentage to the whole.

TABLE 3

CATEGORICAL DISTRIBUTION OF RECIPIENTS OF MEDICAL SERVICES AS OF MAY 1, 1955

No.	Recipient	Number	Present
1.	Recipients of Old Age Security, who qualify for bonus	36,417	52.7
2.	Recipients of Old Age Assistance	8,621	12.5
3.	Recipients of Blind Persons' Allowance	591	.9
4.	Recipients of Mothers' Allowance	1,338	1.9
5.	Recipients of social allowance to unemployables	18,792	27.2
6.	Recipients of Disabled Persons' Allowance	127	.2
7.	Child Welfare Responsibilities	3,167	4.6
	Total	69,053	(100.0%)

Source: Departmental Comptroller, Department of Health and Welfare, Victoria.

The total number of public assistance recipients as of May 1st, 1955 totalled 69,053, or approximately 5 per cent of the 1954 population of 1,266,000. (Figures for British Columbia issued by the Bureau of Statistics.) It will be noted that a large proportion of the recipients, 66.1 per cent are in the age group of 65 and over.

Many administrative problems associated with public assistance are related to a mass of regulations and rules both for eligibility and services provided. The virtue of the British Columbia scheme is that it minimizes these problems in its relatively simple rules for eligibility and its inclusive programme of medical care.

Services

Medical and Surgical

An agreement reached by the Canadian Medical Association (B.C. Division), the Union of B.C. Municipalities and the Government of British Columbia has made available to every recipient of public assistance complete medical, surgical and obstetrical care in home, hospital and doctor's office. The administration and financing of this agreement will be explained in some detail in Chapter 4.

There is free choice of doctors, including specialists. Consultations in a centre where specialists are available can be arranged by the attending doctor, either by communicating directly with the desired specialist or by contacting the local social worker. In the latter case the worker forwards the request, together with a social summary, to the Medical Services Division. The Medical Director reviews the problem in its entirety and discusses it with the appropriate specialist. When arrangements are completed the Division contacts the social worker giving instructions regarding the time and place of the appointment and authorizing return transportation if required.

The services of the physicians are the foundation of medical benefits. According to recent statistics, there are 1,368 doctors in private medical practice in British Columbia, which means that there is one doctor for every 925 persons. The average reported for Canada is one for every 970 people, so British Columbians in general are slightly more fortunate in this respect than the rest of Canada, although there figures do not reflect the distribution of doctors throughout the Province.

Pharmaceutical

Drugs and medicines are provided on prescription without cost to the client. The second edition (1953) of the B.C. Formulary, is the guide to be used in prescribing. It contains a comprehensive list of allowable drugs. The commonly prescribed drugs are supplied through the local druggist. New and unproven drugs may be obtained by the prescribing physician for his patient by obtaining the authorization of the special committee appointed by the Canadian Medical Association (B.C. Division) in 1954. Requests for such drugs are made through the Medical Director of the Division who refers them to the committee.

Transportation

Transportation is provided for clients in need of surgery, special treatment or consultation. Services are arranged at the closest centre at which they are available. The type of transportation most suited to the client's condition is utilized, whether it be by train, bus, aeroplane, taxi, private car, ambulance or boat. An escort is provided if medically indicated. The Medical Director's authority is required if transportation

costs are in excess of a certain specified minimum.

Dental

The dental services which are supplied include extractions, dentures and prophylaxis. These services may be obtained from any qualified dentist who is willing to provide them at allowable rates. Authority for the provision of dentures may be granted by a district supervisor of the Social Welfare Branch when the recipient, or dependent, has been without teeth for four months or less, or when they are to replace dentures which are no longer serviceable.

When dentures are required for a recipient, or dependent, who has been without teeth for more than four months, the request for dentures must be forwarded to the Director of Medical Services Division through the Regional Administrator, and must be accompanied by a complete medical certificate outlining the medical reasons for the request and an estimate by the dentist. Requests for prophylactic dentistry, fillings and partial plates are submitted to the Director of Medical Services through the Regional Administrator.

All cases are dealt with on an individual basis and full information including an itemized estimate from the local dentist accompany all such requests. An arrangement with the B.C. Dental Association provides dental treatment for dependents of less than eleven years of age of persons in receipt of public assistance. Dental services for children in care of the Superintendent of Child Welfare are arranged locally.

Optical

Eye examinations for recipients of public assistance and their dependents can be obtained from an eye specialist or an optometrist according to the doctor's instructions. Optical services not covered under the terms of the agreement with the Canadian Medical Association (B.C. Division); namely, optometric services and glasses, may be authorized by the local welfare office provided the client has not received similar services for a period of two years.

Ancillary

Appliances such as artificial limbs, trusses and elastic stockings may be authorized by a district supervisor on a physician's prescription unless the cost exceeds a specified minimum. More expensive appliances may be provided on the authority of the Director of Medical Services.

Hospitalization

Hospital benefits are available to all persons who have resided one year in the Province and include all services provided by acute general hospitals on the public ward level. Recipients of public assistance are not expected to pay co-insurance charges.

British Columbia has seven hospital beds per thousand population, including beds for treatment of acute or chronic illness. In 1953 the total beds in public and private hospitals across Canada provided five beds per thousand population.[1]

The services of out patient departments are available to the recipient of public assistance and great use is made of the various clinics

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[1] British Columbia Hospital Insurance Service. Does not include available beds in Mental, Tuberculosis or Federal Institutions such as D.V.A., Department of National Defence or Indian Health Services and does not indicate distribution throughout the Province.

of the Vancouver General Hospital's Out-Patients Department in providing medical care for recipients from all parts of the province.

Miscellaneous

Treatments by physiotherapists are approved only when prescribed by a physician to relieve an acute condition. Services of special private duty nurses, chiropractors and chiropodists are not provided by the Department.

All services are expected to be obtained within the Province of British Columbia. However, the Social Assistance Medical Service has a reciprocal agreement with the Province of Alberta. This permits use of facilities in that Province when they are more readily available than those in British Columbia.

Because of the increasing use of specialized resources in Vancouver, such as the Western Society for Rehabilitation, the Canadian Arthritis and Rheumatism Society, the Health Centre for Children, and the British Columbia Cancer Institute. it is imperative that the Social Welfare Branch has adequate personnel to see that the multiplicity of services are made available to the people who require them. The ideal is to have professional workers who have had sound basic training.

The only programme utilized where a comprehensive rehabilitation service is offered is at the Western Society for Rehabilitation where the Branch sponsors a limited number of arthritics, paraplegics and other orthopedically disabled. Many of those persons sponsored are success stories as illustrated by:

Mr. A- - - R- - -, a single man born in March, 1929 was driving a truck in September, 1950. It overturned, fracturing and dislocating his back at the eleventh and twelfth vertebrae. His injury resulted in paralysis of the lower part of his body. He was admitted to the Vancouver General Hospital on September 4th, 1950. He received considerable treatment there until April 26th, 1951 when he was admitted to the Western Society for Rehabilitation under the sponsorship of the Social Welfare Branch.

Prior to Mr. R- - -'s accident, he had completed Grade 10 and during his stay at the Centre, he was tested through the Youth Counselling Service which indicated a fair amount of interest and ability in office work, and suggested that the best possibility for his future was in this line of endeavour. While at the Centre he undertook a correspondence course in accounting which he completed in June, 1952 with fairly high marks. In the meantime he continued to improve, and was supplied with a wheelchair and full length paraplegic braces.

He was discharged from the Centre December 6th, 1951, but continued as an out-patient for a time. He tried several jobs after leaving the Rehabilitation Centre, one as a radio dispatcher with a taxi company, another pay roll work with a cartage company, but neither of these worked out. In January, 1954 he was placed on the Social Welfare Branch staff on a temporary basis as checker in the Provincial Pharmacy. He has proven to be a satisfactory employee and is now on the permanent staff.

Another illustration is Mr. D- - - - of Osoyoos, a single man aged 67 who had been receiving treatment for rheumatoid arthritis at the Oliver

Hospital. He was transferred to Vancouver General Hospital in July, 1953 for screening prior to transfer to the Provincial Infirmary. On July 30th, 1953 he was seen in consultation at the Vancouver General Hospital by the Medical Director of the Canadian Arthritis and Rheumatism Society, who stated, "I think there is a very reasonable hope that this man will respond to active measures and thereby avoid long-term institutional care. In fact he may be able to return to his original employment as a janitor in a hotel. For this reason we are requesting authority to admit him to the Rehabilitation Centre for a period of two months following hospital care".

During the five weeks Mr. D- - - - was in the Vancouver General Hospital he was treated with rest, physiotherapy and drugs with an excellent response. He became a resident trainee in the Western Society for Rehabilitation on August 27th, 1953, his maintenance being paid by the Social Welfare Branch. At the time of transfer all signs of rheumatoid arthritis had subsided and the effusions had cleared from his knees. They both had full range of movement, and his left hip was again normal. He was walking normally and required no analgesics.

The Centre's pre-discharge medical report dated October 16th stated: "On admission to the Centre his only disability was a subsiding shoulder-hand syndrome on the right. The right shoulder had a range of movement approximately 50 per cent of normal with pain (i.e. it was still partially frozen). The right elbow had a slight flexion deformity and his right hand was diffusely swollen. He was unable to make a full fist on the right. Neck movements were slightly restricted. During his stay here he has been treated with rest, physiotherapy and cortisone and improvement

has continued. His shoulder is less painful and its range of movement has increased considerably. The swelling of his hand is subsiding and while he still cannot make a full fist it is stronger. It is felt that with continued use, his shoulder-hand syndrome will subside completely over the next six months or so. It does not constitute a very great disability at present. His general health otherwise is good for a 68 year old. Certainly he does not now appear to be a candidate for the Marpole Infirmary. I feel that if he could be provided with assistance for a few months he could look after himself at home."

The medical social worker of the Canadian Arthritis and Rheumatism Society stated that Mr. D- - - - cooperated fully in the treatment programme and made excellent use of the available arts and crafts facilities. Before Mr. D- - - - left the Centre he was able to walk forty blocks without fatigue or other effects. The Social Welfare Branch in the area was notified of his return in order that they might help in work plans and ensure financial assistance if necessary.

This case is the story of an amazing transition of an almost completely helpless individual in May, 1953 to a physical and mental state of a normal individual in his 60's by the end of October that year. He was discharged October 27th, 1953 and returned to Osoyoos. At that time he was willing and able to accept a job as caretaker of the local community hall. A residue of Rheumatoid Arthritis in his right shoulder and hand, which had greatly subsided, was all that was left to remind him of his former extremely helpless and apparently hopeless condition.

Mr. D- - - - had been in receipt of Social Assistance intermittently since March, 1947 previous to his treatment. The Canadian Arthritis and Rheumatism Society has advised us that Mr. D- - - - is at present self-supporting.

Mr. D- - - -'s remarkable response to treatment has fully justified the efforts of the Department to assist in the efforts of rehabilitation of a selected number of patients in the Rehabilitation Centre. Had this opportunity not been available, Mr. D- - - - would probably have been in the Marpole Infirmary and supported by public funds. As it is, it seems more than likely he will be able to do productive work for another two or three years at least. It is expected too, that he will be able to improve his farm sufficiently to enable him to live in relative comfort when he retires.

CHAPTER 4

ADMINISTRATION AND FINANCING OF MEDICAL SERVICES

Organization of Social Welfare Branch

Before dealing with the administration and financing of medical services, it is advisable to outline the organization of public welfare in the province.

The General Administration, headed by the Deputy Minister of Welfare responsible to the Minister of Health and Welfare, has jurisdiction over the operation and promotion of all social welfare services set up by the provincial government. The Deputy Minister delegates authority to the Director of Welfare and the Assistant Director of Welfare to assist him with the detail involved in this unified administration.

Within the Social Welfare Branch the separate statutes that make up the Province's social legislation are administered by separate specialized divisions responsible through the General Administration to the Deputy Minister. These Divisions are as follows: See Appendix A.

The Family Division is the office administering the Social Assistance and Mothers' Allowance Acts. The Old Age Assistance Board administers the Old Age Security Act, Old Age Assistance Act, Blind Persons' Allowance Act and Disabled Persons' Allowance Act. The Medical Services Division administers medical services. The Child Welfare Division administers the Protection of Children Act, Adoption Act, and Children of Unmarried Parents Act. In addition, this Division is responsible for the

development and direction of the placement of children becoming wards of the government in foster homes. The Girls' Industrial School provides for treatment to girls committed, principally under the Juvenile Delinquents Act. Brannan Lake School for Boys provides treatment to boys committed under the Juvenile Delinquents Act. The Provincial Home located at Kamloops offers institutional care for older men.

The Welfare Institutions' Licensing Board administers the Act which protects through, licensing and inspection, boarding homes, camps, nurseries and kindergartens. The Training Division is responsible for staff development and training of in-service personnel. Tuberculosis and venereal disease services provide case work services within the Health Branch and the social workers are in the employ of the Social Welfare Branch. Psychiatric Social Services provide case work services on behalf of patients at the Provincial Mental Hospital, Crease Clinic, Woodlands School and Child Guidance Clinics. These various establishments are under the jurisdiction of the Provincial Secretary's Department, but the social workers are in the employ of the Social Welfare Branch.

The Field Service Staff is the operational arm of the service, and is located in district offices in every part of the Province, bringing the benefits of the Social Statutes and various programmes directly to the people in need of them. For administration purposes the Province is divided into six regions each headed by a regional administrator whose duty it is to administer the policies of the Branch in his particular region as formulated by the General Administration in Victoria. See Appendix B. In addition the

regional administrator interprets this policy to the municipal offices and acts as the liaison person between the municipalities and the Province.

The supervision of the work done by the provincial social workers, that is, the planning essential to adequate professional treatment of problems encountered and recommendations with respect to the expenditure of public funds, is provided by district supervisors, of whom there are twenty. These supervisors serve both provincial and municipal staffs and are located in strategic positions throughout the Province.

A chief field consultant for Regions two and six acts as a liaison between the Field and the Divisions, and gives direction on casework handling as it effects specific cases brought to his attention. When in the opinion of the chief consultant a change in policy is warranted, it is his duty to bring this matter to the attention of the regional administrator and general administration. He is available at all times on a consultative basis to the district and divisional supervisors.

The provincial social worker is the key person in this organization, as in the final analysis it is he who serves the people directly. There are forty-six social workers in divisional office and one hundred and forty-three in the field service.[1] Each social worker's service is that of family casework in which he used the legislation or programme of government most appropriate to the needs of the family or individual. The use of these resources demands an intimate knowledge of each, and skill and integrity are demanded in establishing need or meeting eligibility requirements, in using public money wisely

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[1] Office of Assistant Director of Welfare, Social Welfare Branch, Department of Health and Welfare, Victoria. Memo. dated September 13th, 1955.

and economically, and in working toward the saving of the family life and the building of self-reliant citizens for the future.

Medical Services Division

The Medical Services Division, Social Welfare Branch, Department of Health and Welfare, is responsible for carrying out the programme formulated by the provincial government to give general medical and special medical, dental and optical services to persons in receipt of public assistance.

The entire programme is administered by a staff of fifteen persons comprising the Medical Services Division. The staff includes a medical director, who serves on a part time basis, a medical social work consultant, pharmacists, checkers, clerks, stenographers and clerk typists. The medical director is responsible to the Director of Welfare.

In his administrative capacity he works with the local doctors and social workers throughout the province to prevent illness, maintain good health, and foster the highest degree of rehabilitation of which the person is capable. The medical social work consultant of the Branch functions as the liaison between the social workers through the province and the medical director and is responsible for bringing out the medical-social aspects of the case problems.

Decisions and arrangements for transportation of assisted persons to and from special treatment centres, and to doctors for consultation, diagnosis and treatment come within the scope of the medical director. All accounts for transportation, drugs, optical, dental and ancillary services

are forwarded to the Division, checked, approved and passed to the Accounting Division of the Branch for payment.

A pharmacy is operated by the Branch and is located in Vancouver. Drugs required on a chronic basis are supplied through this dispensary which employs three qualified pharmacists.

In 1954 the Canadian Medical Association (British Columbia Division) appointed a special committee of medical men to advise the medical director on the advisability of providing new and unproven drugs on the prescription of the private physician. During the past year these prescriptions, when approved, have been filled at the provincial pharmacy.

Nursing and boarding homes in the province having public assistance patients submit a monthly requisition for drugs which are supplied by the pharmacy, and the Protestant and Catholic Children's Aid Societies also secure supplies for their receiving homes. Approximately 1,240 individual prescriptions are dispensed monthly.

Administrative Relationship with the Medical Association

The physicians services programme was initiated after due study disclosed the variation in existing medical arrangements. Discussions throughout the Province culminated in a plan inaugurated March 1st, 1949 when the medical treatment agreement between the Government of the Province of British Columbia and the College of Physicians and Surgeons of British Columbia, now called the Canadian Medical Association - B.C. Division, came into effect to provide full medical, surgical and obstetrical care in home, office or hospital in accordance with recognized medical practice for each beneficiary of public

assistance.

In consideration of the services rendered by the Association, the Government agreed to pay to the Association at the end of each month a sum equal to one-twelfth of an annual all-inclusive capitation fee of fourteen dollars and fifty cents ($14.50) for each person in receipt of public assistance and for each dependent, the amount to be paid to be based on the number of persons entitled to such service as shown on a master list supplied by the Social Welfare Branch of the Department of Health and Welfare. The per capita rate is subject to annual review. The municipalities were to share on a per capita population basis and were to refund to the Province 20 per cent of the per capita cost. The formula used to determine the municipal share is as follows:

$$\frac{\text{Total cost of medical services}}{\text{Total population of province (less Indians)}} \times \frac{20}{100} \times \text{population of municipality} = \text{municipal share.}$$

The administration of the fund paid to the Association and the rendering of the service was placed in the hands of the medical profession. The Social Assistance Medical Service was set up to execute the details of the plan.

The government agreed to provide to the Association at the end of each month a list of all persons and the number of their dependents who have been granted assistance subsequent to the submission of the master list. Also, the government agreed to provide each head of family or single person with an identity card, showing the registration number and the names of the dependents of each such person.

The Association in turn agreed to furnish to the government any information which it might require as often as practicable and, in any event, an annual report was to be submitted not later than the 31st of January of each year. The Association now submits a quarterly report. See Appendix C. It was mutually agreed that the Association will not be required to provide treatment for diseases or conditions for which care is provided without cost by public authorities (for example; pulmonary tuberculosis, venereal diseases and mental illnesses, established preventive care, service-connected disabilities or any care by a tax supported agency). Occupational accidents, or diseases for which the patient is entitled to benefits under any Workmen's Compensation or similar law were also excluded.

Experience showed as time went on that there was an increase[*] in utilization of the services and thus prorated payments to the doctors decreased. After study and negotiation the per capita rate was revised to $18.50 effective April 1st, 1952. Another upward revision to $20.00 was effective April 1st, 1954. Under the most recent agreement, April 1st, 1955, the annual all /inclusive capitation fee was raised to $22.50.

TABLE 4

PERCENTAGE OF ACCOUNTS PAID TO PHYSICIANS
PARTICIPATING IN SOCIAL ASSISTANCE MEDICAL SERVICE

1st Year	67.1%	March 1, 1949	-	February 28, 1950
2nd Year	56.9%	March 1, 1950	-	February 28, 1951
3rd Year	52.0%	March 1, 1951	-	March 31, 1952
4th Year	60.0%	March 1, 1952	-	March 31, 1953
5th Year	53.5%	March 1, 1953	-	March 31, 1954

* Source: Social Assistance Medical Service.

Since the initial agreement in 1949, there have been some minor changes. An agreement entered into May 5th, 1954 reads in part as follows:

> "WHEREAS the Government and the College of Physicians and Surgeons of British Columbia negotiated an Agreement made the 7th day of February, A.D. 1949, to come into force on the 1st day of March, 1949, to provide a complete medical service to be operated on a uniform basis throughout the province,
>
> AND WHEREAS, it is desirable to continue the provisions of a complete medical service to be available to persons resident in the province who are in receipt of allowances under the provisions of the following Provincial Acts, that is to say: Old-age Assistance Act, Blind Persons' Allowances Act, Mothers' Allowance Act, Social Assistance Act, Disabled Persons' Allowances Act and Protection of Children Act and the following Act of Canada, that is to say: Old Age Security Act, who are otherwise eligible under the Regulations of the Social Welfare Branch.
>
> AND WHEREAS it is agreed that the Agreement made the 4th day of June, A.D. 1952, between the Government and the Association be cancelled as of the 31st day of March, 1954.
>
> AND WHEREAS the Government and the Association have negotiated an Agreement for the provision of the said services by the Association through its members on the terms and conditions hereinafter set out:
>
> NOW THEREFORE the parties hereto, for the consideration hereinafter set out, agree as follows:
>
> 1. (a) i. The Association agrees with the Government that it will, through its practising members and as hereinafter provided, provide during the term of this Agreement, without charge to the patients, full medical, surgical and obstetrical care in home, hospital and office, and when referred by the physician, out-patient diagnostic services provided in any hospital defined in the "Hospital Insurance Act", as a hospital required to furnish general hospital services provided under the said Act, in accordance with recognized medical practice to all persons resident in the Province who are entitled to and in receipt of Old Age Security, Pensions, Old Age Assistance, Blind Persons' Allowances, Mothers' Allowances, Disabled Persons' Allowances or social allowances under any of the said Acts, and to their dependents, and to such additional persons as may from time to time be agreed between the parties, and who, when requesting such service, produce an authorization or Health Service identity card provided by the Government".[1]

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[1] Agreement signed May 4, 1954 between Canadian Medical Association (B.C. Division) and Government of British Columbia.

Agreements with Optometric and Pharmaceutical Associations

Arrangements have been entered into with the Optometric and Pharmaceutical Associations for fixed rates for glasses and optical examinations and for drugs at reduced costs.

Financing

In British Columbia, social assistance costs are shared largely by the municipalities with the provincial government on a 20-80 basis. For example, the municipalities pay 20 per cent of social allowance costs for those recipients resident in the municipality or local area under the provisions of the "Residence and Responsibility Act". The municipal share of medical services is on a somewhat different basis. It may be explained as follows:

The gross payment to the Social Assistance Medical Service is reduced by the ratio of population in unorganized territory to the total population of the Province. After this deduction is made, the balance indicates the payment to be made for social assistance cases residing in municipalities, and is further reduced by 80 per cent, being the provincial share. The remaining 20 per cent (municipal share) is assessed on a per capita of population basis, dividing by the total population in municipalities according to their individual populations. All population figures are based on the latest federal census returns. Accounts covering the municipal share of the cost of medical care are rendered on a quarterly basis by the provincial government to the individual municipalities.

The method of determining individual municipalities' share of the cost of Drug and Optical Services is fundamentally the same as that used in computing the municipalities' share of medical costs with the following exception. As the total cost of such service cannot be determined until the books of the provincial government are closed each fiscal year, the amount billed to municipalities is based on the estimated cost of the services for the year. At the end of the fiscal year an adjustment account is rendered in accordance with actual costs. As in the case of medical costs, billing of municipalities is on a quarterly basis.

Costs

Adequate medical services are expensive and the overall costs of such care are mounting. The total expenditure rose from $185,973.68 in the 1946-1947 year to $2,038,096.40 in the 1953-1954 fiscal year. A breakdown of these costs is shown in Table 5.

TABLE 5

MEDICAL SERVICES, DRUGS, OPTICAL, ETC. EXPENDITURES

Year	Medical	Drugs	Dental	Optical	Trans.	Other	Total
1946/47	$ 104,375.86	$ 65,690.53	$ 6,457.75	$ 1,821.06	$ 4,752.15	$ 2,876.33	$ 185,973.68
1947/48	185,613.57	123,913.10	13,008.82	2,615.64	6,319.58	3,602.90	335,073.61
1948/49	250,004.18	172,554.46	19,290.90	3,817.73	10,484.90	10,317.53	466,469.70
1949/50	592,908.17	299,478.71	24,764.96	13,425.22	14,156.08	3,990.96	948,724.10
1950/51	688,829.34	387,242.73	30,915.12	23,543.17	13,612.38	1,839.60	1,145,982.34
1951/52	723,524.87	448,886.21	50,044.06	28,972.01	14,860.51	3,170.24	1,269,457.90
1952/53	1,012,555.82	500,373.41	71,392.69	42,387.62	16,377.71	5,878.82	1,648,966.07
1953/54	1,219,968.63	658,599.63	86,717.17	44,330.50	17,380.03	11,100.36	2,038,096.40

Source: Departmental Comptroller, Department of Health and Welfare, Victoria.

These rising costs may be attributed in part to the increase in numbers of recipients. This increase in turn is due to several factors of which perhaps the most important is the increase in proportions of older people. A study being made by Dr. James Tyhurst, of the Allan Memorial Institute of the Royal Victoria Hospital, Montreal, shows Canada as a country which is "aging" rapidly. Since 1881 Canada's population has increased by three times, while the percentage of those over 65 has jumped by six times.

> "Taken by Provinces, Quebec is the "youngest" with 5.7 per cent over 65. The others: Newfoundland 6.5; Prince Edward Island, 9.9; Nova Scotia, 8.5; New Brunswick, 7.6; Ontario, 8.7; Manitoba, 8.4; Saskatchewan, 8.1; Alberta, 7.1; and British Columbia, 10.8.
>
> When it comes to distribution, about 60 per cent of aged live in Quebec and Ontario, but in trends the Western Provinces are getting "older" much faster than the east. The percentage of increase in the rate of aged in Quebec since 1881, for instance, is 398, compared with 6,546 in Manitoba and 10,146 in British Columbia".[1]

It is a well known fact that older people require relatively greater services. This situation has been brought about in part by medical science's success in increasing our life span and part by the numbers of aged people attracted to this province due to geographical factors and progressive welfare policies and health resources. New legislation has also increased the numbers of eligible recipients. Public awareness of available services has added to the numbers utilizing them and the changes in family patterns result in more people requiring public support rather than depending on their families.

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[1] B.C. Government News "Aging Population" Volume 3, August, 1955 Number 7, page 5.

A second reason for rising costs is increased dependence on public programmes rather than on private agencies. A third is the general acceptance of the philosophy that the provider of service should receive remuneration commensurate with prevailing standards in the community. A general rise in costs has been a fourth factor. A final element is medical advances requiring more costly drugs, equipment and facilities.

Relationships with Municipalities

There is some evidence that the municipalities accept the per capita formula for medical services. This acceptance has come about with years of experience which have proven to municipal councils that the programme is operated efficiently. They approve of having requests for transportation, ancillary services, dental attention and other special needs channelled through the Medical Services Division. In addition, they have come to realize the advantage in having agreements on a provincial basis with the medical, optometric, and pharmaceutical associations which provide the services at reduced costs.

The wealthier municipalities with the lower numbers of public assistance recipients are paying more in proportion for the medical services than the poorer municipalities with the higher numbers of beneficiaries. In effect, tax payers in wealthier municipalities are subsidizing the tax payers in poorer municipalities.

CHAPTER 5

CONCLUSIONS

With the foregoing background of information, it is now possible to make some assessment of the Medical Services Programme in British Columbia.

The British Columbia government has gone a long way, probably further than any other in Canada, in the provision of medical care. Certainly, from the point of view of the recipient the programme has been most satisfactory and is available with a minimum of restrictive regulations. The assisted person may have the services of physicians in home, office or hospital. He has free choice of doctor and his relationship with his professional person is the same as that of an insured person in any prepaid medical care programme. When a consultation is needed, this can be arranged by the doctor. If hospital care is required, the doctor is able to admit his patient.

Boarding home or nursing home care is provided dependent on the person's needs and the resources available. When special treatment is necessary the closest centre to the person's home it utilized. Necessary transportation by means of bus, ambulance, taxi, train, boat or aeroplane is provided. The doctor can issue a prescription for most medicines needed in scientific practice of his profession. Eye attention can be secured through an ophthalmologist or an optometrist, according to the doctor's instructions, and glasses when prescribed, are provided. In dental care, extraction of

teeth and provision of dentures are permitted, and prophylactic work is allowed on a limited scale.

In the furnishing of these various services, the object has been to meet the needs of the individual by alleviating pain and by assisting him to reach his maximum capability, thereby becoming, if possible, a self-respecting and self-dependent member of the community.

An outstanding feature of the British Columbia programme is the fusion of health and welfare in the medical planning for the client. While specific direction of the programme and provision for treatment comes under the medical personnel, the social worker has an important role in facilitating the provision of service. Moreover, the social worker can contribute an understanding and knowledge of the client in his social situation to the attending physician, and the Medical Services Division which will assist in dealing with the emotional aspects of illness which serve as barriers to recovery. In working with the sick and the handicapped, the same basic casework concepts are observed as in working with other groups of people who need the worker's help.

On the other hand, the physicians who render the service have had occasion to complain. They have stated that as more and more people utilize their services and use them more frequently, the government's contribution to the doctors has not increased proportionately. They also point out that other prepaid medical schemes such as Medical Service Association provide only limited medical care for limited periods, whereas under Social Assistance Medical Service, recipients receive complete medical care as long as they live.

Further, under the Medical Service Association Plan, beneficiaries are aware that their contributions have some relationship to utilization of the service. Public assistance recipients do not contribute to the cost of the programme, and it is claimed that they have no interest in minimizing these costs. Accordingly, the Canadian Medical Association, B.C. Division, has asked that an effort be made to educate the persons in receipt of medical services so that there will be little or no abuse of privileges afforded them under this programme. It is the writer's opinion that the major responsibility for this interpretation lies with the medical profession itself.

In assessing the British Columbia Medical programme, reference was made to others on this Continent and the one most comparable was found to be the Saskatchewan scheme. A number of similarities were discovered. Generally speaking the groups covered and services available are similar. Both have province-wide agreements with the medical profession based on per capita payments. Another similarity is their universal hospital plan which obviates the necessity of special programmes for public assistance patients. Both provinces provide comprehensive drug services but maintain some degree of control over mounting costs through the utilization of professional medical advisory committees.

However, certain differences do exist; the principal one being in the field of administration. Saskatchewan delegates this responsibility to its Public Health Department and British Columbia to its Social Welfare Branch. A further administrative variation occurs in the control of the fund providing professional medical care. Saskatchewan has retained government control of the fund while British Columbia entrusts the responsibility

to the medical association.

The per capita payment to the medical men at the present time is substantially higher in British Columbia. However, this may be offset to a certain extent by the transportation allowance made in Saskatchewan for rural home calls. Saskatchewan's drug policy entails payment of 20 per cent of the cost of each prescription by the recipient while British Columbia exacts no payment. British Columbia maintains some degree of regulation through the use of a formulary which lists the allowable drugs. In contrast, Saskatchewan (through its advisory committee) specifies the drugs which are not allowable. Saskatchewan expects the client to bear 50 per cent of the cost of dentures and to negotiate with the dentist the terms of payment. In British Columbia the securing of a contribution depends on the resources of the client and his family.

Emergency transportation for medical treatment is undertaken by Saskatchewan's Air Ambulance Service. No comparable facility exists in British Columbia, although transportation is provided when necessary by normal facilities. Saskatchewan finds it necessary to bear the cost of transporting paraplegics to other provinces for rehabilitation training, while British Columbia does not incur this expense because there excellent facilities exist within the province.

The question of the medical profession administering its own programme is always an issue with many people. Any opinion is dependent on the philosophy of the observer. While there are dangers inherent in a professional group administering government funds, the dangers are minimized if

the parties to the agreement have a sense of purpose and a spirit of co-operation. It is this writer's opinion that this has been the case in British Columbia with the result that the scheme is working out satisfactorily to persons receiving the service, the medical profession who provide the service, and the government which is responsible for the spending of tax funds.

British Columbia's programme, being under provincial control, ensures province-wide uniformity of services and uniformity of means test. This results in generally higher standards of medical care and an equitable distribution of available funds.

Medical care may be the responsibility of public health or welfare departments. Those who believe that public health administration is superior maintain that certain advantages result from closer relationship with health personnel, that competitive demands on available funds are avoided, and that integration with preventive health programmes is desirable. In the writer's opinion, health services under welfare administration are considered as part of the total needs of the client and not as separate entities. This concern for the person as a whole results in the preservation of his sense of personal worth through the relationship with the social worker.

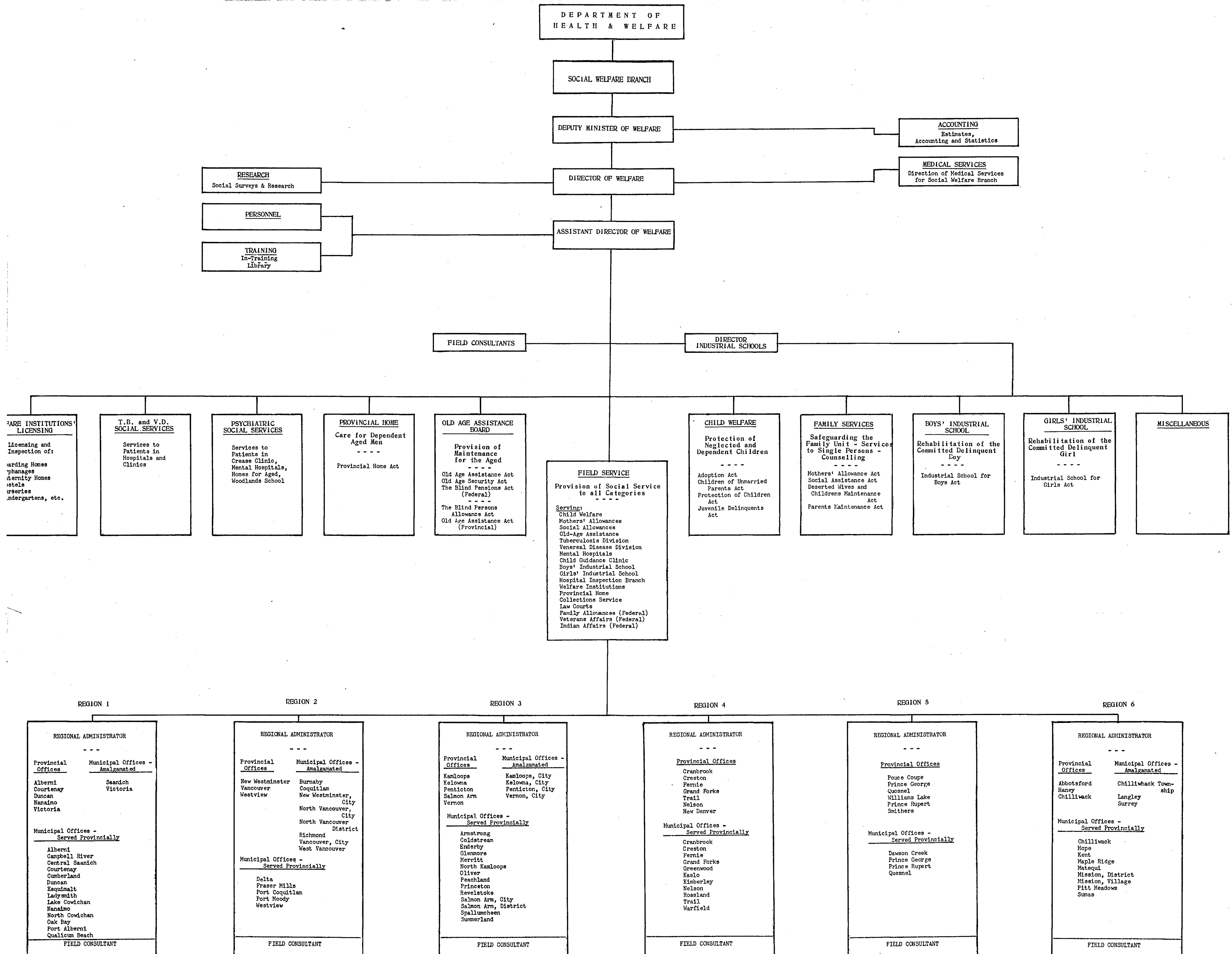
It is difficult to arrive at an objective assessment of the cost of the programme to British Columbia as it is so comprehensive. Saskatchewan's programme is not strictly comparable since provision of service depends to a considerable degree on local initiative.

This thesis has shown amongst other things that public assistance

recipients are really beneficiaries of a comprehensive health insurance programme. At the time of writing health insurance for all Canadians is becoming both a medical and political issue. At least three provinces have now taken a definite stand in urging the federal government to initiate some form of health insurance. While costs of the public assistance medical care programme may loom large in the provincial economy, the prospects are that they soon may be shared by the federal government. British Columbia can take some satisfaction in the pioneer efforts it has made in bringing comprehensive medical care to the most needy portion of its population, and its experience with the programme will undoubtedly offer guidance in the comprehensive programme of health insurance yet to come in Canada.

APPENDIX A

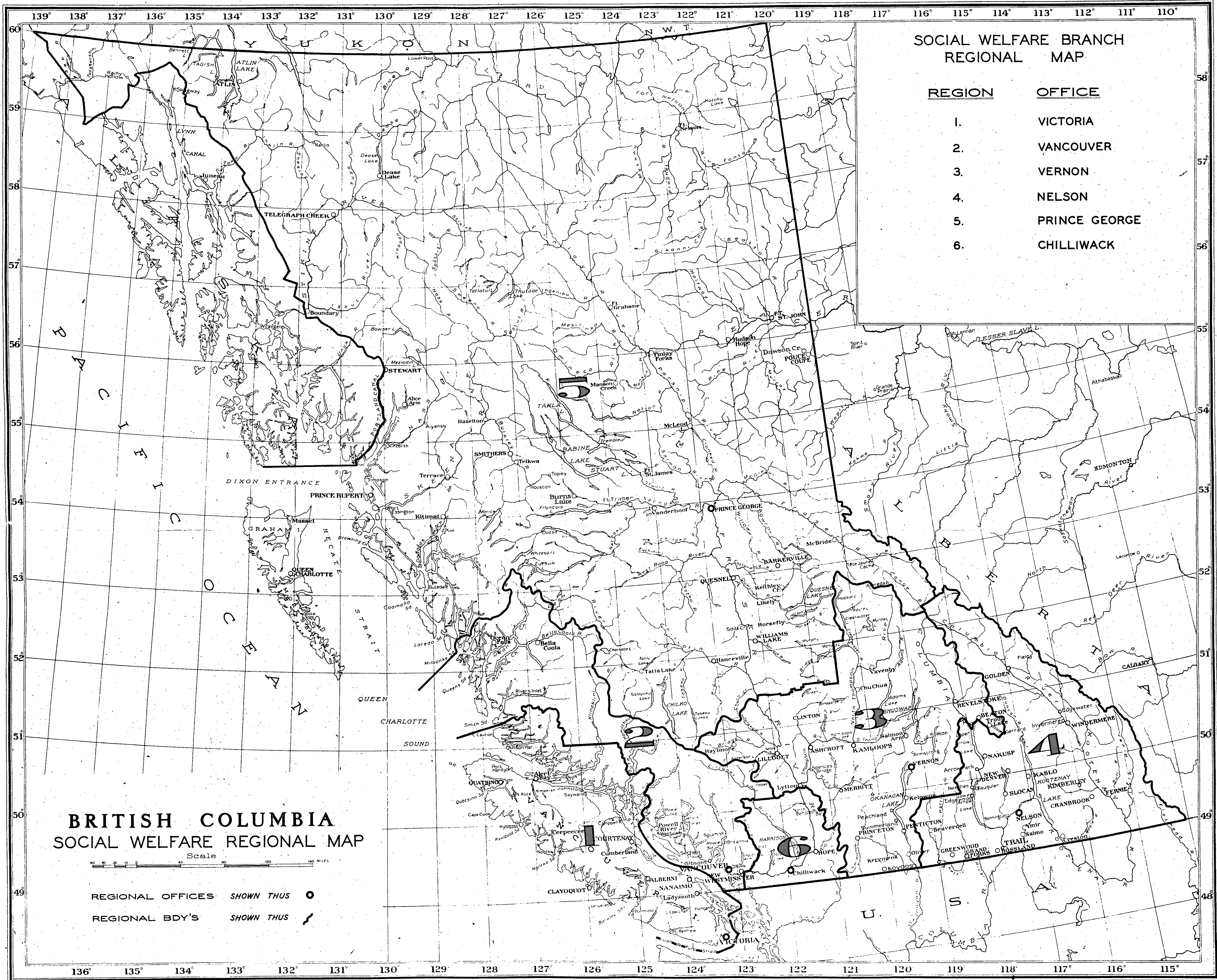
ADMINISTRATIVE STRUCTURE OF SOCIAL WELFARE BRANCH, DEPARTMENT HEALTH AND WELFARE, VICTORIA



APPENDIX B

SOCIAL WELFARE BRANCH REGIONAL MAP,

DEPARTMENT HEALTH AND WELFARE, VICTORIA



SOCIAL ASSISTANCE MEDICAL SERVICE

QUARTERLY REPORT

JANUARY 1/54 TO MARCH 31/54

Income & Expenditure	Quarter Under Review	Year to Date Total	Year to Date Per Person Per Quarter
Income			
Amount Received from Government	$310,057.66	$1,218,486.76	$4.573
Balance from Previous Year:			
Reserve		6,607.06	.025
Contingent Liability		1,691.25	.006
Previous Quarter:			
Reserve	21,198.73		
Contingent Liability	1,899.20		
	$333,155.59	$1,226,785.07	$4.604
Expenditure: Medical			
Doctors in General	$291,797.04	$1,093,050.62	$4.102
Reserve	402.42	1,775.64	.007
V.G.H. Medical Board	12,000.00	42,000.00	.158
Out-Patient Hospital Services	6,729.67	24,685.04	.093
Contingent Liability	1,899.20	7,572.95	.028
Total Medical Expense	$312,023.49	$1,169,084.25	$4.388
Expenditure: Other	11,813.30	48,382.02	.181
Total Expenditure	$323,836.79	$1,217,466.27	$4.569
Amount Transferred to Reserve	7,233.20	7,233.20	.027
Amount Transferred to Cont. Liability	2,085.60	2,085.60	.008
	$333,155.59	$1,226,785.07	$4.604

SOCIAL ASSISTANCE MEDICAL SERVICE

STATEMENT OF INCOME & EXPENDITURE

JANUARY 1/54 TO MARCH 31/54

	Quarter Under Review	Year to Date	
	Amount	Amount	%
Amount Received from Government	$310,057.66	$1,218,486.76	
Balance from Previous Year:			
Reserve		6,607.06	
Contingent Liability		1,691.25	
Previous Quarter:			
Reserve	21,198.73		
Contingent Liability	1,899.20		
	$333,155.59	$1,226,785.07	100.00
Deduct Medical Accounts	312,023.49	1,169,084.25	95.30
	$ 21,132.10	$ 57,700.82	4.70

Breakdown of Administration and Other Expenses

	Quarter Under Review	Year to Date	%
Salaries	$ 8,211.35	$ 33,201.85	
Honoraria	25.00	125.00	
Rent	675.00	2,700.00	
Light	77.18	259.38	
Telephone	150.29	608.31	
Fuel	162.15	351.89	
I. B. M.	835.00	4,561.49	
Office Supplies	536.54	1,136.27	
Postage	224.69	853.10	
Expenses: E. L. D.	150.00	600.00	
Expenses: Drs.'	20.00	20.00	
Janitor's Services & Supplies	180.00	796.55	
Unemployment Insurance	49.56	198.80	
Legal Fees		580.05	
Auditor's Fees		450.00	
Miscellaneous	45.83	206.84	
M.S.A.	46.10	198.94	
Health Insurance	130.84	525.92	
	$ 11,519.53	$ 47,374.39	
Furniture & Fixtures	315.18	1,053.52	
Unemployment Insurance		31.72	
Health Insurance	21.41	14.17	
	$ 11,813.30	$ 48,382.02	3.94
Excess of Income over Expenditure	7,233.20	7,233.20	.59
Amount Transferred to Contingent Liab.	2,085.60	2,085.60	.17
	$ 21,132.10	$ 57,700.82	4.70

SOCIAL ASSISTANCE MEDICAL SERVICE

PROGRESS REPORT

JANUARY 1/54 TO MARCH 31/54

Accounts Receivable		Quarter Under Review	Year to Date
Category	**No. Covered**		
M. A.	1,447		
S. A.	16,587		
C. W. D.	3,060		
O. A. S. & Blind	37,504		
O. A. A.	8,877		
Monthly Average	67,475		
Quarterly Total	202,426 at $1.5416	$310,057.66	$1,218,486.76
Amount Transferred from Balance:			
Reserve		$21,601.15	
Contingent Liability		1,899.20	

Accounts Receivable	Quarter Under Review	Year to Date
No. of Accounts Submitted (Approx.)	36,000	
No. of Doctors Submitting Accounts	993	
No. of Hospitals Submitting Accounts	51	
Total Doctors' & Hospital Accounts as Billed	$659,142.87	$2,402,243.61
Total Doctors' & Hospital Accounts as Assessed	584,931.81	2,133,281.66
Amount Paid Doctors & Hospitals	$298,526.71	$1,117,735.66
Amount Paid from Reserve-	402.42	1,775.64
Amount Paid V.G.H. Medical Staff	12,000.00	42,000.00
Amount Paid from Contingent Liability	1,899.20	9,407.87
Total Medical Expense	$312,023.49	$1,170,919.17
Average Account as Paid with Hospitals	$8.29	$8.54
Average to Doctors as Paid	$293.85	$284.45
Average to Hospitals as Paid	$131.95	$128.27
Cost Per Person: Medical Staff V.G.H.	$ .178	$ .168
Hospital Services	.100	.095
Doctors in General	4.324	4.166
Reserve	.006	.003
Contingent Liability	.028	.035
Other Expenditure	.175	.179
	$4.799	$4.646
Amount Transferred to Reserve	.107	.165
Amount Transferred to Contingent Liability	.031	.030
	$4.937	$4.841
Amount Received Per Person Per Quarter	$4.595	$4.585
Reserve From Last Quarter	.314	.222
Contingent Liability from Last Quarter	.028	.034
	$4.937	$4.841

Percentages Paid	1st Q.	2nd Q.	3rd Q.	4th Q.
1st Year - 67.1 - March 1/49 - Feb. 28/50	70	65	70	65
2nd Year - 56.9 - March 1/50 - Feb. 28/51	55	60	56	58
3rd Year - 52.0 - March 1/51 - March 31/52	55	50	50	53
4th Year - 60.0 - April 1/52 - March 31/53	61	64	62	56
5th Year - 53.5 - April 1/53 - March 31/54	53	57	52	52

Late Accounts Paid at 10% Less

SOCIAL ASSISTANCE MEDICAL SERVICE

SUMMARY OF MEDICAL EXPENSE

JANUARY 1/54 TO MARCH 31/54

	Fee Item	Quarter Under Review		Year to Date	
		Amount	%	Amount	%
General Practice	0100-0110	$139,731.83	46.81	$529,484.71	47.10
Dermatology	0201-0216	1,303.93	.44	6,208.52	.52
Internal Medicine	0301-0319	16,302.93	5.46	57,292.04	5.29
Neurology	0401-0412	407.76	.14	1,205.80	.13
Paediatrics	0501-0516	2,453.10	.82	9,489.71	.84
Psychiatry	0601-0621	1,584.94	.53	5,358.02	.49
Eye, Ear, Nose & Throat	2001-2011	5,692.25	1.91	20,672.47	1.88
Neurosurgery	3001-3011	222.72	.07	659.96	.06
Obstetrics & Gynaecology	4001-4012	398.81	.13	1,204.69	.11
Orthopaedics	5001-5011	748.38	.25	2,501.27	.24
Plastic Surgery	6001-6011	15.60	.01	46.77	
General Surgery	7001-7011	1,700.68	.57	5,163.91	.50
Urology	8001-8011	845.64	.28	2,885.36	.27
Procedures					
Common Office	0001-0024	1,713.02	.57	7,052.74	.65
Special	0030-0049	991.96	.33	3,733.99	.33
Miscellaneous	0060-0081	1,207.94	.40	4,120.34	.37
Anaesthesia	1001-1071	12,963.70	4.34	47,030.02	4.26
Eye, Ear, Nose & Throat	2100-2419	19,870.47	6.66	81,965.59	6.99
Neurosurgery	3020-3063	491.40	.17	3,810.45	.32
Obstetrics & Gynaecology	4100-4542	9,128.89	3.06	33,179.37	2.96
Orthopaedics	5020-5506	14,509.79	4.86	49,416.89	4.72
Plastic Surgery	6020-6360	445.60	.15	2,032.31	.17
General Surgery	7015-7623	35,714.54	11.96	126,248.50	11.78
Urology	8030-8323	14,650.18	4.91	61,766.69	5.12
Laboratory	9000-9305	2,591.16	.87	9,645.77	.85
X-Ray	9500-9811	14,340.03	4.80	50,697.73	4.54
Physiotherapy	9900	149.98	.05	507.26	.05
Miscellaneous Items		404.74	.14	2,258.55	.17
		$300,581.97	100.69	$1,125,639.43	100.71
Plus Debit Balance		68.44	.02	206.66	.02
		$300,650.41	100.71	1,125,846.09	100.73
Less Contingent Liability		2,123.70	.71	8,110.43	.73
Total Cheque Register		$298,526.71	100.00	1,117,735.66	100.00
V.G.H. Medical Board		$ 12,000.00		$ 42,000.00	

The above statistics include payment for Out-Patient Hospital Services exclusive of the Vancouver General Hospital.

SOCIAL ASSISTANCE MEDICAL SERVICE

ANALYSIS OF MEDICAL EXPENSE

JANUARY 1/54 TO MARCH 31/54

	Fee Schedule Item	Amount	Total
General Practice	0100-0110		
Initial Visit		$ 2,433.11	
Minor Office Visits		59,300.83	
House Visits			
First Day Visit		9,184.22	
Subsequent Day Visits		22,588.24	
Night Visits		2,058.02	
Emergency, Sunday, Holidays		3,520.45	
Extra Patients		209.22	
Hospital Visits		37,238.88	
Nursing Home Visits		2,826.86	
Consultations		372.00	$139,731.83
Dermatology	0201-0216		
Formal Consultations		39.00	
Formal Consultation with Biopsy		52.00	
Minor Consultations		20.80	
Initial Visits			
Office Visits		221.60	
Subsequent Visits			
Office Visits		620.93	
Hospital Visits		68.64	
Home Visits		3.90	
All Other Forms of Treatment		277.06	1,303.93
Internal Medicine	0301-0319		
Formal Consultations		2,421.10	
Minor Consultations		203.50	
Repeat Consultations		172.80	
Initial Visits			
Office Visits		737.56	
Hospital Visits		120.24	
Home Visits		261.60	
Extra Patients		4.68	
Subsequent Visits			
Office Visits		4,256.74	
Hospital Visits		3,545.32	
Home Visits		2,437.48	
Emergency Visits		343.20	
Initial E.C.G. & Interpretation		1,061.56	
E.C.G. & Interpretation at Home		15.60	
Interpretation of E.C.G.		707.75	
Repeat E.C.G.		13.80	16,302.93
Neurology	0401-0412		
Formal Consultations		273.60	
Repeat Consultations		13.00	
Initial Visits			
Office Visits		5.20	

	Fee Schedule Item	Amount	Total
Neurology Cont'd	0401-0412		
Subsequent Visits			
Office Visits		$ 28.60	
Hospital Visits		87.36	407.76
Paediatrics	0501-0516		
Formal Consultations		91.00	
Minor Consultations		10.40	
Repeat Consultation within 6 Months		5.20	
Initial Visits			
Office Visits		18.22	
Simple Problems		133.70	
Home Visits		50.70	
Additional Child		1.56	
Subsequent Visits			
Office Visits		292.92	
Hospital Visits		525.02	
Home Visits		66.33	
Child Welfare Cases		1,258.05	2,453.10
Psychiatry	0601-0621		
Formal Consultations		217.40	
Initial Psychiatry Examination		66.60	
Home Visit		20.80	
Continuation of Treatment		385.44	
Hospital Visits		447.34	
Shock Therapy		49.40	
Investigation with Certification		353.76	
Certification		44.20	1,584.94
Eye, Ear, Nose & Throat	2001-2011		
Formal Consultations		146.20	
Minor Consultations		858.36	
Initial Visits			
Office Visits		134.02	
Hospital Visits		4.68	
Examination of Local Condition		1,093.09	
Home Visits		5.20	
Subsequent Visits			
Office Visits		3,231.00	
Hospital Visits		157.30	
Home Visits		62.40	5,692.25
Neurosurgery	3001-3011		
Formal Consultations		183.20	
Minor Consultations		10.40	
Subsequent Visits			
Hospital Visits		29.12	222.72
Obstetrics & Gynaecology	4001-4012		
Formal Consultations		62.40	
Minor Consultations		99.40	
Emergency Consultation for Obstetrics		39.00	
Initial Visits			
Office Visits		37.00	
Home Visits		3.15	
Subsequent Visits			
Office Visits		105.08	
Hospital Visits		38.48	
Home Visits		14.30	398.81

	Fee Schedule Item	Amount	Total
Orthopaedics	5001-5011		
Formal Consultations		$ 142.10	
Minor Consultations		216.66	
Initial Visits			
Office Visits		57.84	
Home Visits		5.20	
Subsequent Visits			
Office Visits		259.50	
Hospital Visits		49.92	
Home Visits		17.16	$ 748.38
Plastic Surgery	6001-6011		
Minor Consultations		15.60	15.60
General Surgery	7001-7011		
Formal Consultations		306.60	
Minor Consultations		403.00	
Initial Visits			
Office Visits		94.16	
Hospital Visits		5.20	
Home Visits		23.40	
Emergency Visits		14.30	
Sunday Visits		5.20	
Subsequent Visits			
Office Visits		427.06	
Hospital Visits		346.70	
Home Visits		75.06	1,700.68
Urology	8001-8011		
Formal Consultations		18.80	
Minor Consultations		277.00	
Initial Visits			
Office Visits		25.00	
Home Visits		15.60	
Subsequent Visits			
Office Visits		421.84	
Hospital Visits		49.44	
Home Visits		37.96	845.64
PROCEDURES			
Common Office Procedures	0001-0024		
Vaccination		3.12	
Intramuscular Medications		1,557.24	
Intravenous Medications		107.34	
Venepuncture		13.52	
Blood Transfusion			
Inside Hospital		31.80	1,713.02
Special Procedures	0030-0049		
Stomach Gavage & Lavage		7.80	
Allergy Skin Tests: Intradermal		25.68	
Scratch		27.24	
Desensitization Treatments		24.96	
E.C.G. by Non-Internist Complete		496.17	
Orthodiagram		10.95	
B.M.R. Determinations: Initial		229.41	
Repeat		10.40	

	Fee Schedule Item	Amount	Total
Special Procedures (Cont'd)	0030-0049		
Lumbar Puncture		$ 124.95	
Pericardium Puncture		10.40	
Biopsy by Puncture: Sternum		8.40	
Vein Dissection: I.V. Therapy		15.60	991.96
Miscellaneous	0060-0081		
Certification Only		16.12	
Advice by Telephone		166.04	
Mileage		810.12	
Emergency Procedures		215.66	1,207.94
Anaesthesia	1001-1071	12,963.70	12,963.70
Eye, Ear, Nose & Throat	2100-2419		
Eye	2100-2139		
Refractions	2100	5,702.26	
Cataracts	2108-2112	7,474.25	
Other		2,766.44	
Ear	2200-2234	237.86	
Nose & Sinuses	2300-2329	738.46	
Throat	2400-2419		
Tonsils & Adenoids			
Children	2401	1,897.70	
Adults	2402	273.20	
Tonsillectomy - Local	2403	33.80	
Adenoidectomy	2404	57.50	
Other		689.00	19,870.47
Neurosurgery	3020-3063	491.40	491.40
Obstetrics & Gynaecology	4100-4542		
Obstetrics	4100-4111	3,919.20	
Gynaecology	4200-4542	5,209.69	9,128.89
Orthopaedics	5020-5606		
Amputations	5100-5124	1,034.30	
Fractures	5200-5278	11,013.27	
Dislocations	5300-5323	361.80	
Other		2,100.42	14,509.79
Plastic Surgery	6020-6360	445.60	445.60
General Surgery	7016-7623		
Care in excess of Surgeon's Fee	7015	2,870.92	
Assistants	7016-7019	3,366.40	
General	7030-7114	2,919.82	
Varicose Veins	7200-7206	991.70	
Venous Thrombosis	7210-7216	71.50	
Bursae, Cysts & Ganglia	7230-7233	567.40	
Abdomen	7300-7340		
Appendectomy	7301-7303	2,117.00	
Gall-Bladder	7304-7309	3,128.30	
Gastrectomy	7315-7316	2,601.00	
Other		5,153.62	

	Fee Schedule Item	Amount	Total
General Surgery (Cont'd)	7016-7623		
Hernia	7341-7367	$ 6,862.80	
Chest	7400-7453	1,519.20	
Head & Neck	7500-7521	1,479.50	
Anus & Rectum	7600-7623	2,065.38	$ 35,714.54
Urology	8030-8323		
Penis & Urethra	8030-8055	591.40	
Bladder, Prostate & Ureter	8100-8124		
Prostatectomy	8113-8116	9,693.70	
Other		3,082.22	
Kidney	8200-8209	732.16	
Scrotum & Contents	8300-8323	550.70	14,650.18
Laboratory Procedures	9000-9305		
Haemotology	9000-9020	1,916.83	
Urine	9050-9073	96.03	
Blood Chemistry	9110-9143	412.94	
Bacteriology, Parasitology, Etc.	9200-9208	81.38	
Miscellaneous	9300-9305	83.98	2,591.16
X-Ray Services	9500-9811		
No Specialist Available	9500-9532	810.94	
Specialist	9550-9615	12,608.65	
Radiation Therapy	9700-9811		
X-Ray Radiation	9700-9735	782.74	
Radium Therapy	9800-9811	137.70	14,340.03
Physiotherapy	9900	149.98	149.98
Miscellaneous Items not in Book		404.74	404.74
			$300,581.97
Plus Debit Balance			68.44
			$300,650.41
Less Contingent Liability			2,123.70
Total Cheque Register			$298,526.71

APPENDIX C

SOCIAL ASSISTANCE MEDICAL SERVICE

QUARTERLY REPORT

Appendix D

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