PROVINCE OF BRITISH COLUMBIA

HOSPITAL INSURANCE ACT

Twenty-second Annual Report

British Columbia Hospital Insurance Service

JANUARY 1 TO DECEMBER 31

1970

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in right of the Province of British Columbia.
1971

VICTORIA, BRITISH COLUMBIA, January 21, 1971.

To Colonel the Honourable JOHN R. NICHOLSON, P.C., O.B.E., Q.C., LL.D.,
Lieutenant-Governor of the Province of British Columbia.

MAY IT PLEASE YOUR HONOUR:

The undersigned has the honour to present the Twenty-second Annual Report of the British Columbia Hospital Insurance Service covering the calendar year 1970.

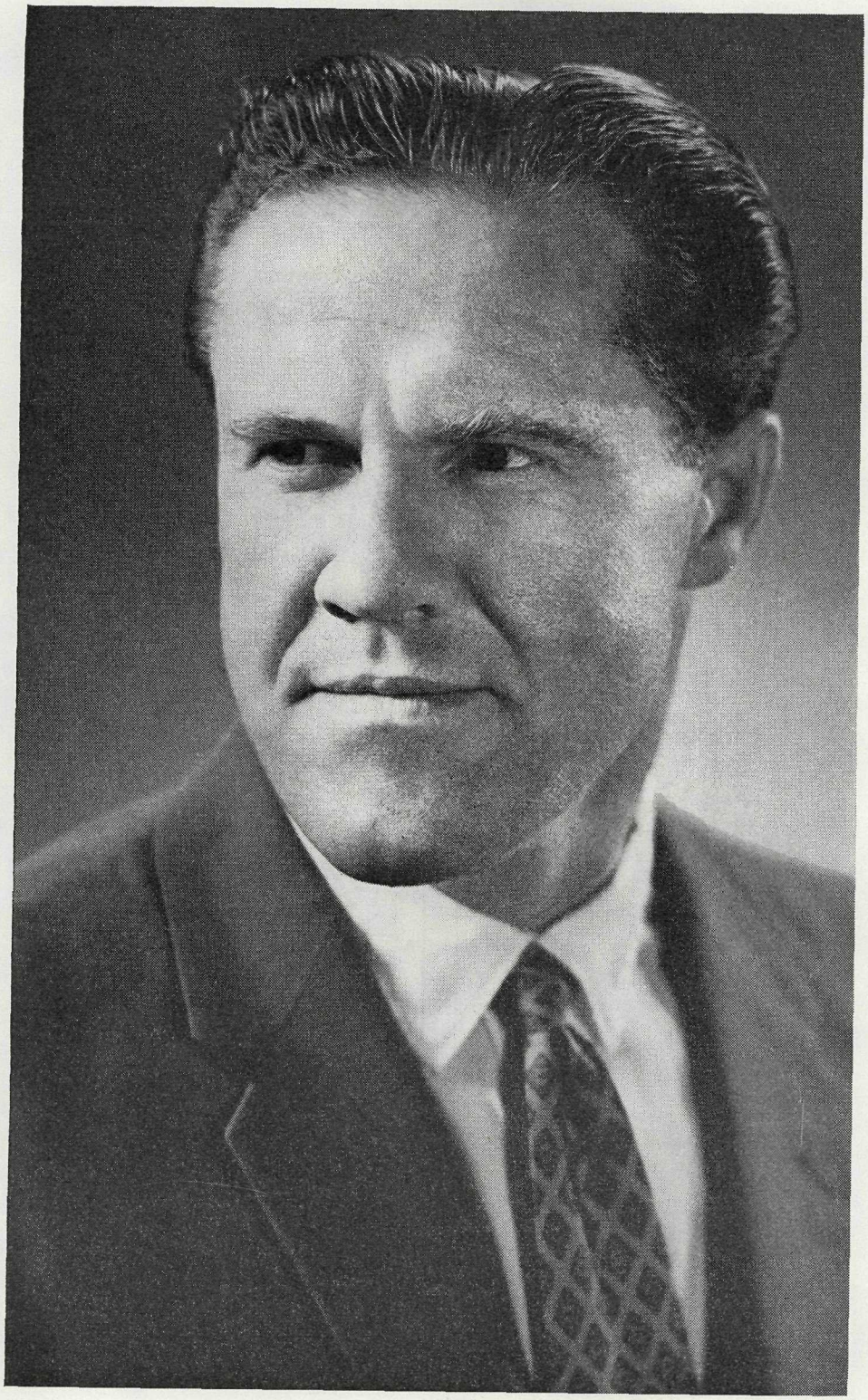
RALPH R. LOFFMARK
Minister of Health Services and Hospital Insurance

BRITISH COLUMBIA HOSPITAL INSURANCE SERVICE,
VICTORIA, BRITISH COLUMBIA, January 21, 1971.

The Honourable Ralph R. Loffmark,
Minister of Health Services and Hospital Insurance,
Parliament Buildings, Victoria, British Columbia.

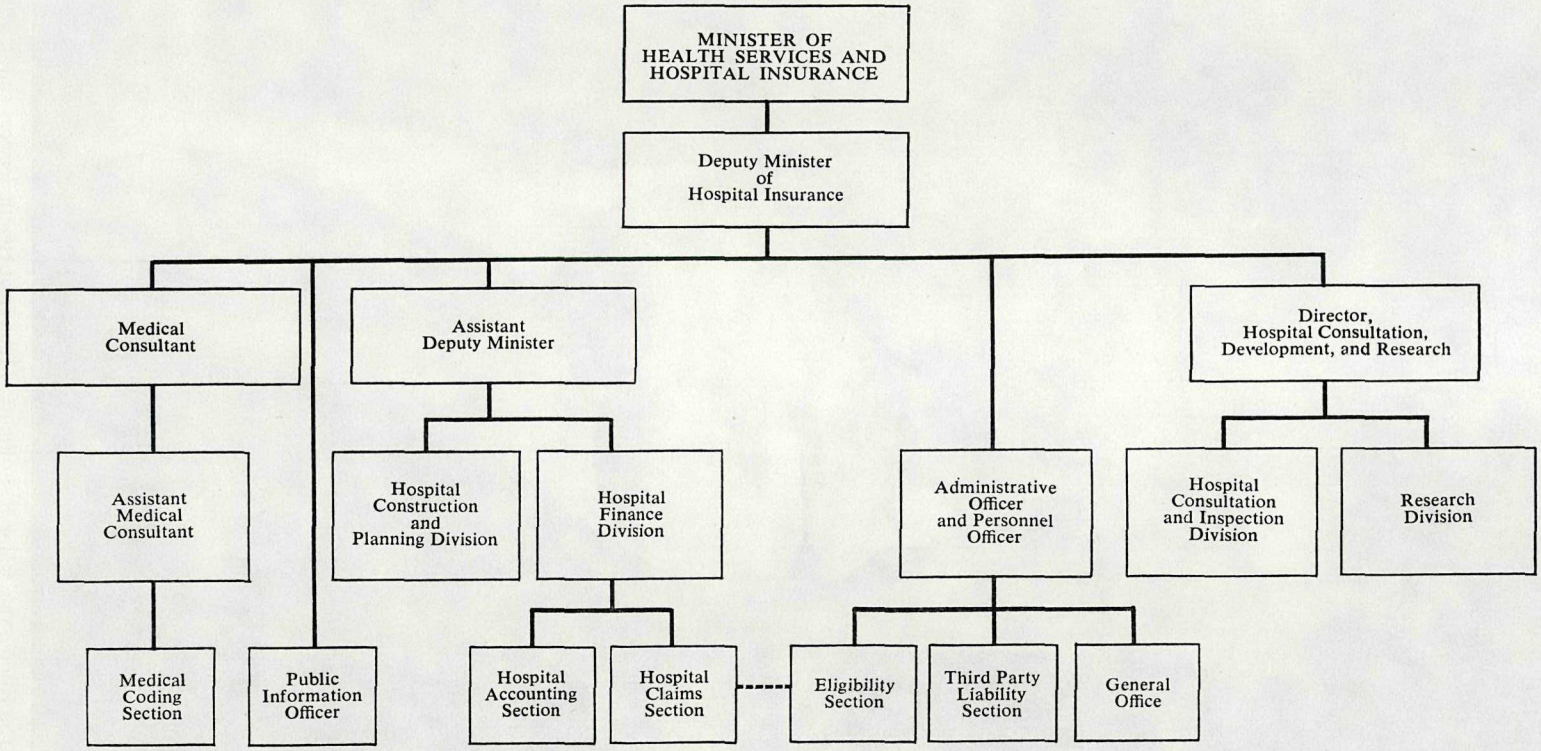
SIR—I have the honour to present herewith the Report of the British Columbia Hospital Insurance Service covering the calendar year 1970.

DONALD M. COX, F.A.C.H.A.
Deputy Minister of Hospital Insurance



The Honourable Ralph R. Loffmark, Minister of Health Services and Hospital Insurance.

ORGANIZATION CHART



Line of authority: (1) Minister.
(2) Deputy Minister.
(3) Assistant Deputy Minister.
(4) Director of Hospital Consultation, Development, and Research.

DEPARTMENT OF HEALTH SERVICES AND HOSPITAL INSURANCE

BRITISH COLUMBIA HOSPITAL INSURANCE SERVICE

THE HONOURABLE RALPH R. LOFFMARK, *Minister of Health Services and Hospital Insurance.*

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J. G. GLENWRIGHT, *Manager, Hospital Construction and Planning Division.*

D. M. N. LONGRIDGE, M.A., B.CH., F.R.C.S., *Assistant Medical Consultant.*

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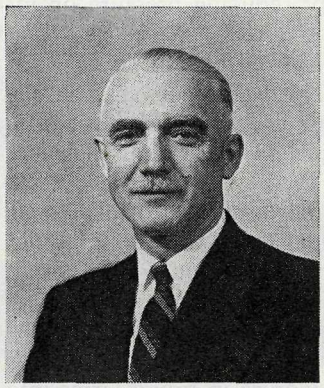
Twenty-second Annual Report of the British Columbia Hospital Insurance Service

GENERAL INTRODUCTION

DONALD M. COX, F.A.C.H.A., DEPUTY MINISTER OF HOSPITAL INSURANCE



The British Columbia Hospital Insurance Service has now completed 22 years of operation. Those years have been marked by development of hospital services and hospital insurance protection for the people of the Province far in excess of anything that would have been possible without a Government-operated hospital insurance programme. The information from the divisions of the Service appearing later in this Report provide a brief summary of what was accomplished during 1970. The record is a tribute to the policy direction of the Government and the efforts of the boards, administration, and staffs of hospitals; the medical profession; the women's auxiliaries; and the boards of regional hospital districts. I would be remiss if I did not acknowledge here the skilled and devoted work of the staff of the British Columbia Hospital Insurance Service. It is my considered opinion that the staff of the Service is outstanding among fine hospital insurance service staffs in Canada.

During the year, British Columbia Hospital Insurance Service payments to hospitals reached an all-time high of an estimated $182,500,000, which is the equivalent of $84.23 being paid on behalf of each man, women, and child living in British Columbia at the present time. Hospital insurance daily payments to hospitals amounted to $490,410, as compared to $432,232 in the 1969/70 fiscal year, an increase of 13.6 per cent.

The report of the Hospital Construction Division describes the continued progress in British Columbia's programme of hospital construction. Unfortunately, work stoppages delayed seriously a number of essential projects. Building programmes under way at year-end, many due for completion early in 1971, will cost an estimated $60,442,394, and projects in the advanced stages of planning represent an additional $33,353,930 in capital expenditure.

The major projects completed during the year involved a total of 589 new beds, of which 203 were for extended care. In addition, 1,302 beds were under construction at year-end, with 573 for extended care.

Communities which witnessed completion of building programmes, including major construction, renovations, and alterations in 1970, were Creston, Kamloops, Kelowna, Murrayville, Princeton, Revelstoke, Surrey, Trail, and Victoria. Centres in which construction projects are currently under way included Burns Lake, Chetwynd, Chilliwack, Golden, Kelowna, Mackenzie, Nanaimo, North Vancouver, Ocean Falls, Penticton, Port Alberni, Prince Rupert, Richmond, Salmon Arm, Sechelt, and Surrey. It is anticipated the majority of these projects will be completed during 1971.

In 1970, coverage under the Hospital Insurance Service was extended to include a cytology service as an out-patient benefit. The cytology programme provides a laboratory service of great value in the early detection of cancer in women. The service, formerly under the administration of the Vancouver General Hospital, is now under the supervision of the British Columbia Cancer Institute.

Provision was also made during the year for coverage as an insured benefit of out-patient and day-care psychiatric services in selected hospitals. Such coverage provides a tremendous step in the over-all psychiatric-care programme, as it enables a person to return to his home after receiving treatments instead of remaining in hospital. These services are a very worth-while benefit to the public and represent a concept of care considered to provide an efficient way of reducing pressure on in-patient hospital beds.

The hospitals authorized to make available these insured benefits were Vancouver General; Royal Jubilee, Victoria; Lions Gate, North Vancouver; and the Prince George Regional Hospital. Prior to this the only coverage for psychiatric out-patient and day-care services was at the pilot project in the Health Sciences Centre Hospital at the University of British Columbia.

The Government also gave approval for construction of a number of diagnostic and treatment centres to provide emergency and out-patient services to communities located at a distance from hospitals and with sufficient population to support a physician's practice.

In early April, two members of the Australian Medical Association—Dr. Nicholas Larkins, secretary, and Dr. Lionel Wilson, council member—visited with British Columbia Hospital Insurance Service officials to inquire in broad terms into the relationship of the practising medical profession with the hospital service in British Columbia, and payment for physicians' services under the Canadian system. They also looked at the organization of hospital accreditation and the whole question of general practitioner access to hospitals, the role played in hospitals by general practitioners and the training of these practitioners. Another distinguished visitor inquiring about our services was William Naylor, Secretary and Chief Administrative Officer of the Sheffield Regional Hospital Board, Sheffield, England, who came here in June.

As in previous years, members of our senior staff were invited to attend the British Columbia Hospitals' Association Convention held in Vancouver in October. We are always grateful for the opportunity the conference presents to meet with representatives of the board of management, administrators, and nursing service from hospitals throughout the Province. In all, 66 meetings were held with hospital delegations during the three days.

During the year, the audio-visual and stockroom staffs of the Provincial Health Branch helped us with photography, printing, and films. This has meant a saving to Hospital Insurance, as otherwise it would have been necessary to have much of the work done outside.

The assistance of the other departments of the Provincial Government, which is always so readily available, was of tremendous value to our Service. The close working relationship that prevails with the Deputy Minister of Health and the Deputy Minister of Mental Health and their staffs, and the steps taken by the Minister of Health Services and Hospital Insurance to encourage that relationship, are particularly gratifying. There is an equally good relationship with the Chairman, Medical Services Commission and the staff of the Commission and the British Columbia Medical Plan.

It gives me great pleasure once again to express my sincere appreciation for the advice and guidance by the College of Physicians and Surgeons, the British

Columbia Medical Association, the medical profession generally, and for the continuing assistance of the British Columbia Hospitals' Association and the Registered Nurses' Association of British Columbia.

The work of the Laboratory and Radiological Advisory Councils was again of inestimable value in assisting hospitals to improve their laboratory and radiological service and in advising the British Columbia Hospital Insurance Service regarding the approval of Provincial grants-in-aid for the purchase of hospital equipment.

Reports submitted by the various divisions which comprise the administrative structure of our Branch appear under "Organization and Administration," commencing on page 21.

BRITISH COLUMBIA REGIONAL HOSPITAL DISTRICTS ACT

The Act provides for the division of the Province into large districts to enable regional planning, development, and financing of hospital projects to be carried out under a revised formula, which provides increased financial assistance from the Provincial Government toward the capital cost of hospital projects. The Province was divided into 29 areas, and 28 of them have been incorporated as regional hospital districts. The district not incorporated is located in an area without hospitals in the northern part of the Province.

As is the case with school construction, each regional hospital district will, subject to the requirements of the Act, be able to pass money by-laws authorizing debentures to be issued covering the total cost of one or more hospital projects. When approval has been obtained from the Minister of Health Services and Hospital Insurance, the district will be able to raise any funds immediately required by temporary bank borrowing on a uniform basis. The Regional Hospital Districts Financing Authority (*see* next page) will in due course issue and sell its own debentures in the amount required, which may cover a number of district debenture issues. At that time the districts will then be able to sell their long-term debentures to the Authority. Following this a district can repay any sum which has been temporarily borrowed.

Each year the Provincial Government will pay through the Hospital Insurance Service its share of the amortization cost in accordance with section 22 of the Act. Each district will in turn raise, by taxation, the remainder of the annual amortization cost required to retire its debentures which are held by the Authority.

Under the new formula the Province pays annually to each district 60 per cent of the net cost of amortizing the district's borrowings for an approved hospital project, after deduction of Federal Government capital grants and items which are the district's responsibility, such as provision of working funds for hospital operation, etc. If a 4-mill tax levy by the district is inadequate to discharge its responsibility in regard to annual charges on old debt for hospital projects, as well as the remaining 40 per cent of the charges on the new debt resulting from a hospital project, the Province will provide 80 per cent of the funds required in excess of the 4-mill levy.

The affairs of each regional hospital district are managed by a board comprised of the same representatives of the municipalities and unorganized areas who comprise the board of the regional district (incorporated under the *Municipal Act*) which has the same boundaries as the regional hospital district. The board of the regional hospital district will be responsible for co-ordinating the requests for funds from hospitals within the district, and for presenting money by-laws to the taxpayers in respect of either single projects or an over-all programme of hospital projects for the district.

A hospital society or corporation is not compelled to seek financing under this new Act. In situations where the community's share of the cost can be, or has already been, raised by other means, a Provincial Government grant under the old 50-per-cent formula can be applied for under the procedure which was applicable up to this time.

BRITISH COLUMBIA REGIONAL HOSPITAL DISTRICTS FINANCING AUTHORITY ACT

This Act establishes a Provincial Government authority similar to the one set up a few years ago to assist school districts in financing their projects. The functions of the Authority are referred to briefly in the second paragraph of the preceding commentary regarding the *Regional Hospital Districts Act.*

THE HOSPITAL INSURANCE ACT

This is the Statute which authorizes British Columbia's hospital insurance plan, and under which the British Columbia Hospital Insurance Service is established. The main provisions of this Act and the regulations may be summarized as follows:

(1) Generally speaking, every permanent resident who has made his home in British Columbia for at least three consecutive months is entitled to benefits under the Act.

(2) Approved hospitals are paid an all-inclusive *per diem* rate for medically necessary in-patient care rendered to qualified British Columbia residents who are suffering from an acute illnes or injury, and those who require active convalescent rehabilitative and extended hospital care. The payment made to a hospital by the British Columbia Hospital Insurance Service amounts to $1 less than the *per diem* rate approved for the particular hospital, and the patient is responsible for paying the remaining dollar. The Provincial Government pays the dollar-a-day charge on behalf of Provincial social welfare recipients.

(3) The wide range of in-patient benefits, together with out-patient benefits, which include emergency, minor surgery, day-care surgical, cancer therapy, psychiatric, cytology, and rehabilitative services, provided under the Act are described on the following pages.

(4) Qualified persons who are temporarily absent from British Columbia are entitled to certain benefits for a period of six months if they are admitted to an approved hospital within the first six months following their departure from the Province. These periods may be extended for an additional period of up to six months by the Lieutenant-Governor in Council.

THE HOSPITAL ACT

One of the important functions of the British Columbia Hospital Insurance Service is the administration of the *Hospital Act.* The Deputy Minister of Hospital Insurance is also the Chief Inspector of Hospitals for British Columbia under the Statute.

The *Hospital Act* controls the organization and operation of hospitals, which are classified as follows:

(1) Public hospitals—nonprofit hospitals caring primarily for acutely ill persons.

(2) Private hospitals. This category includes (*a*) small public hospitals, most of which are operated in remote areas by industrial concerns primarily for their employees, and (*b*) licensed nursing homes which are not under BCHIS coverage.

(3) Rehabilitation and extended-care hospitals. These are nonprofit hospitals approved under Part III of the *Hospital Act,* primarily for the treatment of persons who will benefit from intensive rehabilitative and extended hospital care.

PERSONS ENTITLED TO OR EXCLUDED FROM THE BENEFITS UNDER THE HOSPITAL INSURANCE ACT

Entitled to Benefits

A person is entitled to benefits if he qualifies as a beneficiary under the *Hospital Insurance Act.* Generally speaking, a person is a beneficiary if the provision of hospital care is a medical necessity, and if he establishes that he qualifies under one of the following categories:

(*a*) He is the head of a family, or a single person, who has made his home in the Province and has lived continuously therein during the preceding three consecutive months; or

(*b*) Having qualified under item (*a*), he leaves the Province temporarily and returns after an absence of less than 12 months and resumes residence within the Province; or

(*c*) He is living within the Province and is a dependent of a resident of the Province.

During the three-month residence qualification period, a person is permitted to be temporarily absent from British Columbia for a brief period without incurring any postponement of the date on which he becomes a beneficiary.

With regard to item (*c*) above, a dependent is either the spouse of the head of a family or a child under 21 years of age who is mainly supported by the head of a family.

Excluded From Benefits

Some of the main classes of persons either permanently or temporarily excluded from benefits are as follows:

(*a*) A person who works full or part time in British Columbia but who resides outside the Province; or

(*b*) A qualified person who leaves British Columbia temporarily and fails to return and re-establish residence within 12 months; or

(*c*) A qualified person who leaves British Columbia and who establishes residence elsewhere; or

(*d*) An inmate of a Federal penitentiary; or

(*e*) A resident who receives hospital treatment provided under the *Workmen's Compensation Act*, or a war veteran who receives treatment for a pensionable disability; or

(*f*) Persons entitled to receive hospital treatment under the Statutes of Canada or any other government; for example, members of the Armed Forces or Royal Canadian Mounted Police, and consular officials of other countries.

HOSPITAL BENEFITS AVAILABLE IN BRITISH COLUMBIA

In-patient Benefits

In addition to standard-ward accommodation with meals and necesary nursing services, a beneficiary may receive any of the other services available in the hospital, which may include:

Laboratory and X-ray services.

Drugs, biologicals, and related preparations (with a few exceptions).

Use of operating-room and caseroom facilities.

Use of anæsthetic equipment, supplies, and routine surgical supplies.

Use of radiotherapy and physiotherapy facilities where available.

Other approved services rendered by employees of the hospital.

(Note.—Private or semiprivate rooms cost more to maintain than standard wards, and the patient is required to pay extra for such accommodation if it is requested by or on behalf of the patient.)

Other Benefits

The following services and treatments are also provided in British Columbia public hospitals to beneficiaries who do not require in-patient care:

Emergency treatment within 24 hours of being accidentally injured.

Operating-room or emergency-room services for minor surgery, including application and removal of casts.

Day-care surgical services are available to patients who require operating-room or other specialized-treatment facilities, but who would be discharged within 24 hours.

Out-patient cancer therapy is provided by the branches of the B.C. Cancer Institute in Vancouver and Victoria.

Day-care and night-care psychiatric services are available to patients who come to hospital for an organized programme of treatment which requires that they remain for a minimum of seven hours, but does not necessitate formal admission as in-patients.

Out-patient psychiatric care is available to patients who come to the hospital only for a particular psychiatric service. (During 1970 the number of hospitals authorized to provide day-care and out-patient psychiatric services as insured benefits was increased.)

A cytology service, formerly handled with grants from the Health Branch, was transferred to BCHIS during the year. This service provides for examination by cervical smears for the early detection of cancer in women. The service is operated by the B.C. Cancer Institute and is universally available for residents of the Province.

Day-care rehabilitative services at the G. F. Strong Rehabilitation Centre in Vancouver apply to patients requiring an organized and comprehensive programme of treatment which would require that they remain at the centre for at least a half day.

A beneficiary is required to pay a nominal sum for each visit to the hospital for these services, and the remainder of the cost is paid by the British Columbia Hospital Insurance Service. Charges for medical services incurred at the hospital are not payable by the British Columbia Hospital Insurance Service, and nonbeneficiaries are required to pay the full charge for the hospital services and treatment received.

APPLICATION FOR HOSPITAL INSURANCE BENEFITS

At the time of admission to hospital, a patient wishing to apply for coverage under the hospital insurance programme is required to make an Application for Benefits. The hospital is responsible for verifying the patient's statements regarding length of residence, etc., to determine if the patient is a qualified resident as defined in the *Hospital Insurance Act* and regulations. Payment is then requested by the hospital from the British Columbia Hospital Insurance Service, which may reject any account where either the patient's status as a qualified resident or the medical necessity for his receiving hospital-care benefits has not been satisfactorily established. (*See* Eligibility Section.)

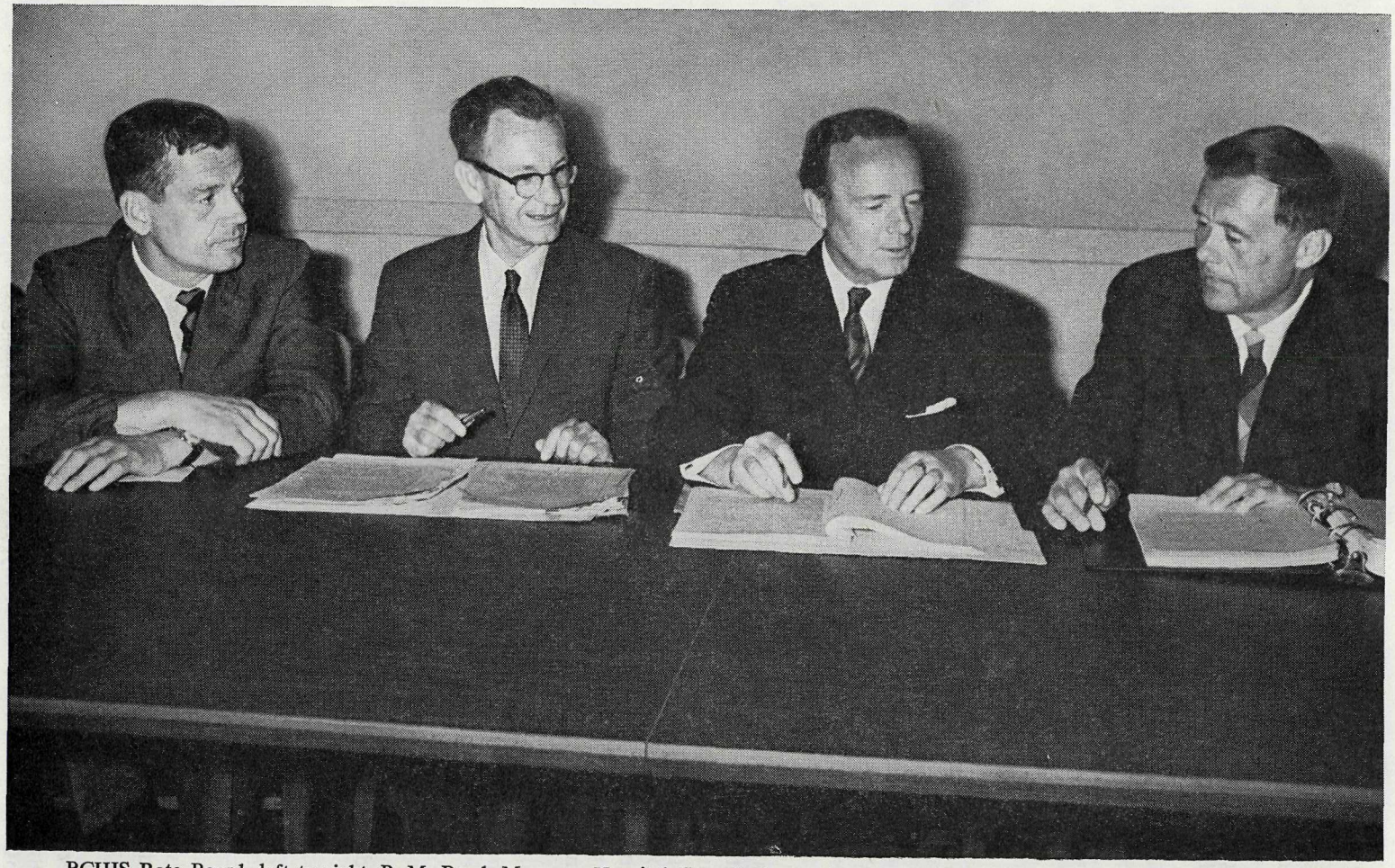
THE HOSPITAL RATE BOARD TO HOSPITALS AND METHODS OF PAYMENT

The Hospital Rate Board, appointed by Order in Council, is composed of the Assistant Deputy Minister of Hospital Insurance, *Chairman;* the Director of Hospital Consultation, Development, and Research, *Vice-Chairman;* the Hospital Finance Manager; and the Hospital Consultation and Inspection Manager. The purpose of the Board is to advise the Deputy Minister in regard to the rates of payments to hospitals for both in-patient and out-patient benefits.

A system of firm budgets for hospitals, which, with modifications, has been in use since January 1, 1951, provides for a review of hospitals' estimates by the Rate Board. Under the firm-budget procedure, hospitals are required to operate within their approved budgets, with the exception of fluctuation in days' treatment and other similar items. They are further advised that deficits incurred through expenditures in excess of the approved budget will not be met by the Provincial Government. However, hospitals retain surplus funds earned as a result of keeping expenditures within the total amount approved. The value of variable supplies used in patient-care has been established. It is generally recognized that the addition of a few more patient-days does not add proportionately to patient-day costs because certain overhead expenses (such as heating, etc.) are not affected. However, some additional supplies will be consumed, and it is the cost of these variable supplies which has been determined. When the number of days' treatment provided by the hospital differs from the estimated occupancy, the budgets are increased or decreased by the number of days' difference multiplied by the patient-day value of the variable supplies. Individual studies and additional budget adjustments are made in those instances where large fluctuations in occupancy involve additions or reductions in stand-by costs.

Policies to be used in the allocation of the total funds provided are approved by the Government. The Hospital Rate Board reviews the detailed revenue and expenditure estimates forwarded by each hospital and applies the policies in establishing approved budgets.

Approximately 96 per cent of all hospital accounts incurred in British Columbia are the responsibility of the British Columbia Hospital Insurance Service. Cash advances to hospitals are made on a semimonthly basis, so that hospitals are not required to wait for payment until patients' accounts are submitted and processed by the British Columbia Hospital Insurance Service. Qualified patients are charged $1 per day, which is deductible when calculating payments to hospitals from the Service. Nonqualifying residents are charged the hospitals' established *per diem* rates, which are all-inclusive; that is, the daily rate covers the cost of all the regular hospital services, such as X-ray, laboratory, operating-room, etc., provided to patients, in addition to bed, board, and nursing care.



BCHIS Rate Board, left to right, P. M. Breel, Manager, Hospital Consultation and Inspection Division; N. S. Wallace, Manager, Hospital Finance Division; W. J. Lyle, Assistant Deputy Minister, *Chairman;* J. W. Mainguy, Director, Hospital Consultation, Development, and Research, *Vice-Chairman.*

BCHIS PLANNING GROUP

The Planning Group co-ordinates and expedites planning for hospital facilities. Its functions are to review research reports on hospital bed needs; study submissions from hospitals and regional hospital districts for increases in beds or services; consider other problems related to orderly planning and provision of facilities and services to meet the needs of the Province; and to consider other matters referred to it by the Deputy Minister. The Planning Group is responsible for making recommendations on these matters to the Deputy Minister.

The regular members are as follows: Director, Hospital Consultation, Development, and Research, *Chairman;* Assistant Deputy Minister, *Vice-Chairman;* Medical Consultant; Manager, Hospital Construction and Planning Division; Director, Research Division; Manager, Hospital Consultation and Inspection Division.

Of the 27 meetings held during the year, six were with outside groups. Detailed discussions were held with the Advisory Committee of the Greater Vancouver Regional Hospital District regarding a number of programmes and studies initiated by that district.

There was increased activity by regional hospital districts in planning total hospital programmes to meet district needs, reflecting a trend evident in 1969. As recommended by the Planning Group, teams from the Service acted as consultants to the boards of the East Kootenay, Central Kootenay, and Comox-Strathcona Regional Hospital Districts to assist them in devising over-all programmes. The Service was also represented on the directing group of a study of health needs initiated by the Kitimat-Stikine Regional Hospital District. The Planning Group worked with other regional hospital districts in developing comprehensive programmes on which money votes were held.

The future planning of cancer-therapy services in the Province was studied by a special task committee appointed by the Medical Advisory Committee to the Service. This followed from discussions in 1969 between Planning Group and the Hospitals' Committee of the British Columbia Medical Association.

A revised system was set up for reviewing the hospital's functional programmes, which form the basis for the design of new hospital construction.

The Task Sub-committee which developed the publication *Hospitals for Extended Care, a Programme and Design Guide* in 1969 was reappointed in 1970 to restudy the guidelines to ensure construction at the lowest reasonable cost and also to review the comments which have come in on the original guide from persons and groups, both inside and outside the Province.

Studies of day-care services and of diagnostic and treatment centres were carried further. Day-care benefits under the Hospital Insurance Service were expanded as described elsewhere in this Report.

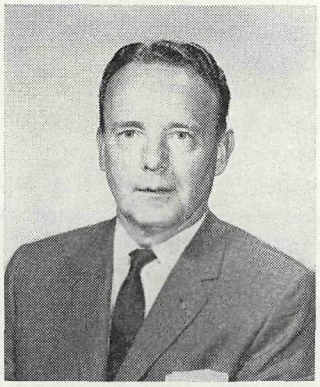
ORGANIZATION AND ADMINISTRATION

The British Columbia Hospital Insurance Service is a branch of the Department of Health Services and Hospital Insurance, the other branches being Health, and Mental Health Services. The administrative head of the Hospital Insurance Service is Mr. Donald M. Cox, F.A.C.H.A., Deputy Minister of Hospital Insurance.

The following reports provide a brief outline of the work carried out during 1970 by the various divisions and offices which comprise the administrative structure of this branch.

ASSISTANT DEPUTY MINISTER

W. J. LYLE, F.C.I.S.



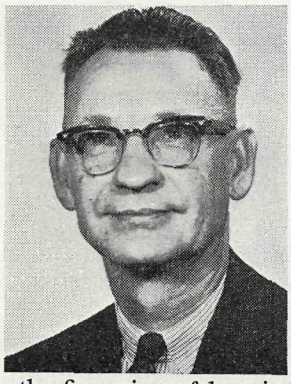
The Assistant Deputy Minister is responsible for the operation of the Hospital Finance Division, the Hospital Construction and Planning Division, and for the administration of the Service in the absence of the Deputy Minister. He is Chairman of the Hospital Rate Board (*see* page 19), Vice-Chairman of the BCHIS Planning Group (*see* page 21), and a member of the following committees: Advisory Committee on Hospital Insurance and Diagnostic Services (a committee appointed by the Federal Government to advise on the administration of the *Hospital Insurance and Diagnostic Services Act*), the Sub-committee on Finance, the Radiological Advisory Council, and the British Columbia Hospitals' Association Liaison Committee.

During 1970 the Assistant Deputy Minister was appointed by the Department of National Health and Welfare as liaison officer for British Columbia to work with the national steering committee on health-care costs.

A summary of the activities of the divisions for which the Assistant Deputy Minister is responsible follows.

HOSPITAL FINANCE DIVISION

N. S. Wallace, C.G.A., Manager



Hospital accounting, the payment of hospital claims, and financing of hospital capital projects are the three main functions of the Hospital Finance Division.

At the 1967 Session of the Legislature, two Acts were passed which changed the method of financing hospital capital projects—the *Regional Hospital Districts Act* and the *British Columbia Regional Hospital Districts Financing Authority Act*. The Finance Division is responsible for reviewing the annual budgets prepared by each regional hospital district as required by the legislation, and works closely with the Hospital Financing Authority and the regional hospital districts in the financing of hospital capital projects and repayment of debentures. During 1970, the Finance Division assisted the regional hospital districts in debenture sales to the British Columbia Regional Hospital Districts Financing Authority amounting to $18,500,000, and recommended capital grants of approximately $2,700,000 toward the repayment of principal and interest on capital borrowings of the regional hospital districts.

The Finance Division is also responsible for the approval of grants to assist hospitals in the purchase of equipment. In 1970, after a review of approximately 5,500 applications received from hospitals, grants estimated at $2,100,000 were approved on movable and fixed technical equipment costing $6,500,000.

As a means of assisting hospital employees to maintain high working standards, the Hospital Insurance Service provided over $135,000 during the year to enable hospital employees to attend or participate in short-term training programmes. This

was additional to the long-term educational training courses sponsored for certain hospital employees through Federal assistance.

Close liaison was continued with the Commissioner of Municipal Superannuation in respect to the application of the Act to hospital personnel, and the postponement of retirement for certain employees who reach maximum retirement age.

The Division Manager continued to perform duties as a member and Secretary of the Hospital Rate Board and as a member of the Sub-committee on Hospital Finance and Accounting (a subcommittee appointed by the Federal Government to advise on the administration of the *Hospital Insurance and Diagnostic Services Act*).

Experience during the first few years' operation of the British Columbia Hospital Insurance Service indicated that operating costs required serious consideration when planning new hospitals and additions to existing hospitals. In order to ensure that plans for new hospitals or hospital additions are prepared with economical and efficient operation in mind, a system of pre-construction operating budgets is used.

The procedure requires a hospital to prepare an estimate of staff and other costs, based upon a reasonable occupancy for the new area. These estimates are submitted to the British Columbia Hospital Insurance Service and are reviewed by the Hospital Rate Board in the same manner as normal operating estimates. It is essential that the estimated operating costs of the new hospital, or new addition, compare favourably with other hospitals actually in operation. Where the hospital's pre-construction operating estimates do not indicate a reasonable operating cost, it is necessary for the hospital board to revise its construction plans to ensure efficient and economical operation. Once a satisfactory pre-construction operating estimate has been agreed upon by the hospital officials and the British Columbia Hospital Insurance Service, the hospital board is required to provide written guarantees relative to the projected operating cost. It is considered that this method of approaching the operating picture for proposed hospital facilities ensures more satisfactory planning, efficient use of hospital personnel, and an economical operation.

Hospital Accounting

H. G. Benjamin, C.G.A., Supervisor

The five main functions of the Hospital Accounting Section are as follows:

(*a*) The assembling of relevant information and preparation of data for the use of the Hospital Rate Board in its review of hospitals' annual and pre-construction estimates. During this process estimated revenues and expenditures are examined in detail, and adjustments to estimated amounts are recommended. The gross expenditure approved by the Hospital Rate Board for public general, rehabilitation, and extended-care hospitals for the year 1970 amounted to $183,000,000.

(*b*) The detailed annual inspecting of each budget-review hospital for purposes of verification of annual and other financial statements. Final settlement with each hospital for that year is based on inspection and review results.

(*c*) The assembling of relevant information and preparation of data for the Deputy Minister in the review of the annual budgets of regional hospital districts.

(*d*) The auditing of hospital construction projects, in the field, to determine the amount shareable by the Province and the regional hospital district.

(*e*) The tabulating of monthly statistical and financial reports from hospitals, correlating these with approved budgets, and the calculation of semi-monthly cash advances to be made to hospitals.

Other functions performed by the Hospital Accounting Section include:

(*a*) The review and amendment of annual financial and statistical reports prepared by hospitals for submission to the Dominion Bureau of Statistics and the Department of National Health and Welfare.

(*b*) The preparation of monthly and annual claims on the Federal Government under the *Hospital Insurance and Diagnostic Services Act.*

(*c*) The tabulation of temporary borrowing for construction projects by regional hospital districts, and the calculation of the Provincial share to be paid to the district. The preparation and issue of debentures to replace short-term borrowing and the calculating of the Provincial share of repayment.

(*d*) The provision of accounting and financial assistance and instruction to public hospitals in the Province.

(*e*) The review of annual operating results and recommendation of year-end adjustments to the hospitals' approved budgets.

(*f*) The preparation of the Annual Report on Hospital Statistics covering the administration of the *Hospital Act.*

One hundred and fifty-five hospital-operating, pre-construction, and regional hospital district budgets were reviewed and processed in 1970. Inspection visits were made to each of 102 public general, rehabilitation, and extended-care hospitals during the year. Construction projects involving approved expenditures of $6,802,-400 were audited, and cost reports involving approved expenditures of $1,338,950 for minor construction projects were prepared for regional hospital districts.

Hospital Claims Section

W. J. Wade, Supervisor

The staff of Hospital Claims is responsible for processing the Admission-Separation Records (accounts), which hospitals submit for each patient, and approving for payment all acceptable claims. Assistance is provided to hospitals by this Section in the proper method of submitting the individual accounts. This is accomplished by correspondence, telephone, and personal visits. During the year the supervisor visited hospitals in the Vancouver Island, Lower Mainland, and Northern areas.

The filing, accounting, and review of the quarterly billings for extended-care hospital patients continued to increase in volume as new units were added to hospitals or new hospitals were added to the programme.

Research and adjustments to accounts, due primarily to changes of responsibility, showed an increase in volume.

Accounts processed were in excess of 1,800 per working-day for in-patients and over 850 emergency-service and minor-surgery account forms were handled per working-day. Discussions with the Data Processing Centre were continued during the year regarding the efficient use of the IBM electronic data-processing equipment. These included discussions on special surveys and statistical procedures.

A brief outline of the work and duties performed by the various offices of the Hospital Claims Section follows.

The staff of *Admission Control* reviews each application for benefits made by patients who claim to be qualified for benefits under the *Hospital Insurance Act.* Details of residence are checked with the verifying documents; during the year over

500 claims had to be returned each month to hospitals because they were incomplete or unacceptable.

Advice and assistance were given to hospital admitting staffs on the proper method of obtaining and recording the patient's residence information and employment history.

In order to further assist in the co-operation between the British Columbia Hospital Insurance Service and hospitals, the supervisor of Admission Control visited hospitals for discussions of the procedures being used for verification of the residence of patients.

A regional meeting held at Terrace was attended by representatives from hospitals in the northern part of the Province. Regional meetings were also held at Comox and Victoria and attended by representatives of Vancouver Island hospitals. The supervisor of Admission Control attended a seminar held by the British Columbia Hospital Association in Vancouver.

The *Accounts Payment* staff pre-audits the charges made to the British Columbia Hospital Insurance Service, and ensures that all information shown on each claim is completed so that it can be coded for statistical purposes, and that it is charged to the correct agency, such as the British Columbia Hospital Insurance Service, Workmen's Compensation Board, the Department of Veterans Affairs, or other provinces and territories. During the year over 6,000 queries on such accounting matters were addressed to the British Columbia hospitals.

Preliminary figures for 1970 show that more than 425,000 accounts (excluding out-of-Province) were processed. For comparison, the figures for 1969 were 415,-844 processed.

The *Day-care Surgical Services, Day-care/Night-care Psychiatric Services,* and *Out-patient Psychiatric* accounts increased in volume from over 1,900 per month in 1969 to over 3,100 per month at the year-end. Several new hospitals were authorized to make Day-care/Night-care and Out-patient Psychiatric Services available as an insured benefit.

The *Voucher and Key-punch* staff are responsible for batching and vouchering the checked accounts, in order to determine the amounts payable to each hospital and for punching of the IBM cards for each account. The cards are punched daily to record statistical, financial, and medical data, and are used to tabulate remittance listings of payments due to hospitals and for morbidity statistics for the Research Division. This procedure includes punching cards for out-of-Province accounts and Day-care Surgical Services accounts.

This section is also compiling statistics for a linkage study of congenital anomalies being carried on by the Atomic Energy of Canada Limited. The study will involve the punching of over 140,000 statistical IBM cards, of which 90,000 cards were punched at the year-end.

The Hospital Claims Section sends statements to patients advising them of the amount paid to hospitals on their behalf through the British Columbia Hospital Insurance Service. During the year, over 325,000 statements were prepared and mailed.

The *Out-of-Province* personnel process all claims for hospital accounts incurred by British Columbia residents in hospitals outside of the Province. This requires establishing eligibility and the payment of claim. During 1970, over 5,400 accounts, amounting to an estimated $1,900,000, were paid on behalf of qualified residents who were hospitalized in other provinces and territories of Canada and the continental United States, including Alaska and Hawaii; Australia, Austria, Belgium, Bermuda, Denmark, England, Finland, France, Germany, Greece, Guam, Holland, Hong Kong, India, Iran, Ireland, Israel, Italy, Japan, Java, Kenya, Malaysia, Mexico,

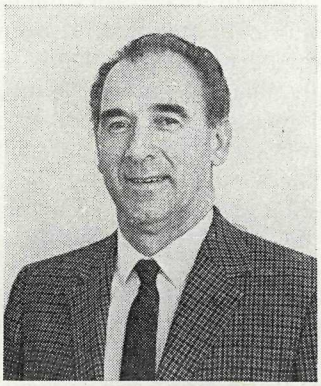
Nepal, New Zealand, Norway, Philippines, Portugal, Puerto Rico, Republic of China, Republic of Panama, Saint Lucia, South Africa, Spain, Sweden, Switzerland, Taiwan, Trinidad, and Yugoslavia.

Correspondence to accomplish the procedures amounted to over 19,000 letters for the year. This office also compiles up-to-date hospital rate schedules for every approved hospital in Canada. All accounts were coded for statistical purposes and an IBM card punched for each account.

The *Filing and Mail Unit* sorted and filed over 8,000 documents and letters daily, an increase of 1,500 over last year. The filing system was expanded and new procedures instituted, in order to accommodate the increase.

Hospital Construction and Planning Division

John Glenwright, Manager



The main functions of this Division can be briefly described as follows:

1. The Division provides hospital boards of management, their architects and planning committees, with a consultative service in the planning of hospital construction projects, including new hospital facilities as well as additions and renovations to existing hospitals. Special emphasis is given to the need for the development of written functional programmes for construction projects related to the proposed new or expanded facilities.

During the year a great deal of time was spent in reviewing programmes and plans of proposed hospital projects, both at the sketch-plan stage and the working-drawing stage. Drawings and architectural programmes which evolved from the hospital's functional programme were reviewed with the various professions represented in the Consultation and Medical Consultation Divisions, as well as in allied organizations, including the Radiology Advisory Council and the Laboratory Advisory Council.

Reviews are made with several objectives in mind, but basically the intent is to ensure that, in terms of the capital funds available, the greatest benefit consistent with economical operation is derived from the construction projects. In planning hospital facilities, attention is also given to the need and method of future expansion in conjunction with the logical and best use of the hospital site. Proposed hospital sites are approved by this Division, and direction and guidance are given in site selection. Wherever possible, potential sites are inspected by a member of the Division. During the year, approximately 250 sets of plans were received by the Division. These drawings covered many phases of planning, including small-scale schematic drawings, preliminary sketch drawings, large-scale detailed drawings, and final working drawings and specifications, including the architectural, mechanical, electrical, and plumbing drawings.

2. The division is responsible for processing, and recommending for approval, applications for Provincial grant assistance, either by direct grants-in-aid or by funds provided through regional hospital districts, for major expansion and improvement projects as well as minor renovations for all public hospitals throughout the Province.

Continuing benefit was derived during 1970 from the co-operation of the Department of Public Works in the assignment of architects to this Division.

In March, John Glenwright returned to his former position as Manager of the Hospital Construction and Planning Division following 1½ years as Administrator of the Matsqui-Sumas-Abbotsford General Hospital. The Manager of the Division is a member of the BCHIS Planning Group, which has the responsibility of reviewing and making recommendations to the Deputy Minister on matters concerning the development of hospital facilities throughout the Province. He is also Chairman of the Functional Programme Review Committee and a member of the Equipment Committee, which are subcommittees of Planning Group.

Mr. J. M. Phillips, Senior Architect of the Division, continued during the year as a member of the Hospital Cost Analysis Group.

Through the co-operation of Health Branch personnel, and members of the medical and nursing profession, hospital boards were provided with a full consultative planning service. The Provincial Health Branch provided assistance through the Technical Supervisor of Clinical Laboratory Services and the Technical Supervisor of Radiology. Through the co-operation of the Provincial Department of Labour, the Office of the Inspector of Factories provided a consultative service to this Division, related to proposals for elevators and dumb-waiter installations in hospitals.

The Manager of the Division acted as a member of the committee established to review and recommend revisions to the publication *Hospitals for Extended Care, a Programme and Design Guide.*

In the interests of applying effective cost-control measures for capital-expenditure projects, policy was established requiring that independent quantity surveyors be retained by hospitals on all major construction projects. The Manager and members of the Division participated in the production of the booklet *Cost Control in Hosptial Design, Using Quantity Surveyors,* which is designed to clarify the role of the quantity surveyor. The booklet includes an outline of the function of a quantity surveyor as well as recommended procedures for preparing estimates and a draft of a suggested form of agreement between the hospital and the quantity surveyor.

During the year, liaison was maintained with the mechanical engineering profession in recognition of the need to design high-quality mechanical systems which would make a maximum contribution toward an efficient and economical hospital operation. Some of the elements included in designs for mechanical systems for new hospital buildings, reflecting this approach, included air recirculation and zoned heating and ventilating controls. Consultative advice is provided in the field of plant operation and maintenance and equipment selection. During 1970, 24 visits were made for inspection and advice pertaining to hospital mechanical plants and electrical installations. A simplified system of preventive maintenance, i.e., the Comac System, has been introduced and is either in use or is being incorporated in 16 hospitals throughout the Province.

Liaison was maintained with the Hospitals Committee of the Architectural Institute of British Columbia. The function of this committee is to review and endeavour to resolve problems arising out of hospital construction projects which affect members of the Architectural Institute. An architect on the Division's staff is a member of this committee.

During 1970, the architects and engineers made a number of inspectional, advisory, and educational visits to hospitals throughout the Province. In addition, the Manager visited convalescent hospitals in California to make comparisons between these facilities and extended-care units in British Columbia.

(*a*) *Hospital Projects Completed During 1970*

Chilliwack General Hospital, Chilliwack—Phase I of expansion programme: Moving nurses' residence and altering building for alternate use.

Creston Valley Hospital, Creston—On May 4, 1970 the Honourable W. D. Black officially opened the expanded Creston hospital. This project involved the construction of a wing, bringing the total capacity up to 52 beds; of these, 44 are being used. The addition included new emergency and administrative departments, new operating-rooms, and boiler-room; also, extensive renovations were carried out in the existing hospital.

Houston Diagnostic and Treatment Centre—The construction of this new facility was completed late in the year and it is now expected to be officially opened and brought into service in the new year.

Royal Inland Hospital, Kamloops—Thirty additional acute and 10 additional psychiatric beds were brought into service on May 1, 1970, as a result of renovations to this hospital.

Kelowna General Hospital, Kelowna—The new acute addition to the Kelowna General Hospital was officially opened by the Honourable Ralph R. Loffmark, Minister of Health Services and Hospital Insurance, on February 28, 1970. This new building, known as Block B, contains 175 acute beds and most of the diagnostic and treatment services for the hospital complex. The 71-bed extended-care unit was also completed this year and the first patients were admitted on December 2, 1970.

Nicola Valley General Hospital, Merritt—A four-bed ward was completed at this hospital and brought into service on January 1, 1970, making the revised capacity of this hospital 41 acute beds.

Langley Memorial Hospital, Murrayville—All unfinished areas in this hospital have now been completed, and by moving the 10 activation beds out of the extended-care unit, 10 additional extended-care beds have been gained. The revised capacity of this hospital is now 107 acute and 50 extended-care beds.

Powell River General Hospital—The last four beds left unfinished in the extended-care unit were completed and brought into service on January 2, 1970. The revised capacity of this unit is now 34 extended-care beds.

Princeton General Hospital—The Honourable Ralph R. Loffmark officially opened the new 25-bed acute hospital at Princeton on May 9, 1970. However, due to the construction strike during the summer which delayed the final completion of the building, patients were not admitted or transferred until October 17.

Queen Victoria Hospital, Revelstoke—The construction strike also delayed by several months the completion of the new hospital at Revelstoke, which was officially opened by the Hon. Ralph R. Loffmark on December 19, 1970. The new building, which has 50 acute beds and 10 more beds which can quickly be brought into use when required, replaces the old hospital, part of which dated back to 1901.

Mater Misericordiæ Hospital, Rossland—Renovations.

Surrey Memorial Hospital—A 78-bed extended-care unit was completed and placed in operation during May 1970.

Trail Regional Hospital—Two projects were constructed concurrently at this hospital—a 50-bed extended-care unit and an addition to provide 24 psychiatric beds on one floor and a regional laboratory above. Both projects were opened officially on January 31, 1970.

Royal Jubilee Hospital, Victoria—New laboratory facilities were officially opened at this hospital on January 16, 1970, as a result of adding another floor onto the South Wing. Adjacent areas were also renovated as part of the project.

(*b*) *Hospital Projects Under Construction at Year-end*

Burns Lake and District Hospital—Construction of additions and alterations to provide an additional 17 acute beds and six extended-care beds.

Chetwynd and District Hospital—A new facility of 30 acute beds to serve the Chetwynd and Hudson's Hope area.

Chilliwack General Hospital—Phase II of the expansion project is currently under way involving an addition for 75 extended-care, 20 psychiatric, and 16 activation beds; new laboratory, physical medicine and dietary departments, laundry; plus the renovation of part of the existing hospital.

Fort St. James Hospital—A new facility of 25 acute beds.

Golden and District General Hospital—Additions and alterations to provide eight more acute beds (plus two unfinished) and six extended-care beds.

Victorian Hospital, Kaslo—A new hospital of 10 beds is being built to replace the existing Kaslo hospital.

Mackenzie and District Hospital—Construction of a prefabricated unit of 18 beds.

Nanaimo Regional General Hospital—Construction of a two-story addition to provide 24 psychiatric and 25 activation/rehabilitation beds and an 84-bed extended-care unit, as well as renovations, etc.

Royal Columbian Hospital, New Westminster—The construction of modular units to provide 174 acute beds temporarily to allow the demolition of the 1912 Wing preparatory to the construction of permanent additions to the hospital; plus renovation of existing areas.

Lions Gate Hospital, North Vancouver—A 169-bed extended-care unit is being constructed adjacent to the acute hospital.

Ocean Falls General Hospital—Renovations to an existing building, Kimsquit Lodge, are being carried out to convert the building to a 12-bed hospital.

Penticton Hospital—An extensive expansion programme at this hospital involves the construction of additions to provide a further 38 acute beds, 63 extended-care beds, a floor in "shell" form, enlarged diagnostic and treatment facilities, and renovations to the existing building.

West Coast General Hospital, Port Alberni—Due to the strike, construction has been delayed and work on the additions and renovations is still under way to provide a net gain of 28 additional acute beds, a 30-bed extended-care unit, and renovation of the existing building.

Prince Rupert General Hospital—New hospital of 128 acute beds and 18 extended-care beds to replace the existing building.

Richmond General Hospital—Construction of a 75-bed extended-care unit adjacent to the acute hospital.

Shuswap Lake General Hospital, Salmon Arm—Additions and alterations to provide 12 more acute beds, plus 25 extended-care beds.

St. Mary's Hospital, Sechelt—Expansion of the hospital to 45 acute beds.

Surrey Memorial Hospital—One hundred and eighty-six acute beds and supporting services which form part of the major expansion programme under way since 1968 were declared "open" by the Honourable Ralph R. Loffmark on December 13, 1970. Patients were transferred a few days later to the new wings so that the renovation of the older parts of the hospital could be started.

Vancouver General Hospital—Tenders were received and it is anticipated that construction of the 201-bed extended-care unit will commence.

St. John Hospital, Vanderhoof—New 45-bed acute hospital to replace existing building.

In addition, at the year-end, the following projects were out to tender:

Lady Minto Hospital, Ashcroft—New 41-bed acute hospital.

G. F. Strong Rehabilitation Centre, Vancouver—Expansion of hospital and facilities to 100 beds, plus "shell" floor.

Gorge Road Hospital, Victoria—Addition to provide 300 extended-care beds.

(*c*) *Projects in Advanced Stages of Planning*

Burnaby General Hospital—Extended-care unit.
Chilliwack General Hospital—Renovations.
Lady Minto Gulf Islands Hospital, Ganges—Extended-care unit.
Fraser Canyon Hospital, Hope—Expansion.
Kelowna General Hospital—Renovation of previous main hospital building.
Royal Columbian Hospital, New Westminster—New power plant.
St. Martin's Hospital, Oliver—Replacement.
Prince George Regional Hospital—Expansion and extended-care unit.
Vancouver General Hospital—Willow Pavilion renovations.

(*d*) *Additional Projects Approved and in Various Planning Stages in 1970*

R. W. Large Memorial Hospital, Bella Bella—Replacement.
Burnaby General Hospital—Expansion of acute beds and services.
Campbell River and District General Hospital—Expansion.
Clearwater—Diagnostic and treatment centre.
St. Joseph's General Hospital, Comox—Expansion.
Cranbrook and District Hospital—Expansion of extended-care unit.
Cowichan District Hospital, Duncan—Extended-care unit.
Fernie Memorial Hospital—New hospital to serve Fernie and Michel areas.
Gold River—Diagnostic and treatment centre.
Boundary Hospital, Grand Forks—Extended-care unit.
Wrinch Memorial Hospital, Hazelton—Replacement of acute hospital, plus seven extended-care beds.
Windermere District Hospital, Invermere—Expansion.
Royal Inland Hospital, Kamloops—Expansion, including extended-care unit, psychiatric and activation/rehabilitation beds.
Kimberley and District Hospital—Renovations to complete five additional acute beds, air-conditioning, etc.
Ladysmith and District General Hospital—Expansion (six beds).
Lillooet District Hospital—Expansion of acute beds, plus extended-care unit.
Maple Ridge Hospital—Expansion of acute hospital and extended-care unit.
Mount Waddington Regional Hospital District—Approval given to acquire a site and plan a central regional hospital facility, construct ambulatory care and diagnostic facilities at Rumble Beach and Port Hardy, and renovate St. George's Hospital, Alert Bay.
Langley Memorial Hospital, Murrayville—Expansion.
Arrow Lakes Hospital, Nakusp—Replacement to serve Nakusp and New Denver.
Kootenay Lake General Hospital, Nelson—Expansion of services and bed reallocation.
Royal Columbian Hospital, New Westminster—Acute expansion and extended-care unit.
Lions Gate Hospital, North Vancouver—Expansion of services.
One Hundred Mile District General Hospital, One Hundred Mile House—Expansion.

Pouce Coupe Community Hospital—Conversion of acute beds to extended care.

G. R. Baker Memorial Hospital, Quesnel—Extended-care unit.

Saanich Peninsula—New 75-bed acute hospital (replacing Rest Haven Hospital, Sidney) and 75 extended-care beds.

Bulkley Valley District Hospital, Smithers—Expansion.

Squamish General Hospital—Renovations.

Stewart General Hospital—Expansion.

Tahsis—New hospital to replace Esperanza General Hospital.

Children's Hospital, Vancouver—Replacement.

Holy Family Hospital, Vancouver—Expansion and extended-care unit.

Mount St. Joseph's Hospital, Vancouver—Expansion and extended-care unit.

St. Paul's Hospital, Vancouver—Services expansion.

St. Vincent's Hospital, Vancouver—Expansion of services, psychiatric beds, extended-care unit, etc.

Vancouver General Hospital—Activation/rehabilitation unit.

Health Science Centre, Vancouver—Acute hospital (Phase III).

Mount St. Mary Hospital (St. Joseph's), Victoria—Extended-care beds.

Priory Hospital, Victoria—Extended-care unit.

Royal Jubilee Hospital, Victoria—Renovations.

St. Joseph's Hospital, Victoria—Renovations.

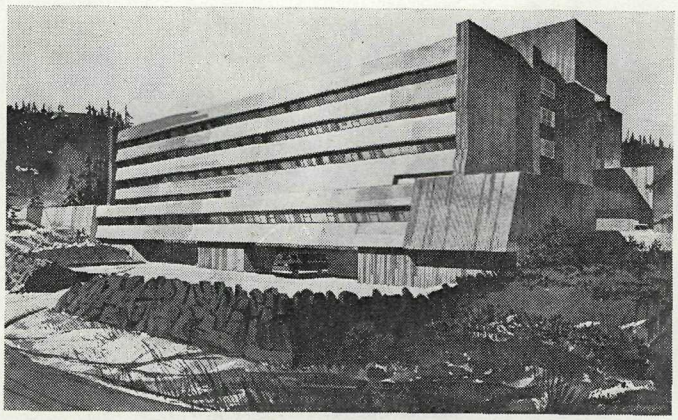
Cariboo Memorial Hospital, Williams Lake—Expansion.

Major Hospital Projects, 1970

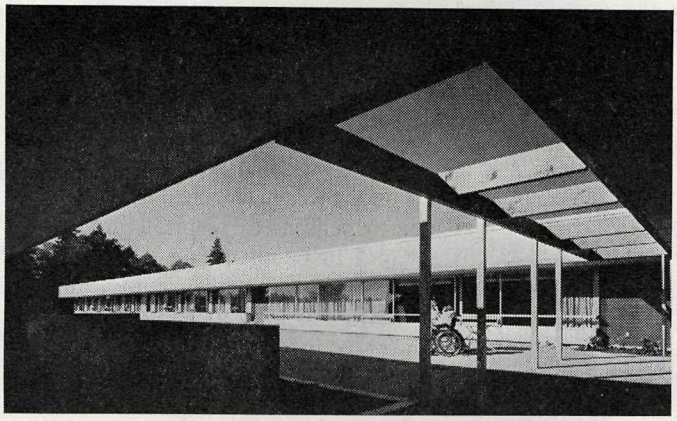
Completed—Creston, Kamloops, Kelowna, Princeton, Revelstoke, Surrey, Trail, Victoria (Royal Jubilee).

Under Construction—Burns Lake, Chetwynd, Chilliwack, Fort St. James, Golden, Kaslo, Mackenzie, Nanaimo, New Westminster (Royal Columbian), North Vancouver (Lions Gate), Ocean Falls, Penticton, Port Alberni, Prince Rupert, Richmond, Salmon Arm, Sechelt, Surrey, Vanderhoof.

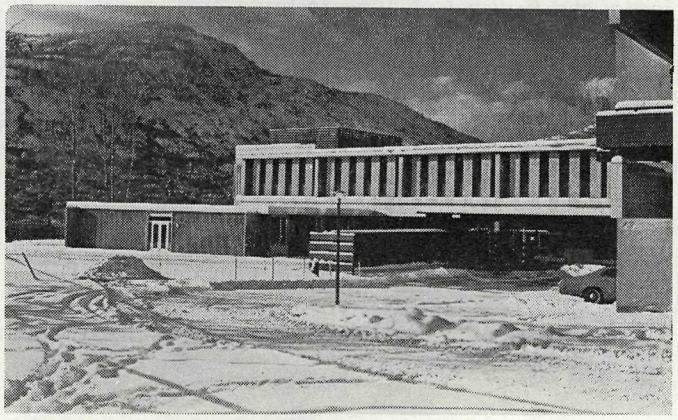
For details, *see* pages 28, 29, and 30.



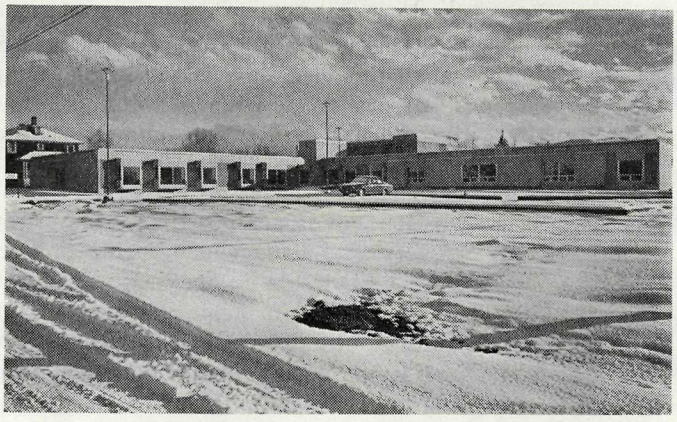
Architect's perspective of the new Prince Rupert Hospital now under way. (Architects: Thompson, Berwick, Pratt and Partners.)



The new Extended-care Unit at Surrey Memorial Hospital. (Architects: Underwood, McKinley, Cameron, Wilson, Smith and Associates.)



The new Psychiatric Unit and Regional Laboratory addition at Trail Regional Hospital. (Architects: Paul Smith Associates.)



The recently completed Extended-care Unit at Kelowna General Hospital. (Architects: McCarter, Nairne and Partners.)

DIRECTOR OF HOSPITAL CONSULTATION, DEVELOPMENT, AND RESEARCH

J. W. Mainguy, M.H.A.

The Director is responsible for the operation of both the Hospital Consultation and Inspection Division and the Research Division, and is Assistant Chief Inspector of Hospitals under the *Hospital Act,* the Chief Inspector being the Deputy Minister. The Director is responsible for the administration of the Service in the absence of the Deputy and Assistant Deputy Minister. He is Chairman of the BCHIS Planning Group and Vice-Chairman of the Hospital Rate Board. The work undertaken during the year in connection with these activities is outlined on pages 21 and 19 respectively. He represents the Service on a number of committees of Government and community agencies, including the Co-ordinating Committee on Paramedical Training of the British Columbia Institute of Technology, Burnaby; the Liaison Committee between the Service and the British Columbia Hospitals' Association; and the Sub-committee on Quality of Care and Research, Ottawa.

The Director participated in a research project, under Federal Public Health Research Grant 609-7-197, on a system of patient classification according to need for nursing care. The study was conducted through the Vancouver General Hospital and involved five British Columbia hospitals.

The Hospital Administrators' Association and the British Columbia Hospitals' Association instigated discussion and reviews of the National Task Force Reports on the Cost of Health Services in Canada. The Director, who was chairman of one of the task forces, was involved in these programmes.

Reports of the activities undertaken by the two Divisions responsible to the Director follow.

Hospital Consultation and Inspection Division

P. M. Breel, Manager

This Division provides public and private hospitals with consultative services in all matters of hospital operation and administration. It is responsible for an inspectional programme to ensure that basic standards are met, and for the licensing of private hospitals.

Its staff is composed of administrative, nursing, dietary, and management engineering consultants.

The Division co-operates with all other divisions of the Service in achieving aims of mutual interest and responsibility. It is responsible for the analysis, and subsequent recommendations, for approved staffing patterns resulting from hospital estimates. The Manager is a member of the Hospital Rate Board, the Planning Group, the Functional Programme Review Committee, and the Equipment Committee. Staff members also participate in the hospital-planning functions of the British Columbia Hospital Insurance Service, including the review of the operational implications of

construction projects, and the setting of standards. Programmes and plans for construction are analysed and assessed, in conjunction with the Medical Consultation and Hospital Construction and Planning Divisions. The Division represents the Service on a large number of councils, committees, and working parties associated with hospitals and the health field, and works with Federal, Provincial, and municipal representatives on related matters.

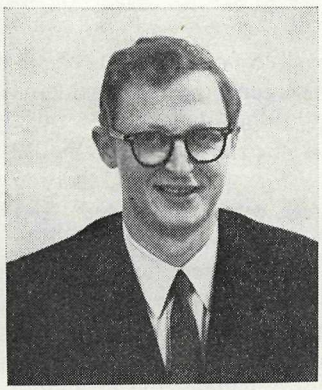
During 1970, 278 staff visits were made to acute, rehabilitation, chronic, convalescent, and extended-care hospitals. In addition, 203 visits by nursing and other staff consultants were made to private hospitals giving nursing-home care.

During the course of 1970 the Management Engineering Unit has expanded its scope of activities in hospitals. Study reports, released with the approval of the hospitals concerned, were circulated throughout British Columbia, other parts of Canada, the United States, and the United Kingdom. Consulting services are now being provided in addition to in-depth studies.

Personnel of the Division attended a variety of educational sessions during the year, as a necessary means of keeping abreast of changing concepts and techniques in the hospital field.

Research Division

Wm. E. Selwood, B.A., *Acting Director*



The Research Division is responsible for compiling and maintaining statistical data relating to hospitalization and morbidity in British Columbia. The hospitals submit Admission/Separation Records for each in-patient and a similar record for each out-patient. These records serve as the major source of reference in deriving statistical information. The data used are key-punched by the Hospital Claims Section of this Service, and then transferred to magnetic tape by the Data Processing Division of the Department of Industrial Development, Trade, and Commerce, which produces the required tabulations.

Each year the Division carries out bed-requirement studies and prepares statistical data on hospital utilization at the request of hospitals and independent consultants. During 1970, over 80 requests were answered involving patient-flow data and population-growth projections relating to hospital catchment areas, school districts, and regional hospital districts.

The formation of regional hospital districts has brought about a greater need for determining hospital requirements on a regional scale, particularly concerning services that can be shared by one or more hospitals within a region. During 1970, the Division took part in "team visits" to several regional hospital districts for the purpose of providing guidelines for hospital development on a regional basis. The team consisted of members from several divisions of this Service, and following each visit a report was prepared for the region, outlining the needs for each of the defined levels of hospital care. The regions visited were East Kootenay, Central Kootenay, and Comox-Strathcona.

The Division is responsible for the publication of several annual bulletins which have, over the years, been useful to various research groups and agencies throughout the Province and Canada. This year the publications have been redesigned to

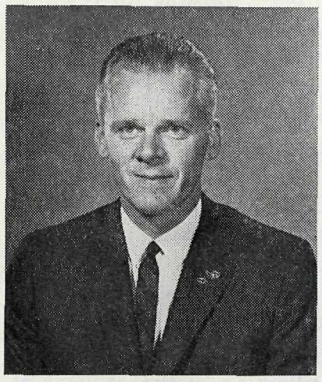
conform to the change from the 7th revision of the *International Classification of Diseases, Adapted,* to the 8th revision. *Statistics of Hospital Cases Discharged During 1969,* completed during the year, included standard morbidity tables as suggested by the Federal Advisory Committee on Hospital Insurance and Diagnostic Services, along with an analysis of the Province's hospitalization experience by race, age, regional hospital district, major diagnostic group, and type of service. *Statistics of Hospitalized Accident Cases* provided a broad analytical coverage of hospitalized accidents by circumstance, by type of accident, and by nature of injury. Another bulletin prepared and issued by the Division was an *Alphabetical Listing of Place-names in British Columbia, With Geographical Code.* In addition, a number of statistical tables, entitled "Hospital Indicators," were circulated to all hospitals. The format and detail of several tables were modified in order to give a broad view of hospitalization on a regional scale. However, these indicators still allow the individual hospital to focus attention on its own performance, as well as making a comparison with hospitals of a similar size-group.

An increasing number of special requests by community agencies, private organizations, and by Government are processed each year.

Mr. D. S. Thomson, Director of the Research Division, is presently on educational leave, and will be returning in mid-1971.

MEDICAL CONSULTATION DIVISION

D. G. Adams, M.D., Medical Consultant



This Division is responsible for medical consultation within the Service, between other Departments of Government, with hospitals at all levels of care, and with regional hospital districts. Additionally, the Division is responsible for the medical coding and assessing of all discharge records received from hospitals, and for the central screening and quarterly review of patients for eligibility under the extended-care programme.

The Admission/Separation Record, which is completed for each patient admitted to a hospital either in British Columbia or outside of the Province, is assessed with regard to its medical aspects by this Division. This review includes coding, which is done in accordance with the "International Classification of Diseases, Adapted for Indexing Hospital Records by Diseases and Operations," and is a function which requires the professional knowledge and training of medical coders. The competence and accuracy applied to this work is reflected in the statistical end-product, and, to ensure a continuing high standard, all coders on the staff of this Division are graduate nurses. The statistical data are basic to planning decisions, for expanding or developing hospital facilities generally, and special departments in certain hospitals, in particular. In addition, this coded information is utilized by the Research Division of the British Columbia Hospital Insurance Service and the Dominion Bureau of Statistics for the publication of hospital morbidity and mortality data. Other functions of the review include bed usage, identifying special area requirements by reason of geographical or industrial development, and assessing complicated individual cases, when required.

The assessment and review of individual patients' applications for extended-care coverage continued to provide an increasing work load. A quarterly review of

all extended-care hospitals was undertaken, with two objectives—(1) a medical audit, to ensure patients continue to be medically qualified for this benefit, and (2) for the purpose of reviewing and assisting in the treatment programme provided by the hospital in order that the care which the patient receives is commensurate with current thinking in the management of chronically disabled individuals. In the development of this programme the Medical Consultation Division had the assistance of qualified consultants in physical medicine and physiotherapy, whose specialized knowledge has been of great value. New extended-care units were opened during the year, increasing the application review load, and at the same time placing increased demands for professional advice on the implementation of treatment programmes in these new units.

Dr. D. M. N. Longridge, Assistant Medical Consultant, has major administrative supervisory responsibility for the Coding Section, and the survey and review projects previously mentioned. In addition, administration of the medical aspects of the extended-care programme is under his supervision. Management of the day-to-day problems which arise in the administration of these matters enables Dr. Longridge to participate with the Medical Consultant in the preparation of policy recommendations to the Deputy Minister, dealing with hospital conditions and needs.

Day-care surgical services, approved as a hospital insurance benefit in 1968, have improved the utilization of the Province's health facilities, and the Medical Consultant continued to advise the Service in its planning for an expanded role in ambulatory patient care. As was the case with the in-patient admission records, all day-care surgical services records were assessed and coded according to the International Classification of Diseases, so that this data may be tabulated in preparation for statistical reviews.

The Medical Consultants provided continuing and active liaison with all health agencies, through visits to hospitals, special disease groups, societies, regional hospital districts, and professional bodies. Liaison with the British Columbia Medical Association has become particularly important, and active participation on its Hospitals Committee and the Advisory Sub-committees on Chronic Renal Failure, Intensive Cardiac Care, Nuclear Medicine, and Cancer Therapy Services continued during the year.

The encouragement of hospitals to achieve accreditation standards imposes certain pressures to conform to the requirements of accreditation, and when these pressures produce problems for the medical staff of the hospital, the Medical Consultant is able, with the assistance of the Hospital Consultation and Inspection Division, to render assistance.

The Medical Consultants assist in the planning and implementation of new services in hospitals by representation on the Planning Group, the Equipment Committee, and the Functional Programme Review Committee at the Hospital Insurance Service.

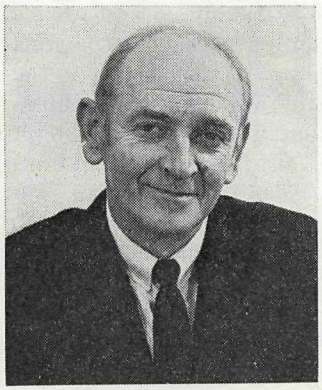
The Medical Consultant and the Assistant Medical Consultant participated in the postgraduate continuing medical education programmes sponsored through the university and the Provincial and local medical societies, as well as special and pertinent continuing medical education seminars or courses offered outside British Columbia.

The Medical Record Consultant serves in a consultative capacity to the British Columbia Hospital Insurance Service, and also to hospitals within the Province. During the year, visits were made to hospitals, primarily to encourage a high standard of medical record-keeping, in accordance with the guidelines offered by the Canadian Council on Hospital Accreditation. Emphasis is placed on the need

for accuracy and adequacy in the reporting of diagnoses and surgical procedures for coding purposes. This ensures the production of meaningful statistical and research studies undertaken by this Division and the Research Division. Plans for construction and renovation projects for various hospitals were reviewed and assessed, according to the work load within the respective medical record departments. Participation as a member of the Provincial Education Committee of the British Columbia Association of Medical Record Librarians ensured further liaison with medical record personnel.

ADMINISTRATIVE OFFICER

K. G. Wiper



The Administrative Officer is responsible for the drafting of legislation, regulations, and Orders in Council for the British Columbia Hospital Insurance Service. In the performance of these duties, a close working relationship exists between this office and the Attorney-General's Department.

Hospital societies may apply to the Administrative Officer for assistance in connection with the drafting of hospital constitutions and by-laws, and their interpretation and application. Changes in hospital by-laws were reviewed by this office prior to their submission for Government approval, as required under the *Hospital Act.* A set of model by-laws has been developed for use by hospitals as a guide in making revisions.

Under the *Regional Hospital Districts Act,* described earlier in this Report, the Administrative Officer worked closely with the officials of other departments and of the various districts in arranging for money by-laws, temporary borrowing, and related matters.

In collaboration with the Hospital Consultation and Inspection Division, the Administrative Officer processes, for approval under section 14 of the *Hospital Act,* transfers of private-hospital property and transfers of shares in the capital stock of private-hospital corporations. In addition, close liaison is maintained with the Land Registry Office to ensure that the property records of both general hospitals and private hospitals are suitably endorsed so that land transfers are not made until they are approved under sections 14 (2) and 41 (1) (*c*) of the *Hospital Act.*

As in previous years, considerable time was spent in 1970 on matters related to the Federal-Provincial hospital insurance arrangements. Methods of streamlining administrative procedures and improving liaison were discussed with officials of the Federal Government and other provinces at meetings held in Ottawa and Victoria.

The Administrative Officer is the Personnel Officer for the British Columbia Hospital Insurance Service. He is also responsible for the over-all supervision of the General Office and the Third-party Liability and the Eligibility Sections.

Eligibility Representatives' Section

P. A. Bacon

In order to ensure that only qualified British Columbia residents receive hospital insurance benefits, the staff of the Eligibility Section review the Applications for Benefits made by, or on behalf of, persons admitted to hospital. A detailed check is made of all doubtful applications, resulting in the rejection of a consider-

able number of claims for hospital insurance benefits made by unqualified persons. Numerous inquiries from the general public with regard to eligibility matters are dealt with by personal interview, telephone, and correspondence.

Eligibility Representatives visit hospitals on a regular schedule to see that the British Columbia Hospital Insurance Service eligibility procedures are being properly carried out. The Representatives also assist in the training of hospital admitting personnel to deal with problems connected with the admission of patients to hospitals and the determination of their status under the *Hospital Insurance Act*. This training assistance is provided by means of visits to hospitals and by regional meetings.

This Section keeps the great majority of employers in British Columbia supplied with certificates on which an employee's length of employment can be certified. The Representatives maintain close liaison with these firms to ensure their continuing co-operation in providing their employees with this form of proof of residence for hospital insurance purposes.

Close liaison is maintained with the British Columbia Medical Plan, and Eligibility Representatives supply Medical Plan applications and information to the general public in many communities throughout the Province. Regional representatives are located in Prince George, Kamloops, Nelson, and Kelowna, as well as in Vancouver and Victoria.

Third-party Liability Section

J. W. Brayshaw

The hospitalization reports that are completed by hospitals for every patient admitted with accidental injuries are processed by the Third-party Liability Section. This Section also handles the arrangements under which the British Columbia Hospital Insurance Service receives reimbursement from public liability insurance companies and self-insured corporations for hospital expenses paid by this Service on behalf of accident victims. The Senior Eligibility Representative in Vancouver, Mr. H. E. Drab, is responsible for maintaining a third-party liability clearing-house for the convenience of solicitors and insurance adjusters in the Greater Vancouver area. Up-to-date information regarding the hospitalization of accident victims is available through the Vancouver office, and negotiations may be carried out in person or by telephone, thus avoiding the necessity of corresponding with the head office in Victoria.

General Office

C. R. Leighton

The main responsibility of the General Office is the recording and accounting of all receipts and expenditures connected with the internal administration of the Hospital Insurance Service. This also includes preparation of the annual estimates, which is done in conjunction with the Division Managers. This office is also responsible for purchasing and distributing the office supplies and equipment used by the Branch, and is generally responsible for maintenance and safe custody of office machinery. In addition, the General Office handles the shipping of forms to hospitals and the sorting and distribution of mail. Stenographic services were provided to the Information Office, and to other Divisions when the work volume permitted. The Supervisor of this office is also the Safety Officer for the Branch.

INFORMATION OFFICE

C. N. SHAVE

The Information Office is responsible for the continuing development of public information activities. Its three main areas of involvement are general hospitals, public, and in-service requirements.

During the year, an effective public relations programme was carried out which involved hospitals, employees of the British Columbia Hospital Insurance Service, the press, and other branches of the Department.

The *BCHIS Bulletin,* an administrative aid providing detailed explanation of policy and procedures, was changed in format to include interesting items and pictures from hospitals and our own staff. This change had several purposes, namely, to give hospitals a better understanding of the British Columbia Hospital Insurance Service and its problems, to make the *Bulletin* more interesting, and to improve morale. Published every two months, with a circulation of 1,800, it is sent to public and private hospitals as well as interested members of the general public.

A departmental contest was held in May to find a suitable BCHIS symbol. There were over 50 entries, from which the four judges (representing the Department staff) selected the winning entry which appears on the cover of this Report. The use of symbols for identification of government and industry is increasing, so it was felt that if the Service was to carry out an effective public relations programme, an identifying symbol should be included as a basic element of that programme. Recently, name tags bearing the symbol were purchased for our consultants for ready identification in hospitals. And, besides appearing on our publications, it will progressively be incorporated on stationery, pins, vehicles, and crests.

Emphasis has been placed on developing a close working relationship with members of the press and press gallery, and, during the year, health reporters from the local press were invited to visit with our senior officials for a "behind the scenes" look, in order to give them a better understanding of the problems British Columbia Hospital Insurance Service has to cope with. The result has been greater co-operation on the part of both.

Excellent active co-operation was established with the Health Branch Audio-Visual Section and Stockroom, which resulted in much of our photographic, art work, and printing being done at considerable saving. BCHIS films were also transferred to the Health Branch Film Library during the year, where they are now being cared for with the latest film-cleaning facilities, and distributed to hospitals as part of their own film stock. This has resulted in greater efficiency.

Visits were made to the Pacific National Exhibition, Vancouver, in July for a complete updating of the BCHIS display. Later, in September, our display for the British Columbia Hospitals' Association Convention was redesigned, set up, and manned at the convention, which was held in October at the Bayshore Inn, Vancouver. In addition, a small pamphlet was printed to coincide, which gave the latest hospital statistics on construction and costs of benefits. Hotel accommodation and transportation facilities were also arranged for the saff.

Numerous telephone and mail inquiries were received regarding hospital insurance benefits, many from new residents of the Province. In addition, there were 700 Annual Reports and over 36,000 pamphlets sent out to hospitals and the general public on the British Columbia Hospital Insurance Service and its benefits. Several manuals and serial letters were also sent out.

Numerous press releases were issued during the year to keep the public informed on hospital construction programmes, policy changes, and other items of

public interest. Several articles were also written, as well as newspaper fillers, and a history of the British Columbia Hospital Insurance Service has been started.

Other duties included summarizing annual reports from hospitals for the information of the Minister and Deputy Minister, maintaining a photograph file and a newspaper clipping service, replying to general correspondence, and the preparation and editing of this 22nd Annual Report.

APPROVED HOSPITALS

Public Hospitals

Armstrong and Spallumcheen Hospital, Armstrong.
Arrow Lakes Hospital, Nakusp.
Bella Coola General Hospital, Bella Coola.
Boundary Hospital, Grand Forks.
British Columbia Cancer Institute, Vancouver.
Bulkley Valley District Hospital, Smithers.
Burnaby General Hospital, Burnaby.
Burns Lake and District Hospital, Burns Lake.
*Campbell River and District General Hospital, Campbell River.
Cariboo Memorial Hospital, Williams Lake.
Castlegar and District Hospital, Castlegar.
Chemainus General Hospital, Chemainus.
Children's Hospital, Vancouver.
*Chilliwack General Hospital, Chilliwack.
*Cowichan District Hospital, Duncan.
*Cranbrook and District Hospital, Cranbrook.
Creston Valley Hospital, Creston.
Cumberland General Hospital, Cumberland.
Enderby and District Memorial Hospital, Enderby.
Esperanza General Hospital, Esperanza.
Fernie Memorial Hospital, Fernie.
Fort Nelson General Hospital, Fort Nelson.
Fraser Canyon Hospital, Hope.
G. R. Baker Memorial Hospital, Quesnel.
Golden and District General Hospital, Golden.
Grace Hospital, Vancouver.
Kelowna General Hospital, Kelowna.
Kimberley and District Hospital, Kimberley.
Kitimat General Hospital, Kitimat.
Kootenay Lake General Hospital, Nelson.
Lady Minto Hospital, Ashcroft.
Lady Minto Gulf Islands Hospital, Ganges.
Ladysmith and District General Hospital, Ladysmith.
*Langley Memorial Hospital, Murrayville.
Lillooet District Hospital, Lillooet.
Lions Gate Hospital, North Vancouver.
McBride and District Hospital, McBride.
Maple Ridge Hospital, Maple Ridge.
Mater Misericordiæ Hospital, Rossland.
Matsqui, Sumas, and Abbotsford General Hospital, Abbotsford.
Michel-Natal District Hospital, Michel.
Mills Memorial Hospital, Terrace.
Mission Memorial Hospital, Mission City.
*Mount St. Joseph Hospital, Vancouver.
Nanaimo Regional General Hospital, Nanaimo.
Nicola Valley General Hospital, Merritt.
Ocean Falls General Hospital, Ocean Falls.
100 Mile District General Hospital, 100 Mile House.
*Peace Arch District Hospital, White Rock.
Penticton Hospital, Penticton.
*Pouce Coupe Community Hospital, Pouce Coupe.
*Powell River General Hospital, Powell River.
Prince George Regional Hospital, Prince George.
Prince Rupert Regional Hospital, Prince Rupert.
Princeton General Hospital, Princeton.
Providence Hospital, Fort St. John.
Queen Alexandra Solarium for Crippled Children, Victoria.
Queen Charlotte Islands General Hospital, Queen Charlotte City.
Queen Victoria Hospital, Revelstoke.
Rest Haven Hospital, Sidney.
Richmond General Hospital, Richmond.
Royal Columbian Hospital, New Westminster.
Royal Inland Hospital, Kamloops.
*Royal Jubilee Hospital, Victoria.
R. W. Large Memorial Hospital, Bella Bella.
St. Bartholomew's Hospital, Lytton.
St. George's Hospital, Alert Bay.
St. John Hospital, Vanderhoof.
St. Joseph General Hospital, Dawson Creek.
*St. Joseph's General Hospital, Comox.
St. Joseph's Hospital, Victoria.
St. Martin's Hospital, Oliver.
St. Mary's Hospital, New Westminster.
St. Mary's Hospital, Sechelt.
St. Paul's Hospital, Vancouver.
St. Vincent's Hospital, Vancouver.
Shuswap Lake General Hospital, Salmon Arm.
Slocan Community Hospital, New Denver.
Squamish General Hospital, Squamish.

Stewart General Hospital, Stewart.
Summerland General Hospital, Summerland.
*Surrey Memorial Hospital, North Surrey.
Tofino General Hospital, Tofino.
*Trail Regional Hospital, Trail.
University Health Service Hospital, University of British Columbia, Vancouver.
University of British Columbia Health Sciences Centre Hospital, Vancouver.
*Vancouver General Hospital, Vancouver.
*Vernon Jubilee Hospital, Vernon.
Victorian Hospital, Kaslo.
West Coast General Hospital, Port Alberni.
Windermere District Hospital, Invermere.
Wrinch Memorial Hospital, Hazelton.

Outpost Hospitals

Red Cross Outpost Nursing Station, Alexis Creek.
Red Cross Outpost Nursing Station, Atlin.
Red Cross Outpost Nursing Station, Bamfield.
Red Cross Outpost Nursing Station, Blue River.
Red Cross Outpost Nursing Station, Edgewood.
Red Cross Outpost Nursing Station, Kyuquot.
Red Cross Outpost Nursing Station, Masset.

Federal Hospitals

Veterans' Hospital, Victoria.
Shaughnessy Hospital, Vancouver.
*Miller Bay Indian Hospital, Prince Rupert.
RCAF Station Hospital, Holberg.

Licensed Private Hospitals

Industrial Hospitals in Remote Areas With Which the Province Has Entered Into an Agreement Requiring Them to Furnish the General Hospital Services Provided Under the Hospital Insurance Act.

Bralorne Private Hospital, Bralorne.
Cassiar Asbestos Corporation Private Hospital, Cassiar.
Mica Creek Private Hospital, Mica Creek.
Port Alice Private Hospital, Port Alice.

Rehabilitation Hospitals

G. F. Strong Rehabilitation Centre, Vancouver.
The Gorge Road Hospital, Victoria.
Holy Family Hospital, Vancouver.
Pearson Hospital (Poliomyelitis Pavilion), Vancouver.
Queen Alexandra Solarium for Crippled Children, Victoria.
*Shaughnessy Hospital, Vancouver.
*Sunny Hill Hospital for Children, Vancouver.
*Veterans' Hospital, Victoria.
(A number of the larger public hospitals also have rehabilitation units.)

Other

Hollywood Hospital Ltd., New Westminster (licensed under the *Mental Health Act*).

Extended-care Hospitals

The Louis Brier Hospital, Vancouver.
Menno Hospital, Abbotsford.
Mount St. Francis Hospital, Nelson.
Mount St. Mary Hospital, Victoria (excluding top floor).
Pearson Hospital, Vancouver (excluding facilities for tuberculosis patients).
Priory Hospital, Colwood (24-bed unit and 71-bed unit).

* Hospitals with extended-care units.

STATISTICAL DATA

The tables on the following pages represent statistical data compiled by the Hospital Finance Division. The data deal with the volume of hospital insurance coverage provided to the people of British Columbia through the British Columbia Hospital Insurance Service.

In 1970 there were 91 public general hospitals approved to accept British Columbia Hospital Insurance Service patients. Care was also provided in seven outpost hospitals, four Federal hospitals, five contract hospitals, five public rehabilitation hospitals, and one rehabilitation hospital operated by the Provincial Government. Hospital insurance coverage for patients in nonprofit extended-care hospitals and units commenced December 1, 1965. At the end of 1970 there were 27 hospitals providing extended care. Data for the year 1970 have been estimated from reports submitted by hospitals to October 31, and are subject to minor revision when actual figures for the year are submitted.

Table IA shows a total of 354,700 British Columbia Hospital Insurance Service adult and children patients were separated (discharged) from British Columbia hospitals in 1970, an increase of 15,291 or 4.4 per cent over 1969. This table also shows that 95.6 per cent of the total patients separated (discharged) from British Columbia public hospitals were covered by hospital insurance, compared to 95.7 in 1968 and 95.6 in 1969. Table 1B indicates that in 1970 the British Columbia Hospital Insurance Service paid public hospitals in British Columbia for 3,233,100 days of care for adults and children, an increase of 76,929 days or 2.4 per cent over 1969.

As shown in Table 2A, the average length of stay of British Columbia adult and child patients in public hospitals during 1970 was 9.12 days, and the days of care per thousand population were 1,736. For comparison purposes, the data for extended-care hospitals is not included in the above observations, but it should be noted that an additional 260 days of care per thousand population were provided for these patients.

Table 2B, under "Minor Surgery Patients," includes an estimated 30,000 day-care surgery and psychiatric patients. An additional estimated 30,000 out-patient cancer treatments were covered by the British Columbia Hospital Insurance Service, which are not included in this table.

TABLE 1A—PATIENTS SEPARATED AND PROPORTION COVERED BY BRITISH COLUMBIA HOSPITAL INSURANCE SERVICE, BRITISH COLUMBIA PUBLIC GENERAL HOSPITALS[1] ONLY (EXCLUDING FEDERAL, PRIVATE, EXTENDED-CARE, AND OUT-OF-PROVINCE HOSPITALIZATION).

	Total Hospitalized in Public Hospitals			Covered by BCHIS		
	Adults and Children	New-born	Total	Adults and Children	New-born	Total
Patients separated—						
1949	164,964	26,272	191,236	140,168	24,640	164,808
1955	216,743	33,190	249,933	199,774	31,515	231,289
1960	261,128	39,599	300,727	249,654	38,980	288,634
1961	271,609	38,226	309,835	259,953	37,558	297,511
1962	277,073	37,697	314,770	264,655	36,505	301,160
1963	285,998	37,231	323,229	272,597	35,878	308,475
1964	292,119	35,688	327,807	278,023	34,196	312,219
1965	301,510	33,555	335,065	286,799	31,863	318,662
1966	314,585	32,488	347,073	299,518	30,814	330,332
1967	326,793	32,014	358,807	311,718	30,377	342,095
1968	338,923	33,529	372,452	324,769	31,635	356,404
1969[2]	354,766	36,550	391,316	339,409	34,576	373,985
1970[3]	370,600	38,000	408,600	354,700	36,000	390,700
Percentage of total, patients separated—						
1949	----	----	----	84.9	93.8	86.2
1955	----	----	----	92.2	95.0	92.5
1960	----	----	----	95.6	98.4	96.0
1961	----	----	----	95.7	98.3	96.0
1962	----	----	----	95.5	96.8	95.7
1963	----	----	----	95.3	96.4	95.4
1964	----	----	----	95.2	95.8	95.2
1965	----	----	----	95.1	95.0	95.0
1966	----	----	----	95.2	94.8	95.2
1967	----	----	----	95.4	94.9	95.3
1968	----	----	----	95.8	94.4	95.7
1969[2]	----	----	----	95.7	94.6	95.6
1970[3]	----	----	----	95.7	94.7	95.6

[1] Includes rehabilitation hospitals.
[2] Amended as per final reports received from hospitals.
[3] Estimated, based on hospital reports to October 31, 1970.

TABLE 1B—TOTAL PATIENT-DAYS AND PROPORTION COVERED BY BRITISH COLUMBIA HOSPITAL INSURANCE SERVICE, BRITISH COLUMBIA PUBLIC GENERAL HOSPITALS[1] ONLY (EXCLUDING FEDERAL, PRIVATE, EXTENDED-CARE, AND OUT-OF-PROVINCE HOSPITALIZATION).

	Total Hospitalized in Public Hospitals			Covered by BCHIS		
	Adults and Children	New-born	Total	Adults and Children	New-born	Total
Patient-days—						
1949	1,682,196	213,874	1,896,070	1,430,646	200,585	1,631,231
1955	2,198,863	227,674	2,426,537	2,005,165	212,514	2,217,679
1960	2,581,042	249,273	2,830,315	2,451,839	241,157	2,692,996
1961	2,675,402	240,207	2,915,609	2,546,344	231,043	2,777,387
1962	2,708,337	274,032	2,982,369	2,573,634	263,475	2,837,109
1963	2,778,668	270,298	3,048,966	2,631,671	257,736	2,889,407
1964	2,820,122	260,979	3,081,101	2,670,176	246,813	2,916,989
1965	2,895,476	245,756	3,141,232	2,747,232	230,096	2,977,328
1966	3,008,632	235,796	3,244,428	2,861,260	220,270	3,081,530
1967	3,093,372	239,972	3,333,344	2,946,000	222,543	3,168,543
1968	3,225,333	244,715	3,470,048	3,074,959	226,633	3,301,592
1969[2]	3,315,760	248,324	3,564,084	3,156,171	231,803	3,387,974
1970[3]	3,386,500	253,800	3,640,300	3,233,100	238,500	3,471,600
Percentage of total, patient-days—						
1949	.....	.....	.....	85.0	93.8	86.0
1955	.....	.....	.....	91.2	93.3	91.4
1960	.....	.....	.....	95.0	96.7	95.1
1961	.....	.....	.....	95.2	96.1	95.3
1962	.....	.....	.....	95.0	96.1	95.1
1963	.....	.....	.....	94.7	95.4	94.8
1964	.....	.....	.....	94.7	94.6	94.7
1965	.....	.....	.....	94.0	93.0	94.0
1966	.....	.....	.....	95.1	93.4	95.0
1967	.....	.....	.....	95.2	92.7	95.0
1968	.....	.....	.....	95.3	92.6	95.1
1969[2]	.....	.....	.....	95.2	93.3	95.1
1970[3]	.....	.....	.....	95.5	94.0	95.4

[1] Includes rehabilitation hospitals.
[2] Amended as per final reports received from hospitals.
[3] Estimated, based on hospital reports to October 31, 1970.

TABLE 2A—PATIENTS SEPARATED, TOTAL PATIENT-DAYS, AND AVERAGE LENGTH OF STAY ACCORDING TO TYPE AND LOCATION OF HOSPITAL FOR BCHIS PATIENTS ONLY, AND DAYS OF CARE PER THOUSAND OF COVERED POPULATION.

	Total (Excluding Extended Care)		B.C. Public Hospitals		Other B.C. Hospitals, Including Federal and Private		Institutions Outside B.C.		Extended-care Hospitals (Including Federal)
	Adults and Children	New-born	Adults and Children	New-born	Adults and Children	New-born	Adults and Children	New-born	
Patients separated—									
1949	149,280	24,989	140,168	24,640	7,093	151	2,019	198	.....
1955	209,999	32,035	199,774	31,515	8,313	361	1,912	159	.....
1960	264,120	39,488	249,654	38,980	11,557	241	2,909	267	.....
1961	273,293	37,968	259,953	37,558	10,361	151	2,979	259	.....
1962	278,021	36,942	264,655	36,505	10,226	157	3,140	280	.....
1963	286,753	36,326	272,597	35,878	10,895	169	3,261	279	.....
1964	293,144	34,652	278,023	34,196	11,605	149	3,516	307	.....
1965	301,522	32,240	286,799	31,863	11,417	114	3,306	263	.....
1966	314,391	31,152	299,518	30,814	11,459	101	3,414	237	699
1967	325,861	30,804	311,718	30,377	9,436	83	4,707	344	873
1968	338,706	32,031	324,769	31,635	9,310	80	4,627	316	990
1969[1]	353,457	34,974	339,409	34,576	8,867	94	5,181	304	1,100
1970[2]	368,270	36,385	354,700	36,000	8,120	85	5,450	300	835
Patient-days—									
1949	1,498,121	203,197	1,430,646	200,585	45,960	1,146	21,515	1,466	.....
1955	2,100,386	215,980	2,005,165	212,514	75,599	2,271	19,622	1,195	.....
1960	2,650,129	244,480	2,451,839	241,157	169,401	1,417	28,889	1,906	.....
1961	2,756,665	233,794	2,546,344	231,043	182,690	878	27,631	1,873	.....
1962	2,789,355	266,351	2,573,634	263,475	183,042	850	32,679	2,026	.....
1963	2,850,559	260,771	2,631,671	257,736	187,714	1,018	31,174	2,017	.....
1964	2,905,544	249,827	2,670,176	246,813	199,164	878	36,204	2,136	.....
1965	2,985,092	232,438	2,747,232	230,096	205,488	619	32,372	1,723	.....
1966	3,110,701	222,475	2,861,260	220,270	212,413	541	37,028	1,664	305,940
1967	3,189,212	225,479	2,946,000	222,543	195,564	451	47,648	2,485	358,675
1968	3,309,533	229,053	3,074,959	226,633	188,152	434	46,422	1,986	409,514
1969[1]	3,397,005	234,098	3,156,171	231,803	186,565	463	54,269	1,832	502,365
1970[2]	3,467,575	241,065	3,233,100	238,500	178,475	415	56,000	2,150	556,500
Average days of stay—									
1949	10.03	8.13	10.21	8.14	6.48	7.59	10.66	7.40	.....
1955	10.00	6.74	10.04	6.74	9.09	6.29	10.26	7.52	.....
1960	10.03	6.19	9.82	6.19	14.66	5.88	9.93	7.14	.....
1961	10.09	6.16	9.80	6.15	17.63	5.81	9.27	7.23	.....
1962	10.03	7.21	9.72	7.22	17.90	5.41	10.41	7.24	.....
1963	9.94	7.18	9.65	7.18	17.23	6.02	9.56	7.23	.....
1964	9.91	7.21	9.60	7.22	17.16	5.89	10.30	6.96	.....
1965	9.90	7.21	9.57	7.22	18.00	5.43	9.79	6.55	.....
1966	9.89	7.14	9.55	7.15	18.53	5.36	10.84	7.02	437.68
1967	9.79	7.32	9.45	7.32	20.72	5.43	10.12	7.22	410.85
1968	9.77	7.15	9.47	7.16	20.21	5.42	10.03	6.28	413.64
1969[1]	9.61	6.69	9.30	6.70	21.04	4.92	10.47	6.03	456.70
1970[2]	9.42	6.62	9.12	6.62	21.98	4.88	10.28	7.17	666.47

[1] Amended as per final reports from hospitals.

[2] Estimated, based on hospital reports to October 31, 1970. Estimated patient-days (including newborn days) per thousand of population covered by British Columbia Hospital Insurance Service: 1949, 1,528; 1950, 1,548; 1951, 1,496; 1952, 1,527; 1953, 1,600; 1954, 1,733; 1955, 1,720; 1956, 1,688; 1957, 1,626; 1958, 1,665; 1959, 1,724; 1960, 1,804; 1961, 1,806; 1962, 1,841; 1963, 1,835; 1964, 1,815; 1965, 1,799; 1966, 1,779; 1967, 1,754; 1968, 1,774; 1969, 1,757; 1970, 1,736. (1954 and subsequent years are based on total population. Because the Armed Forces, Royal Canadian Mounted Police, and some other groups are not insured under the Provincial plan, the actual incidence of days would be somewhat higher than shown.) In addition, estimated patient-days per thousand population for extended care amounted to 243 in 1969 and 260 in 1970. Population figures are revised according to latest census figures.

TABLE 2B—SUMMARY OF THE NUMBER OF BCHIS IN-PATIENTS AND OUT-PATIENTS

	Total Adults, Children, and Newborn In-patients	Estimated Number of Emergency, Minor-surgery, Day Care, and Out-patients	Total Receiving Benefits
1949	174,269	29,000	203,269
1955	242,034	70,553	312,587
1960	303,608	107,312	410,920
1961	311,261	121,000	432,261
1962	314,963	128,000	442,963
1963	323,079	135,000	458,079
1964	327,796	141,000	468,796
1965	333,762	160,000	493,762
1966	346,242	175,000	521,242
1967	357,538	195,000	552,538
1968	371,727	210,000	581,727
1969[1]	389,531	220,000	609,531
1970[2]	404,655	235,000	639,655
Totals	6,267,649	2,534,073	8,801,722

[1] Amended as per final reports received from hospitals.
[2] Estimated, based on hospital reports to October 31, 1970.

TABLE 3—PATIENTS SEPARATED, TOTAL DAYS' STAY, AND AVERAGE LENGTH OF STAY IN BRITISH COLUMBIA PUBLIC HOSPITALS FOR BCHIS PATIENTS ONLY, GROUPED ACCORDINGLY TO BED CAPACITY, YEAR 1970[1] (EXCLUDING EXTENDED-CARE HOSPITALS).

	Bed Capacity					
	Total	250 and Over	100 to 249	50 to 99	25 to 49	Under 25
Patients separated—						
Adults and children	354,700	175,000	86,400	51,700	34,200	7,400
Newborn	36,000	16,600	9,700	6,400	2,700	600
Patient-days—						
Adults and children	3,233,100	1,701,300	718,100	507,000	251,500	55,200
Newborn	238,500	114,100	62,700	41,500	16,600	3,600
Average days of stay—						
Adults and children	9.12	9.72	8.31	9.80	7.35	7.46
Newborn	6.62	6.87	6.46	6.48	6.15	6.00

[1] Estimated, based on hospital reports to October 31, 1970.

TABLE 4—PERCENTAGE DISTRIBUTION OF PATIENTS SEPARATED AND PATIENT-DAYS FOR BCHIS PATIENTS ONLY, IN BRITISH COLUMBIA PUBLIC HOSPITALS, GROUPED ACCORDING TO BED CAPACITY, YEAR 1970[1] (EXCLUDING EXTENDED-CARE HOSPITALS).

	Bed Capacity					
	Total	250 and Over	100 to 249	50 to 99	25 to 49	Under 25
Patients separated—	Per Cent	Per Cent	Per Cent	Per Cent	Per Cent	Per Cent
Adults and children	100.00	49.34	24.36	14.57	9.64	2.09
Newborn	100.00	46.11	26.94	17.78	7.50	1.67
Patient-days—						
Adults and children	100.00	52.62	22.21	15.68	7.78	1.71
Newborn	100.00	47.84	26.29	17.40	6.96	1.51

[1] Estimated, based on hospital reports to October 31, 1970.

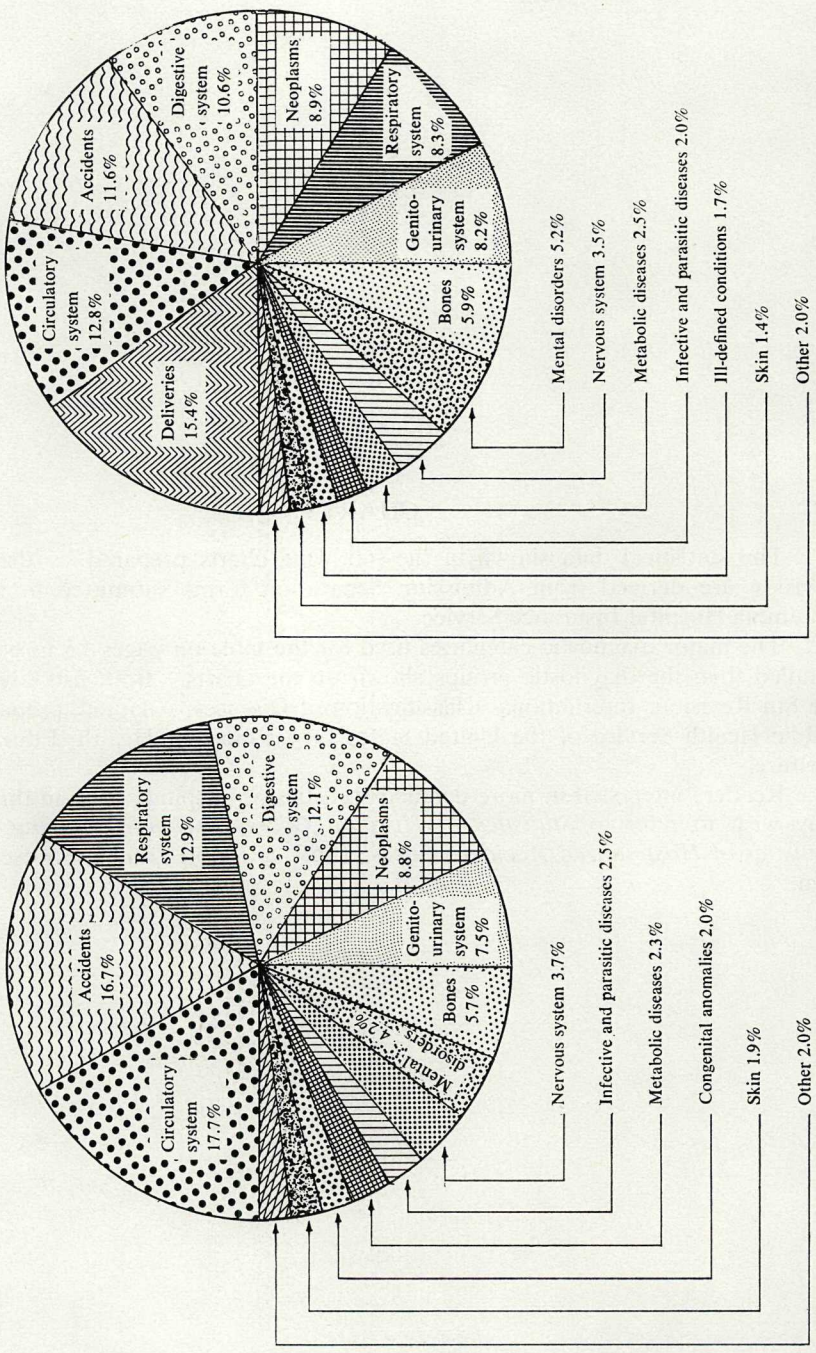
CHARTS

The statistical data shown in the following charts prepared by the Research Division are derived from Admission/Separation forms submitted to the British Columbia Hospital Insurance Service.

The major diagnostic categories used for the table on pages 55 to 60 are more detailed than the diagnostic groups shown on the charts. Both lists are based on the 8th Revision, International Classification of Diseases, Adapted, prepared by the Public Health Service of the United States Department of Health, Education, and Welfare.

Readers interested in more detailed statistics of hospitalization in this Province may wish to refer to *Statistics of Hospital Cases Discharged During 1969* and *Statistics of Hospitalized Accident Cases, 1969,* available from the Research Division.

CHART I—PERCENTAGE DISTRIBUTION OF DAYS OF CARE* BY MAJOR DIAGNOSTIC GROUPS, 1969
(IN DESCENDING ORDER)



* Including rehabilitative care.

CHART II—PERCENTAGE AGE DISTRIBUTION OF MALE AND FEMALE* HOSPITAL CASES AND DAYS OF CARE,† 1969

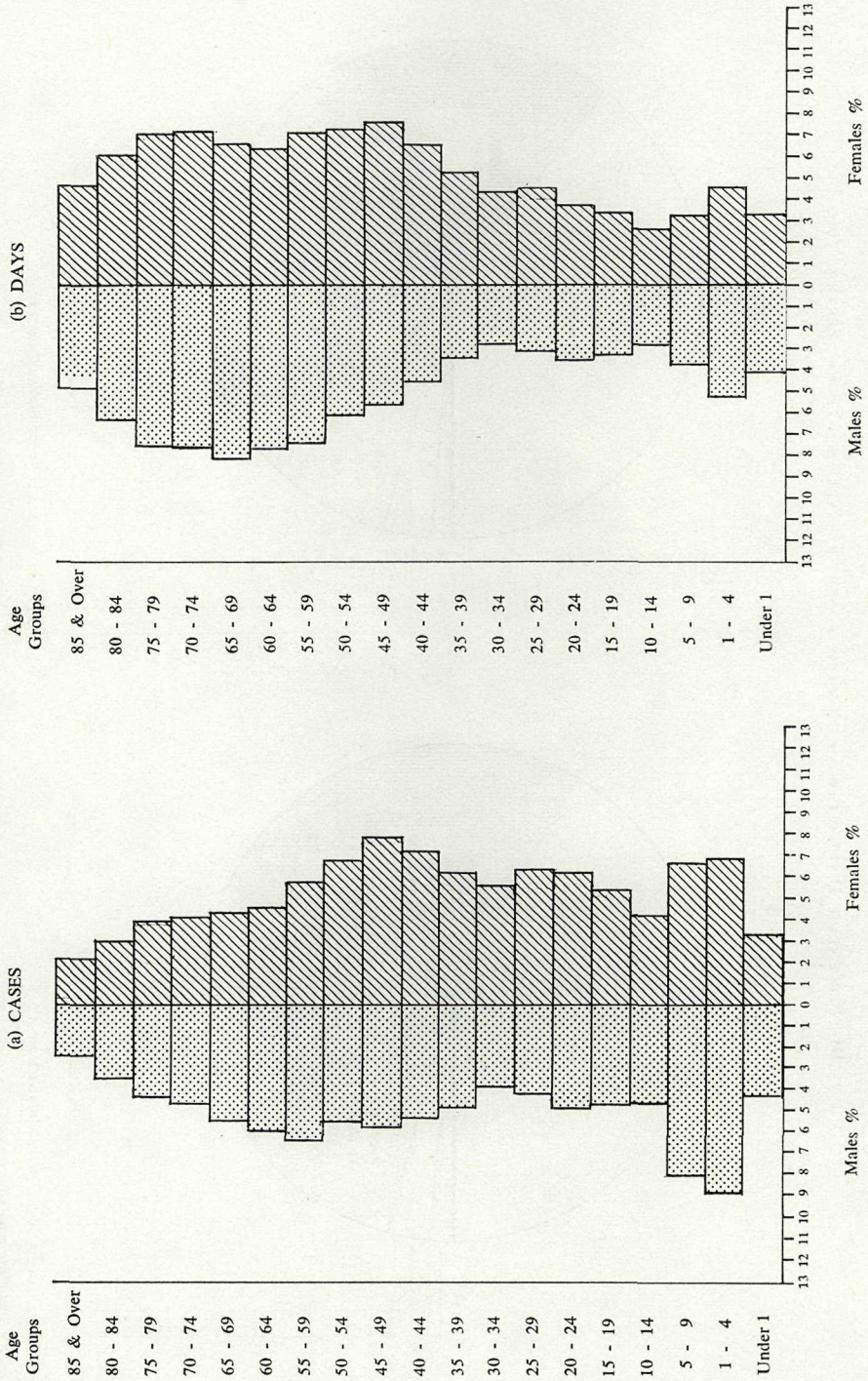
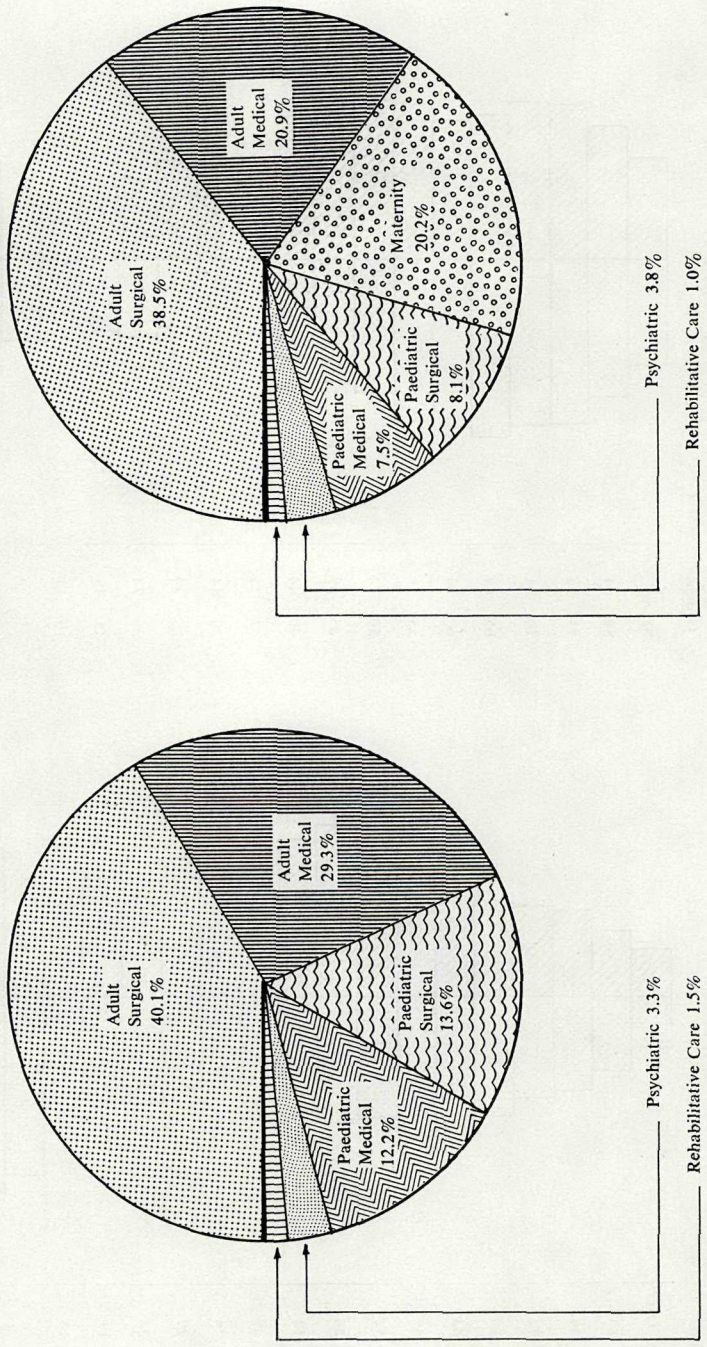
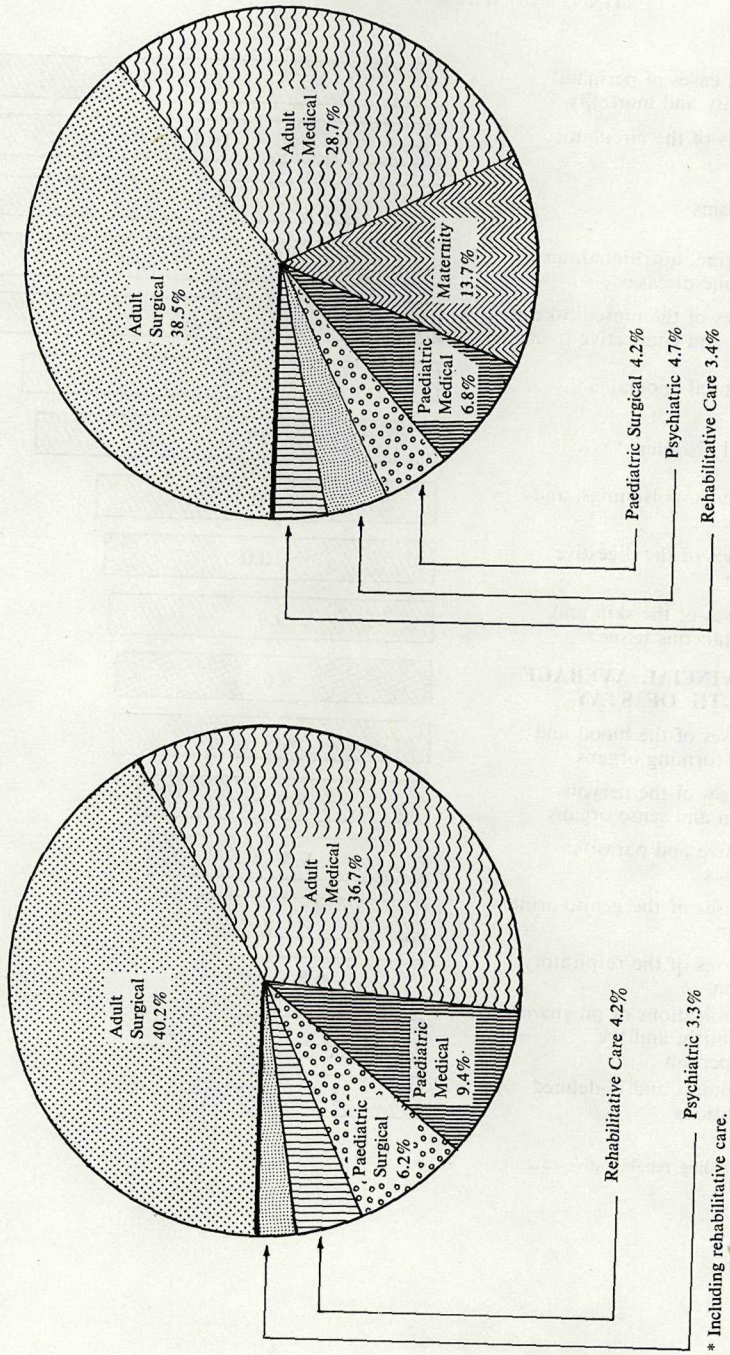


CHART III—PERCENTAGE DISTRIBUTION OF HOSPITAL CASES* BY TYPE OF CLINICAL SERVICE, 1969



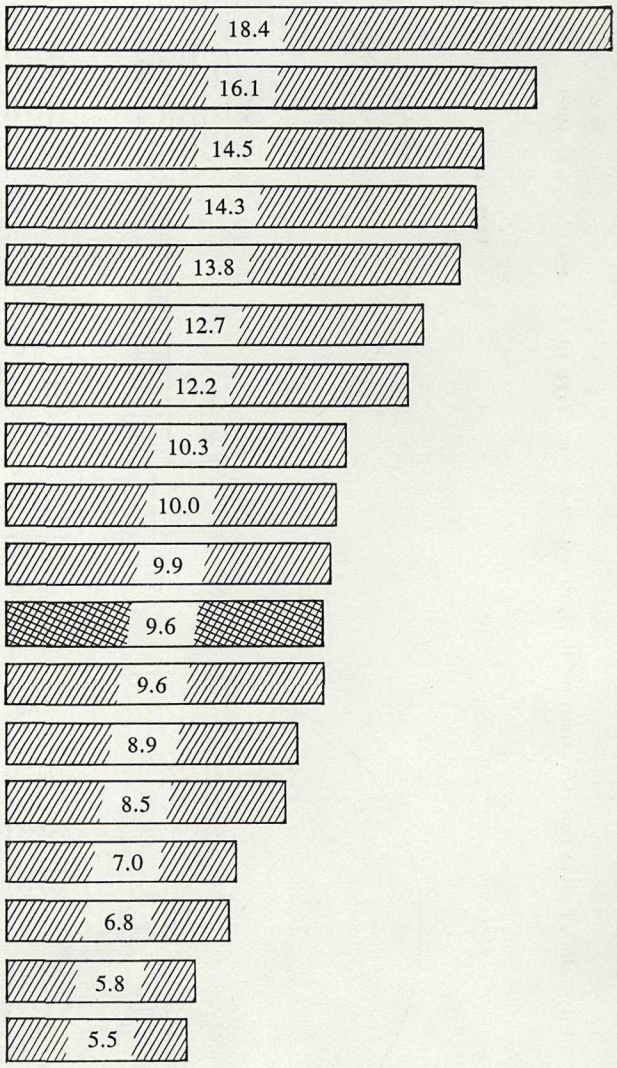
* Including rehabilitative care.

CHART IV—PERCENTAGE DISTRIBUTION OF HOSPITAL DAYS* BY TYPE OF CLINICAL SERVICE, 1969



* Including rehabilitative care.

CHART V—AVERAGE LENGTH OF STAY OF CASES* IN HOSPITALS IN BRITISH COLUMBIA, BY MAJOR DIAGNOSTIC GROUPS IN DESCENDING ORDER, 1969 (EXCLUDING NEWBORNS).



* Including rehabilitative care.

HOSPITALIZATION[1] BY MAJOR DIAGNOSTIC CATEGORIES, 1969 (EXCLUDING NEWBORNS)

List Number and Diagnosis	ICDA No.	Cases	Days of Care	Average Length of Stay	Percentage Distribution	
					Cases	Days of Care
I. Infective and parasitic diseases	000–136	9,335	79,547	8.5	2.6	2.3
1. Salmonella infections	000–003	136	2,045	15.0	0.0	.01
2. Other intestinal infections	004–009	5,252	31,552	6.0	1.5	0.9
3. Tuberculosis	010–019	334	6,001	18.0	0.1	0.2
4. Streptococcal sore throat, scarlet fever, and erysipelas	034, 035	215	1,294	6.0	0.1	0.0
5. Acute poliomyelitis	040–043	0	0	---	---	---
6. Viral encephalitis	062–066	70	1,486	21.2	0.0	0.0
7. Infectious hepatitis	070	758	10,341	13.6	0.2	0.3
8. Other virus diseases	044–061, 067, 068, 071–079	1,800	17,813	9.9	0.5	0.5
9. Venereal disease	090–099	178	1,560	8.8	0.0	0.0
10. Other infectious and parasitic diseases	020–033, 036–039, 080–089, 100–136	592	7,455	12.6	0.2	0.2
II. Neoplasms	140–239	21,241	308,426	14.5	5.9	8.8
11. Malignant neoplasm of buccal cavity and pharynx	140–149	236	4,210	17.8	0.1	0.1
12. Malignant neoplasm of stomach	151	590	13,199	22.4	0.2	0.4
13. Malignant neoplasm of intestine, except rectum	152, 153	992	24,501	24.7	0.3	0.7
14. Malignant neoplasm of rectum and rectosigmoid junction	154	654	18,226	27.9	0.2	0.5
15. Malignant neoplasm of other digestive organs	150, 155–159	689	16,421	23.8	0.2	0.5
16. Malignant neoplasm of trachea, bronchus, and lung	162	1,322	27,349	20.7	0.4	0.8
17. Malignant neoplasm of other respiratory organs	160, 161, 163	195	3,266	16.7	0.1	0.1
18. Malignant neoplasm of bone	170	74	1,562	21.1	0.0	0.0
19. Malignant neoplasm of skin	172, 173	429	5,557	13.0	0.1	0.2
20. Malignant neoplasm of breast	174	1,635	28,129	17.2	0.5	0.8
21. Malignant neoplasm of cervix uteri	180	932	8,366	9.0	0.3	0.2
22. Malignant neoplasm of uterus	181, 182	508	5,443	10.7	0.1	0.2
23. Malignant neoplasm of ovary	183	399	7,431	18.6	0.1	0.2
24. Malignant neoplasm of other female genital organs	183.1, 183.9, 184	76	1,430	18.8	0.0	0.0
25. Malignant neoplasm of prostate	185	1,119	23,172	20.7	0.3	0.7
26. Malignant neoplasm of bladder	188	1,078	13,119	12.2	0.3	0.4
27. Malignant neoplasm of other genito-urinary organs	186, 187, 189	339	7,414	21.9	0.1	0.2
28. Malignant neoplasm of brain	191	125	3,808	30.5	0.0	0.1
29. Other primary and secondary malignant neoplasms	171, 190, 192–199	744	15,304	20.6	0.2	0.5
30. Leukæmia	204–207	565	9,290	16.4	0.2	0.3
31. Other neoplasms of lymphatic and hæmatopoietic tissue	200–203, 208, 209	891	15,069	16.9	0.2	0.4
32. Benign neoplasm of skin	216	112	412	3.7	0.0	0.0
33. Benign neoplasm of breast	217	444	1,190	2.7	0.1	0.0
34. Benign neoplasm of uterus	218, 219	2,915	22,980	7.9	0.8	0.7
35. Benign neoplasm of ovary	220	542	4,321	8.0	0.2	0.1

[1] Includes rehabilitative care.

HOSPITALIZATION[1] BY MAJOR DIAGNOSTIC CATEGORIES, 1969 (EXCLUDING NEWBORNS)—*Continued*

List Number and Diagnosis	ICDA No.	Cases	Days of Care	Average Length of Stay	Percentage Distribution	
					Cases	Days of Care
II. Neoplasms—*Continued*						
36. Benign neoplasm of other female genital organs	221	267	1,230	4.6	0.1	0.0
37. Benign neoplasm of brain and other parts of nervous system	225	171	2,889	16.9	0.0	0.1
38. Other benign neoplasms	210–215, 222–224, 226–228	1,723	11,778	6.8	0.5	0.4
39. Carcinoma *in situ* of cervix uteri	234	1,122	7,922	7.1	0.3	0.2
40. Other neoplasms of unspecified nature	230–233, 234.1, 234.9, 235–239	353	3,438	9.7	0.1	0.1
III. Endocrine, nutritional, and metabolic diseases	240–279	5,869	83,914	14.3	1.6	2.4
41. Nontoxic goitre	240–241	341	2,402	7.0	0.1	0.1
42. Thyrotoxicosis, with or without goitre	242	233	2,967	12.7	0.1	0.1
43. Other diseases of thyroid gland	243–246	203	2,420	11.9	0.1	0.1
44. Diabetes mellitus	250	3,347	51,178	15.3	0.9	1.5
45. Other endocrine diseases	251–258	368	4,508	12.3	0.1	0.1
46. Avitaminoses and other nutritional deficiency	260–269	774	10,531	13.6	0.2	0.3
47. Congenital disorders of metabolism	270–273	154	3,271	21.2	0.0	0.1
48. Other metabolic diseases	274–279	449	6,637	14.8	0.1	0.2
IV. Diseases of the blood and blood-forming organs	280–289	2,407	23,134	9.6	0.7	0.7
49. Iron-deficiency anæmias	280	493	6,004	12.2	0.1	0.2
50. Pernicious anæmia and other deficiency anæmias	281	190	3,369	17.7	0.1	0.1
51. Other diseases of blood and blood-forming organs	282–289	1,724	13,761	8.0	0.5	0.4
V. Mental disorders	290–315	13,623	165,968	12.2	3.8	4.8
52. Alcoholic psychosis	291	1,208	13,580	11.2	0.3	0.4
53. Schizophrenia	295	1,494	27,448	18.4	0.4	0.8
54. Affective psychoses	296	1,348	21,928	16.3	0.4	0.7
55. Other psychoses	290, 292–294, 297–299	634	11,021	17.4	0.2	0.3
56. Neuroses	300	5,231	57,872	11.1	1.5	1.7
57. Alcoholism	303	1,508	8,597	5.7	0.4	0.3
58. Drug dependence	304	270	1,479	5.5	0.1	0.0
59. Other nonpsychotic mental disorders	301, 302, 305–309	1,784	21,804	12.2	0.5	0.6
60. Mental retardation	310–315	146	2,239	15.3	0.0	0.1
VI. Diseases of the nervous system and sense organs	320–389	14,248	126,152	8.9	3.9	3.6
61. Meningitis and other inflammatory diseases of central nervous system	320–324	235	3,988	17.0	0.1	0.1
62. Hereditary and familial diseases of nervous system	330–333	90	2,026	22.5	0.0	0.1
63. Multiple sclerosis	340	336	11,105	33.1	0.1	0.3
64. Paralysis agitans	342	216	5,475	25.3	0.1	0.2
65. Epilepsy	345	1,108	9,290	8.4	0.3	0.3
66. Other diseases of central nervous system	341, 343, 344, 346–349	913	18,149	19.9	0.3	0.5
67. Diseases of nerves and peripheral ganglia	350–358	1,071	10,144	9.5	0.3	0.3
68. Inflammatory diseases of the eye	360–369	649	4,787	7.4	0.2	0.1
69. Strabismus	373	1,588	4,035	2.5	0.4	0.1

70. Cataract	374	1,945	18,623	9.6	0.5	0.6
71. Glaucoma	375	498	3,577	7.2	0.1	0.1
72. Other diseases of the eye	370–372, 376–379	916	6,893	7.5	0.3	0.2
73. Otitis media, without mention of mastoiditis	381	3,083	19,334	6.3	0.9	0.6
74. Mastoiditis, with or without otitis media	382, 383	269	2,068	7.7	0.1	0.1
75. Other diseases of ear and mastoid process	380, 384–389	1,331	6,658	5.0	0.4	0.2
VII. Diseases of circulatory system	390–458	32,821	527,784	16.1	9.1	15.1
76. Active rheumatic fever	390–392	269	5,630	20.9	0.1	0.2
77. Chronic rheumatic heart disease	393–398	909	13,605	15.0	0.3	0.4
78. Hypertensive disease	400–404	1,660	19,234	11.6	0.5	0.6
79. Acute myocardial infarction	410	4,546	93,333	20.5	1.3	2.8
80. Other ischemic heart disease	411–414	9,259	136,589	14.8	2.6	4.1
81. Other forms of heart disease	420–429	2,005	24,803	12.4	0.6	0.7
82. Cerebral hæmorrhage	431	340	5,132	15.1	0.1	0.2
83. Cerebral embolism and thrombosis	432–434	1,271	35,972	28.3	0.4	1.1
84. Other cerebrovascular diseases	430, 435–438	3,317	79,198	23.9	0.9	2.4
85. Arteriosclerosis	440	728	13,831	19.0	0.2	0.4
86. Other diseases of arteries, arterioles, and capillaries	441–448	1,356	27,700	20.4	0.4	0.8
87. Pulmonary embolism and infarction	450	252	4,122	16.4	0.1	0.1
88. Phlebitis, thrombophlebitis, venous embolism, and thrombosis	451–453	921	12,604	13.7	0.3	0.4
89. Varicose veins of lower extremities	454	3,412	36,075	10.6	1.0	1.1
90. Hæmorrhoids	455	2,277	16,503	7.2	0.6	0.5
91. Other diseases of circulatory system	456–458	299	3,453	11.5	0.1	0.1
VIII. Diseases of the respiratory system	460–519	53,981	365,760	6.8	14.9	10.5
92. Acute upper respiratory infection, except influenza	460–466	9,601	64,675	6.7	2.7	1.9
93. Influenza	470–474	2,114	14,952	7.1	0.6	0.4
94. Pneumonia	480–486	11,116	125,500	11.3	3.1	3.7
95. Bronchitis and emphysema	490–492	4,849	49,881	10.3	1.4	1.5
96. Asthma	493	3,794	34,167	9.0	1.1	1.0
97. Hypertrophy of tonsils and adenoids	500	17,022	38,617	2.3	4.8	1.1
98. Chronic sinusitis	503	655	3,053	4.7	0.2	0.1
99. Deflected nasal septum	504	1,759	7,446	4.2	0.5	0.2
100. Other diseases of upper respiratory tract	501, 502, 505–508	1,320	5,644	4.3	0.4	0.2
101. Empyema and abscess of lung	510, 513	135	2,446	18.1	0.0	0.1
102. Pneumoconiosis and related diseases	515, 516	63	880	14.0	0.0	0.0
103. Other diseases of respiratory system	511, 512, 514, 517–519	1,553	18,499	11.9	0.4	0.6
IX. Diseases of the digestive system	520–577	39,672	395,479	10.0	10.9	11.3
104. Diseases of teeth and supporting structures	520–525	3,389	7,718	2.3	0.9	0.2
105. Other diseases of oral cavity, salivary glands, and jaws	526–529	580	3,510	6.1	0.2	0.1
106. Ulcer of duodenum	532	3,389	45,376	13.4	0.9	1.3
107. Ulcer of stomach, and peptic ulcer site unspecified	531, 533	1,722	25,277	14.7	0.5	0.8
108. Gastritis and duodenitis	535	1,547	10.101	6.5	0.4	0.3
109. Other diseases of œsophagus, stomach, and duodenum	530, 534, 536, 537	984	11,564	11.8	0.3	0.3
110. Appendicitis	540–543	4,245	31,147	7.3	1.2	0.9
111. Hernia, without mention of obstruction	550, 551	6,521	51,172	7.8	1.8	1.5
112. Hernia, with obstruction	552, 553	549	6,199	11.3	0.2	0.2
113. Intestinal obstruction, without mention of hernia	560	1,322	14,678	11.1	0.4	0.4

[1] Includes rehabilitative care.

HOSPITALIZATION[1] BY MAJOR DIAGNOSTIC CATEGORIES, 1969 (EXCLUDING NEWBORNS)—*Continued*

List Number and Diagnosis	ICDA No.	Cases	Days of Care	Average Length of Stay	Percentage Distribution	
					Cases	Days of Care
IX. Diseases of the digestive system—*Continued*						
114. Chronic enteritis and ulcerative colitis	563	665	11,556	17.4	0.2	0.3
115. Other diseases of intestines and peritoneum	561, 562, 564–569	4,287	44,158	10.3	1.2	1.3
116. Cirrhosis of liver	571	744	14,467	19.4	0.2	0.4
117. Other diseases of liver	570, 572, 573	134	2,221	16.6	0.0	0.1
118. Cholelithiasis	574	6,870	85,720	12.5	1.9	2.6
119. Cholecystitis and cholangitis, without mention of calculus	575	1,774	17,379	9.8	0.5	0.5
120. Other diseases of gall bladder and biliary ducts	576	262	3,426	13.1	0.1	0.1
121. Diseases of pancreas	577	688	9,810	14.3	0.2	0.3
X. Diseases of the genito-urinary system	580–629	39,291	273,863	7.0	10.8	7.8
122. Nephritis and nephrosis	580–584	6,048	20,531	3.4	1.7	0.6
123. Infections of kidney	590	2,624	24,880	9.5	0.7	0.7
124. Calculus of urinary system	592, 594	2,969	22,310	7.5	0.8	0.7
125. Cystitis	595	1,926	12,964	6.7	0.5	0.4
126. Other diseases of urinary system	591, 593, 596–599	3,791	33,390	8.8	1.1	1.0
127. Hyperplasia of prostate	600	3,241	49,904	15.4	0.9	1.5
128. Redundant prepuce and phimosis	605	701	2,025	2.9	0.2	0.1
129. Other diseases of male genital organs	601–604, 606, 607	1,793	11,992	6.7	0.5	0.4
130. Diseases of breast	610, 611	1,840	6,184	3.4	0.5	0.2
131. Diseases of ovary, Fallopian tube, and parametrium	612, 616	1,777	14,165	8.0	0.5	0.4
132. Infective diseases of uterus, vagina, and vulva	620, 622	1,478	8,168	5.5	0.4	0.2
133. Uterovaginal prolapse and malposition of uterus	623, 624	2,891	33,272	11.5	0.8	1.0
134. Disorders of menstruation	626	4,805	14,731	3.1	1.3	0.4
135. Other diseases of female genital organs	621, 625, 627–629	3,407	19,347	5.7	1.0	0.6
XI. Complications of pregnancy, childbirth, and the puerperium	630–678	48,729	283,078	5.8	13.5	8.1
136. Infection of genital tract during pregnancy, and urinary infections during pregnancy and puerperium	630, 635	548	2,926	5.3	0.2	0.1
137. Hæmorrhage of pregnancy	632	1,964	9,837	5.0	0.5	0.3
138. Toxæmias of pregnancy and the puerperium	636–639	1,363	8,157	6.0	0.4	0.2
139. Other complications of pregnancy	631, 633, 634	4,479	13,561	3.0	1.3	0.4
140. Abortion	640–645	4,330	15,810	3.7	1.2	0.5
141. Delivery, without mention of complication	650	26,827	159,112	5.9	7.5	4.7
142. Delivery complicated by placenta previa or antepartum hæmorrhage, retained placenta, or other postpartum hæmorrhage	651–653	1,464	12,781	8.7	0.4	0.4
143. Delivery complicated by abnormality of pelvis, fetopelvic disproportion, malpresentation, or other prolonged labour	654–657	3,206	27,665	8.6	0.9	0.8
144. Delivery, with other complications, including anæsthetic death in uncomplicated delivery	658–662	3,853	30,498	7.9	1.1	0.9
145. Complications of puerperium	670–678	695	2,731	3.9	0.2	0.1
XII. Diseases of the skin and subcutaneous tissue	680–709	5,748	56,691	9.9	1.6	1.6
146. Infections of skin and subcutaneous tissue	680–686	2,775	24,401	8.8	0.8	0.7

147. Other inflammatory conditions of skin and subcutaneous tissue	690–698	1,546	18,469	11.9	0.4	0.5
148. Other diseases of skin and subcutaneous tissue	700–709	1,427	13,821	9.7	0.4	0.4
XIII. Diseases of the musculoskeletal system and connective tissue	710–738	14,762	203,443	13.8	4.1	5.8
149. Rheumatoid arthritis and allied conditions	712	1,188	31,282	26.3	0.3	0.9
150. Osteoarthritis and allied conditions	713	1,519	30,986	20.4	0.4	0.9
151. Other arthritis and rheumatism	710, 711, 714–718	1,117	11,831	10.6	0.3	0.4
152. Osteomyelitis and other diseases of bone	720–723	1,194	27,606	23.1	0.3	0.8
153. Displacement of intervertebral disk	725	3,785	51,449	13.6	1.1	1.5
154. Other diseases of joint	724, 726–729	2,197	19,977	9.1	0.6	0.6
155. Synovitis, bursitis, and tenosynovitis	731	1,241	6,926	5.6	0.3	0.2
156. Other diseases of musculoskeletal system	730, 732–738	2,521	23,386	9.3	0.7	0.7
XIV. Congenital anomalies	740–759	5,056	64,264	12.7	1.4	1.8
157. Spina bifida and congenital hydrocephalus	741, 742	185	6,813	36.8	0.1	0.2
158. Congenital anomalies of heart	746, 747.0–747.2	603	10,204	16.9	0.2	0.3
159. Cleft palate and cleft lip	749	204	3,001	14.7	0.1	0.1
160. Other congenital anomalies of digestive system	750, 751	395	5,240	13.3	0.1	0.2
161. Congenital anomalies of genito-urinary system	752, 753	1,457	12,309	8.4	0.4	0.4
162. Congenital anomalies of musculoskeletal system	754–756	1,027	16,314	15.9	0.3	0.5
163. Other and unspecified congenital anomalies	740, 743–745, 747.3–747.9, 748, 757–759	1,185	10,383	8.8	0.3	0.3
XV. Certain causes of perinatal morbidity and mortality	760–779	156	2,870	18.4	0.0	0.1
164. Birth injury	764–768 with 4th digit .0–.3,772	12	209	17.4	0.0	0.0
165. Asphyxia, anoxia, or hypoxia	764–768 with 4th digit .4,776	40	741	18.5	0.0	0.0
166. Hæmolytic disease of newborn	774, 775	30	277	9.2	0.0	0.0
167. Immaturity unspecified	777	14	601	42.9	0.0	0.0
168. Other causes of perinatal morbidity and mortality	760–763, 764–768 with 4th digit .9,769–771, 773, 778, 779	60	1,042	17.4	0.0	0.0
XVI. Symptoms and ill-defined conditions	780–796	7,850	43,556	5.5	2.2	1.2
169. Observation, without need for further medical care	793	222	975	4.4	0.1	0.0
170. Symptoms, senility, and ill-defined conditions	780–792, 794–796	7,628	42,581	5.6	2.1	1.2
XVII. Accidents, poisonings, and violence (supplementary classifications)	N800–N999, Y00–Y29	47,378	488,919	10.3	13.1	14.0
171. Fracture of the skull, and other intracranial injury	N800–N804, N850–N854	5,947	42,567	7.2	1.7	1.3
172. Fracture of spine and trunk	N805–N809	2,396	52,053	21.7	0.7	1.5
173. Fracture of upper limb	N810–N819	4,663	26,498	5.7	1.3	0.8
174. Fracture of femur	N820, N821	2,788	108,956	39.1	0.8	3.2
175. Other fractures of lower limbs	N822–N829	3,922	52,735	13.4	1.1	1.6
176. Dislocation without fracture, sprains and strains of joints and adjacent muscles	N830–N848	5,233	41,727	8.0	1.5	1.2
177. Internal injury of chest, abdomen, and pelvis	N860–N869	846	10,573	12.5	0.2	0.3
178. Laceration, open wound, superficial injury, contusion, and crushing with intact skin surface	N870–N929	8,378	50,108	6.0	2.3	1.5

[1] Includes rehabilitative care.

HOSPITALIZATION[1] BY MAJOR DIAGNOSTIC CATEGORIES, 1969 (EXCLUDING NEWBORNS)—*Continued*

List Number and Diagnosis	ICDA No.	Cases	Days of Care	Average Length of Stay	Percentage Distribution	
					Cases	Days of Care
XVII. Accidents, poisonings, and violence—*Continued*						
179. Foreign body entering through orifice	N930–N939	518	2,221	4.3	0.1	0.1
180. Burns	N940–N949	1,402	21,876	15.6	0.4	0.7
181. Injury to nerves and spinal cord	N950–N959	179	2,149	12.0	0.1	0.1
182. Adverse effects of medical agents	N960–N979	3,573	19,466	5.4	1.0	0.6
183. Toxic effects of substances chiefly nonmedical	N980–N989	865	3,673	4.2	0.2	0.1
184. Complications peculiar to certain surgical procedures, other complications of surgical procedures, and other complications to medical care	N997–N999	2,816	28,394	10.1	0.8	0.8
185. Other effects of external causes	N990–N996	736	9,629	13.1	0.2	0.3
186. Special conditions and examinations, without sickness	Y00–Y13	3,116	16,294	5.2	0.9	0.5
187. Mature infant	Y20, 22, 23, 26, 27	----------	----------	---	---	---
188. Immature infant	Y21, 24, 25, 28, 29	----------	----------	---	---	---
Totals		362,167	3,492,848	9.6	100.0	100.0

[1] Includes rehabilitative care.

STATEMENT OF RECEIPTS AND DISBURSEMENTS FOR THE FISCAL YEAR ENDED MARCH 31, 1970

Administration—	
Salaries	$873,411.00
Temporary assistance	7,633.00
	$881,044.00
Office expense	60,080.00
Travelling expense	59,101.00
Office furniture and equipment	14,393.00
Printing and publications	2,677.00
Tabulating and rentals	3,806.00
Motor-vehicles and accessories	2,356.00
Incidentals and contingencies	879.00
Construction and consultation fees	60,995.00
Technical surveys	50,587.00
	$1,135,918.00
Payments to hospitals	155,782,683.00
Grants in aid of construction	1,982,409.00
Total	$158,901,010.00

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