PROVINCE OF BRITISH COLUMBIA

HOSPITAL INSURANCE ACT

Twenty-third Annual Report

British Columbia Hospital Insurance Service

JANUARY 1 TO DECEMBER 31

1971

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1972

VICTORIA, BRITISH COLUMBIA, January 20, 1972.

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-third Annual Report of the British Columbia Hospital Insurance Service covering the calendar year 1971.

RALPH R. LOFFMARK
Minister of Health Services and Hospital Insurance

BRITISH COLUMBIA HOSPITAL INSURANCE SERVICE,
VICTORIA, BRITISH COLUMBIA, January 20, 1972.

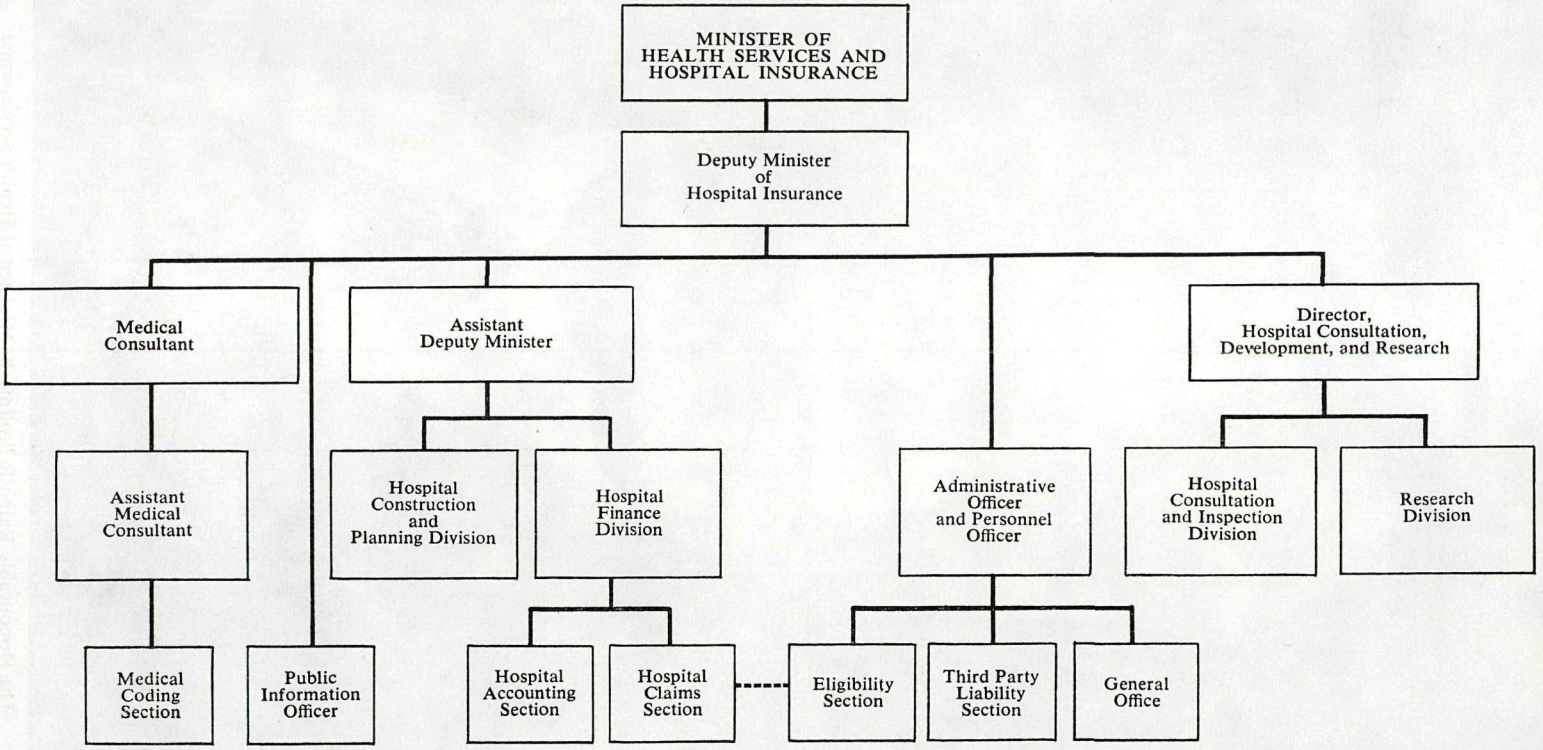
The Honourable Ralph R. Loffmark,
Minister of Health Services and Hospital Insurance,
Parliament Buildings, Victoria, British Columbia.

SIR: I have the honour to present herewith the Report of the British Columbia Hospital Insurance Service covering the calendar year 1971.

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.*

SENIOR ADMINISTRATIVE STAFF

D. M. COX, F.A.C.H.A., F.C.I., F.C.I.S., *Deputy Minister of Hospital Insurance.*

W. J. LYLE, F.C.I.S., *Assistant Deputy Minister of Hospital Insurance.*

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N. S. WALLACE, C.G.A., *Manager, Hospital Finance Division.*

K. G. WIPER, *Senior Administrative Officer.*

P. BREEL, *Manager, Hospital Consultation and Inspection Division.*

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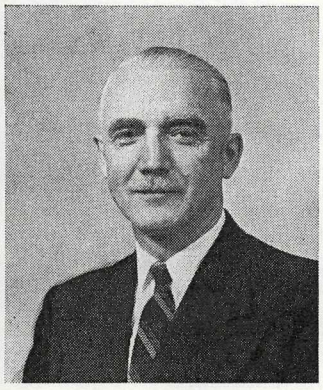
Twenty-third Annual Report of the British Columbia Hospital Insurance Service

GENERAL INTRODUCTION

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



Since the inception of hospital insurance coverage in British Columbia in 1949, residents of the Province have witnessed a development of hospital facilities which today rank among the finest to be found anywhere in the world.

Credit for this development must go to the fine co-operation and efforts of the boards and staffs of hospitals, the medical profession, regional hospital districts, and the Provincial Government.

During this 23-year period, there has been a steady increase in population and a corresponding increase in the need for new or renovated hospital buildings, equipment, and services, as indicated by the following comparisons:

	1949	1971 (Estimated)
Population	1,113,000	2,196,000
Active-treatment beds	5,840	10,700
Rehabilitation beds	----------	415
Extended-care beds	----------	2,100
Adult and child admissions—		
Acute and rehabilitation	164,964	395,303
Extended care	----------	1,647
Adult and child days of care—		
Acute and rehabilitation	1,682,196	3,633,713
Extended care	----------	670,000
Average hospital stay—active-treatment beds	10.21	8.95
Staff employed in hospitals	7,068	23,600
Payments to hospitals	$16,533,000	$205,000,000

The average length of stay in the Province for 1971 is the lowest on record in British Columbia. This did not occur by chance but is due to the combined efforts of the medical profession and hospital staffs. The significance of this accomplishment is evident when it is realized that a reduction of only one-tenth of a day in the average stay in a 400-bed hospital makes possible the admission of at least 120 more patients each year.

During the past year, payments to hospitals toward expenses incurred by residents totalled $205,000,000, which is the equivalent of $93.35 being paid on behalf of each man, woman, and child residing in British Columbia. Hospital insurance daily payments to hospitals amounted to $560,000, as compared to $490,410 in the 1970/71 fiscal year, an increase of 15 per cent.

Since January 1, 1949, British Columbia's programme of hospital construction, initiated by public-minded citizens at community level and stimulated by generous financial aid from the Provincial Government, has produced 56 new hospitals plus major additions to many other hospitals, and including new diagnostic and treatment centres, emergency departments, laboratory facilities, laundry buildings, and schools of nursing. In all, over 10,000 beds, including 2,100 extended-care beds, have been provided. Building programmes under way at year-end, many due for completion early in 1972, will cost an estimated $51,000,000.

Major projects completed during 1971 involved a total of 772 new beds, of which 221 were for extended care. In addition, 1,799 beds were under construction at year-end, with 1,054 of these for extended care.

Building programmes, including major construction, renovations, and alterations, were completed in the following communities: Burns Lake, Chetwynd, Golden, Kaslo, Mackenzie, New Westminster, North Vancouver, Ocean Falls, Prince Rupert, Sechelt, Surrey, and Victoria (Glendale).

During the past year, this Service worked closely with St. Paul's Hospital, Vancouver; the Vancouver General Hospital; and the Royal Jubilee Hospital, Victoria, to develop plans for major expansion of open-heart surgery programmes.

Arrangements were also made to bring under Hospital Insurance coverage the methadone-treatment programme provided through the Narcotic Addiction Foundation in Vancouver. Payments have been in effect since April 1, 1971. In addition, this Service brought under coverage the out-patient services at the G. F. Strong Rehabilitation Centre.

Other services involving Hospital Insurance personnel during 1971 included the sharing in the development of a programme for personal-care units in Vancouver, Victoria, and Kamloops to be constructed by the Provincial Government; representation on a ways-and-means committee set up to assist in the implementation of recommendations as contained in a report prepared for the Minister on cancer services in British Columbia; representation on a therapeutic abortion committee to study therapeutic abortion facilities in the Greater Vancouver Regional Hospital District; and to assist financially the Vancouver General Hospital to establish the first medical computer of its kind in Canada as a pilot project.

In late May, J. R. Ham, Chief Inspector of the Hospitals and Charities Commission, Melbourne, Australia, visited with the British Columbia Hospital Insurance Service staff to inquire about services and to discuss matters relating to hospital administration, staffing, industrial matters, and ambulance services in British Columbia.

The laboratory and radiological advisory councils continued to be of outstanding value in helping hospitals to improve the laboratory and radiological services, and in advising the Hospital Insurance Service regarding the approval of Provincial grants-in-aid for the purchase of major hospital equipment.

I should like also to express my 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 Registered Nurses' Association of British Columbia.

Finally, may I offer my sincere thanks to the skilled and devoted staff of the British Columbia Hospital Insurance Service for helping make 1971 another successful year of operation.

Reports by the various divisions which comprise the administrative structure of our Branch appear under "Organization and Administration" beginning on page 20.

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* below) 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.

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 illness 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 Act.

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 require 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 necessary 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 1971 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.

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 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 26 meetings held during the year, seven were with outside groups, including regional hospital districts. 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 continued activity by regional hospital districts in planning total hospital programmes to meet district needs. The Planning Group worked with seven regional hospital districts in developing comprehensive programmes on which

money votes were held and with four other districts whose programmes are expected to go before the ratepayers in 1972.

Following receipt of the report from the special task committee on cancer services in British Columbia, the Minister approved the formation of a Ways and Means Committee representative of the interested agencies to guide the implementation of the recommendations.

Studies of day-care services and of diagnostic and treatment centres were continued.

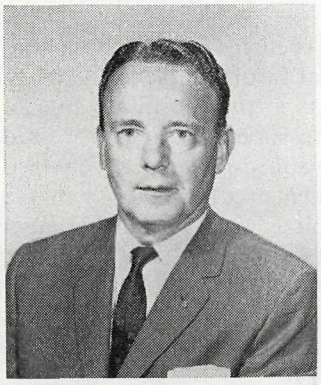
ORGANIZATION AND ADMINISTRATION

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 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 1971 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 18), Vice-Chairman of the BCHIS Planning Group (*see* page 19), 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 Radiological Advisory Council, and the British Columbia Hospitals' Association Liaison Committee. 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 1971, the Finance Division assisted the regional hospital districts in debenture sales to the British Columbia Regional Hospital Districts Financing Authority amounting to $29,000,000.

The Finance Division is also responsible for the approval of grants to assist hospitals in the purchase of equipment. In 1971, after a review of approximately 6,000 applications received from hospitals, grants estimated at $2,200,000 were approved on movable and fixed technical equipment costing $7,000,000.

As a means of assisting hospital employees to maintain high working standards, the Hospital Insurance Service provided over $140,000 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 Subcommittee 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 1971 amounted to $202,000,000.

(*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 recommendations 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 hospital-operating, pre-construction, and regional hospital district budgets were reviewed and processed in 1971. Inspection visits were made to each of 102 public general, rehabilitation, and extended-care hospitals during the year. Construction projects involving approved expenditures of $10,205,000 were audited, and cost reports involving approved expenditures of $424,000 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 the payment of 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 of Hospital Claims attended Admitting and Eligibility seminars held at Kamloops, Prince George, Fort St. John, and Castlegar. These seminars were attended by hospitals in the various regions. The Supervisor also visited new hospitals opened at Houston, Mackenzie, and Chetwynd to give advice and guidance on all matters handled by the Hospital Claims Section. He also visited the hospitals at Pouce Coupe, Dawson Creek, Smithers, and hospitals

in the Greater Vancouver area. While in Vancouver, the Supervisor of Hospital Claims visited the Workmen's Compensation Board to discuss matters of mutual concern.

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

Accounts processed were in excess of 1,850 per working-day, 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 IBM electronic data-processing equipment in order to refine 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 also checked with the verifying documents, and as a result over 4,000 claims had to be returned to hospitals during the year 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 assist further 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 residence of patients.

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, also 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 500 queries per month were addressed to the British Columbia Hospitals on such accounting matters.

Preliminary figures for 1971 show that more than 440,000 accounts (excluding out-of-Province) were processed. For comparison, the figures for 1970 were 435,385 accounts processed.

The Day-care Surgical Services, Day-care/Night-care Psychiatric Services, and Out-patient Psychiatric accounts increased in volume from 3,326 per month in 1970 to over 4,000 per month in 1971. During the year a quarterly statistical run of Day-care Surgical Services was introduced.

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 the punching of the data-processing 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. Over 140,000 statistical cards have been punched and verified.

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 340,000 statements were prepared and mailed.

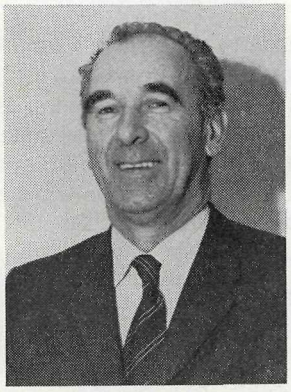
The out-of-Province personnel process all claims for hospital accounts incurred by British Columbia residents in hospitals outside the Province. This requires establishing eligibility and the payment of claims. During 1971 over 5,800 accounts amounting to an estimated $2,000,000 were paid on behalf of qualified residents hospitalized in other provinces and territories of Canada, the continental United States (including Alaska and Hawaii), Antigua, Australia, Belgium, Bermuda, Bolivia, British Honduras, Canary Islands, Ceylon, Colombia, Costa Rica, Denmark, England, Finland, France, Germany, Greece, Holland, Hong Kong, Hungary, India, Ireland, Israel, Italy, Japan, Liberia, Mexico, Morocco, Nepal, New Zealand, Norway, Philippines, Portugal, Rhodesia, Spain, Sweden, Switzerland, Tahiti, Taiwan, Uganda, and Yugoslavia.

Correspondence to accomplish the procedures amounted to over 20,000 letters for the year. This office also maintains up-to-date hospital rate schedules for every hospital in Canada. All claims were coded for statistical purposes and a data-processing card punched for each account.

The Filing and Mail Unit sorted and filed over 9,000 documents and letters daily. In order to handle increased volume, new procedures were instituted.

Hospital Construction and Planning Division

John Glenwright, Manager



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

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 master programmes which contain a clear definition of the hospital's role, supported by 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 other 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 most logical and the 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.

BCHIS Equipment Committee: Left to right, John Glenwright, Manager, Hospital Construction and Planning Division; Peter Breel, Manager, Hospital Consultation and Inspection Division, *Chairman;* Dr. David Longridge, Assistant Medical Consultant; and Bill Holborn, Finance Division Representative, *Secretary*.

During the year, over 200 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.

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.

The Division works with representatives of hospitals and regional hospital districts in the review and processing for consideration of Government those programmes of proposed capital expenditure to be included in a by-law and made the subject of regional hospital district referendums.

Continuing benefit was derived during 1971 from the co-operation of the Department of Public Works in the assignment of architects to this Division.

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.

The Manager of the Division also acted as a member of a special interdepartmental committee established to develop a "Design Guide" for personal-care homes. The Design Guide was used as a basis for proposals submitted by developers for the erection of personal-care homes planned for certain specific locations within the Province.

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

O. Brian Padden returned to the Division in August and resumed duties as a consultant architect.

Donald G. Coolidge, formerly Assistant Administrator at the Royal Inland Hospital, Kamloops, joined the staff of the Division as a Planning Consultant.

The members of the medical and nursing professions, and the staff of the Provincial Health Branch, through the Technical Supervisor of Clinical Laboratory Services and Technical Supervisor of Radiology, contributed materially to the provision of consultative services to hospitals. Also, 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 dumbwaiter installations in hospitals.

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. A five-day seminar for hospital maintenance engineers was held in Vancouver in September. This was conducted through the co-operation of the British Columbia Hospitals' Association. The Comac System, which is a simplified system of preventive maintenance developed by members of the Engineering staff of the Division is now in use or is being incorporated in many hospitals throughout the Province. Consultative advice is provided in the field of plant operation and maintenance and equipment selection. During the year a num-

ber of visits was made for inspection and advice pertaining to hospital mechanical plants and electrical installations.

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 1971 the Manager, as well as the architects and engineers, made a number of inspectional, advisory, and educational visits to hospitals throughout the Province.

(*a*) *Hospital Projects Completed During 1971*

Burns Lake and District Hospital — Seventeen additional acute and six extended-care beds came into operation on July 1, 1971, as a result of the addition and alterations project. The official opening was held on September 11, 1971.

Chetwynd and District Hospital—This new facility of 30 acute beds to serve the Chetwynd and Hudson's Hope area was officially opened by the Prime Minister, the Honourable W. A. C. Bennett, on October 4, 1971.

Golden and District General Hospital — The construction project to provide eight more acute beds (plus two for future use), six extended-care beds, and enlarged service departments was completed and officially opened by the Honourable J. R. Chabot on November 27, 1971.

Victorian Hospital, Kaslo—This new 10-bed acute hospital, replacing the old Victorian Hospital, was opened by the Honourable Patricia Jordan and Burt Campbell, M.L.A., on October 16, 1971.

Kimberley and District Hospital—A project, including a chiller unit, ventilation system, and sun screens, to provide air conditioning was completed during the summer, and the patient accommodation was rearranged on two floors, which resulted in five additional acute beds being brought into operation at the beginning of December.

Ladysmith and District General Hospital—A small project was completed at this hospital involving the provision of six additional acute beds for a total of 49, and an addition for the administrative department.

Mackenzie and District Hospital—The Minister of Health Services and Hospital Insurance, the Honourable Ralph R. Loffmark, officially opened the new facility at Mackenzie on July 9, 1971, although the prefabricated hospital actually came into operation on May 3, 1971.

Royal Columbian Hospital, New Westminster—The modular units containing 174 acute beds and the new department of physical medicine were opened by the Honourable Grace McCarthy on October 7, 1971. (The demolition of most of the 1912 wing and the renovation of existing areas, all part of this project, are still continuing.)

Lions Gate Hospital, North Vancouver—The first patients were admitted to the new 169-bed extended-care unit on June 1, 1971. The unit was officially opened by the Honourable Ralph R. Loffmark on June 26, 1971.

Ocean Falls General Hospital—The renovation of an existing building, known as Kimsquit Lodge, was completed to provide a 12-bed hospital. The official opening was held on September 14, 1971, although the first patients were transferred or admitted on May 22, 1971.

Prince Rupert Regional Hospital — Her Majesty the Queen officiated at the opening ceremonies for the new hospital on May 10, 1971. The new building has accommodation for 128 acute and 18 extended-care patients and replaces the old Prince Rupert hospital which had a capacity of 88 beds.

St. Mary's Hospital, Sechelt—The construction of a second storey to this hospital resulting in 10 additional acute beds, and an extended-care unit of 22 beds was completed and certain areas of the existing hospital were renovated. The project was officially opened by the Honourable Isabel Dawson on December 5, 1971.

Surrey Memorial Hospital—The final phase of the expansion programme was completed and the first patients admitted to the renovated old hospital building on August 1, 1971. This hospital now has a rated capacity of 297 acute and 78 extended-care beds.

Glendale Lodge, Victoria — On October 20, 1971, the Honourable W. A. C. Bennett officially opened this building, which includes accommodation for 150 extended-care patients.

(b) Hospital Projects Under Construction at Year-end

Lady Minto Hospital, Ashcroft—New 41-bed acute hospital to replace the old existing hospital which has a capacity of 29 acute beds.

Burnaby General Hospital—A 150-bed extended-care unit is being constructed adjacent to the acute hospital.

Chilliwack General Hospital — Phase II of the expansion project is nearing completion. The project involves 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.

Cranbrook and District Hospital—Fifteen-bed addition to extended-care unit.

Dr. Helmcken Memorial Hospital, Clearwater—A new facility of 10 beds.

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

Lady Minto Gulf Islands Hospital, Ganges—A 15-bed extended-care unit is being added on to the existing acute hospital. In addition, the dietary department and mechanical room are being enlarged.

Fraser Canyon Hospital, Hope—Additions and alterations to provide a total of 38 acute beds and enlarged service departments.

Windermere District Hospital, Invermere — Additions and alterations to provide a total of 31 acute beds and enlarged service departments.

Kelowna General Hospital—The final phase of the expansion programme, consisting of the renovation of the old existing hospital (now known as Block A), is currently under way. The project, when complete, will provide 74 acute beds, including a 23-bed psychiatric unit, a 21-bed activation/rehabilitation unit, and new physio- and occupational-therapy departments; an addition at the main-floor level to provide an enlarged regional laboratory facility; and five beds for future use.

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

Royal Columbian Hospital, New Westminster—Renovation of existing areas. In addition, a new power plant, including two new water-tube boilers and related mechanical and electrical services, is under construction.

South Okanagan General Hospital, Oliver — A new 45-bed acute hospital to replace the existing St. Martin's Hospital, which has a capacity of 37 acute beds.

Penticton Hospital—The extensive expansion programme is expected to be finished early in the new year. The project 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 renovation of the existing building.

West Coast General Hospital, Port Alberni—The expansion programme at this hospital is also nearing completion. This project involves additions and renovations which will result in a net gain of 28 additional acute beds, a 30-bed extended-care unit, and the renovation of the existing building.

Port Hardy and *Rumble Beach*—Diagnostic and treatment centres; the one at Port Hardy will have 10 temporary in-patient beds and the one at Rumble Beach, three emergency beds.

Prince George Regional Hospital—Construction of the West Wing Addition to provide a net gain of 135 beds, of which 35 will be used for extended care; an enlarged power plant, dietary, central sterilizing, laundry departments, storage, etc.

Richmond General Hospital — 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, 25 extended-care beds, and enlarged service departments.

Stewart General Hospital—Additions and renovations to provide 10 more acute beds, expanded diagnostic and treatment facilities, doctors' clinic.

Vancouver General Hospital—A 201-bed extended-care unit.

G. F. Strong Rehabilitation Centre, Vancouver—Construction of an addition containing 100 activation/rehabilitation beds as well as the renovation of the existing building.

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

Gorge Road Hospital, Victoria—An addition of 300 extended-care beds to the existing 99-bed activation/rehabilitation hospital.

St. Joseph's Hospital, Victoria—An ambulatory care unit for day-care surgery patients.

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

Armstrong and Spallumcheen Hospital, Armstrong—Alterations and renovations to upgrade diagnostic, treatment, and service facilities.

R. W. Large Memorial Hospital, Bella Bella—Replacement of existing building with a new hospital of 19 acute and four extended-care beds.

Campbell River and District General Hospital—Thirty additional acute beds and expansion of services.

Chilliwack General Hospital—Third phase of expansion programme—the renovation of existing areas of the hospital.

St. Joseph's General Hospital, Comox—Completion of the unfinished top floor to provide approximately 50 acute beds, additional construction of 20 psychiatric beds, day-care facilities, expansion of services.

Cowichan District Hospital, Duncan—A 100-bed extended-care unit (75 beds to be finished) to be built on the old King's Daughters' Hospital site.

Enderby and District Memorial Hospital—Alterations and additions to improve diagnostic, treatment, and service facilities.

St. Vincent's Hospital, Vancouver—Expansion of the hospital to provide a 75-bed extended-care unit, 20 psychiatric beds, 10 day-care psychiatric spaces, occupational-therapy facilities, personnel lockers, storage, dietary facilities.

Vancouver General Hospital—Renovation of the Willow Pavilion, expanded open-heart surgery facilities.

(*d*) *Additional Projects Approved and in Various Planning Stages in 1971*

Matsqui-Sumas-Abbotsford General Hospital, Abbotsford — Expansion programme to include extended-care beds.

St. George's Hospital, Alert Bay—Improvements to buildings and grounds.

Central Saanich—Seventy-five extended-care beds and 75 acute beds to replace Rest Haven Hospital, Sidney.

Chemainus General Hospital—Alterations and renovations to upgrade diagnostic, treatment, and service facilities.

Fernie Memorial Hospital—Replacement of existing building with a new hospital to serve Fernie and Michel areas.

Gold River—Diagnostic and treatment centre.

Boundary Hospital, Grand Forks—Addition of extended-care beds.

Wrinch Memorial Hospital, Hazelton—Replacement of existing building with a new acute hospital to include extended-care beds.

Royal Inland Hospital, Kamloops—Expansion of acute hospital, including psychiatric and activation/rehabilitation and extended-care unit.

Lillooet District Hospital—Expansion of acute hospital, plus extended-care unit.

Maple Ridge Hospital—Expansion of acute hospital and extended-care unit.

Nicola Valley General Hospital, Merritt—Completion of four acute beds.

Mount Waddington Regional Hospital District—Approval to select and acquire a site and plan a central regional hospital facility.

Langley Memorial Hospital, Murrayville—Expansion of acute hospital.

Arrow Lakes Hospital, Nakusp—Replacement hospital to serve Nakusp and New Denver.

Kootenay Lake District Hospital, Nelson—Expansion of acute hospital and services.

Mount St. Francis Hospital, Nelson—Renovations and improvements to upgrade the facilities.

100 Mile District General Hospital, 100 Mile House—Expansion of acute hospital.

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

G. R. Baker Memorial Hospital, Quesnel—Extended-care unit, expanded X-ray and dietary departments.

Bulkley Valley District Hospital, Smithers—Expansion of acute hospital to include extended-care beds.

Squamish General Hospital—Additions and alterations.

Tahsis—New hospital to replace Esperanza General Hospital.

Tatla Lake—Outpost nursing station.

Burnaby General Hospital—Expansion of acute beds and services.

Royal Columbian Hospital, New Westminster—Expansion of acute beds and services.

Lions Gate Hospital, North Vancouver—Expansion of services.

Children's Hospital, Vancouver—Care-by-parent unit; children's diagnostic, treatment, and services.

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.

Vancouver General Hospital—Activation/rehabilitation unit.

Health Sciences Centre, Vancouver—350-bed acute hospital (Phase III).

Vernon Jubilee Hospital — New extended-care unit, including extended-care beds for children; conversion of existing extended-care unit for acute care.

Royal Jubilee Hospital, Victoria—Expansion.

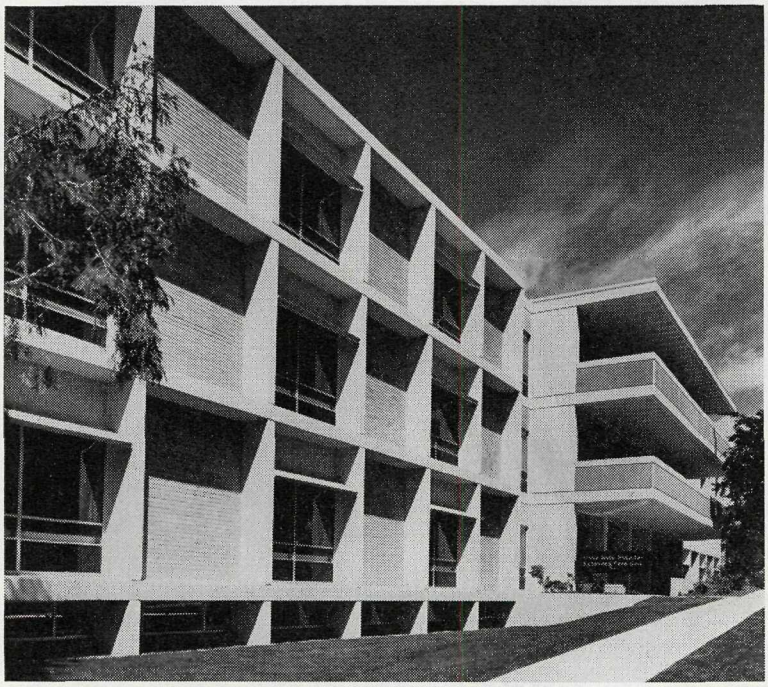
Cariboo Memorial Hospital, Williams Lake—Expansion.

Major Hospital Projects, 1971

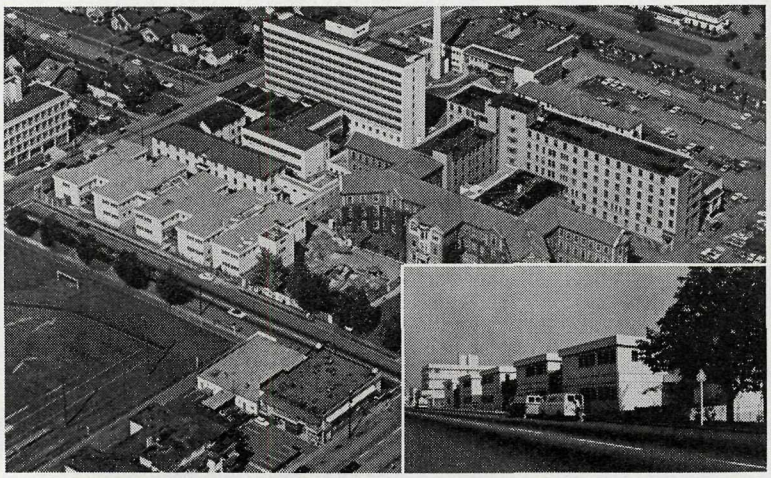
Completed—Burns Lake, Chetwynd, Cranbrook, Golden, Kaslo, Kimberley, Ladysmith, Mackenzie, New Westminster (Royal Columbian), North Vancouver, Ocean Falls, Prince Rupert, Sechelt, Surrey, Victoria (Glendale).

Under construction — Ashcroft, Burnaby, Chilliwack, Clearwater, Fort St. James, Ganges, Hope, Invermere, Kelowna, Nanaimo, New Westminster (Royal Columbian), Oliver, Penticton, Port Alberni, Port Hardy, Rumble Beach, Prince George, Richmond, Salmon Arm, Stewart, Vancouver (Vancouver General) (G. F. Strong Rehabilitation Centre), Vanderhoof, Victoria (Gorge Road) (St. Joseph's).

For details, *see* pages 27, 28, 29, 30, and 31.

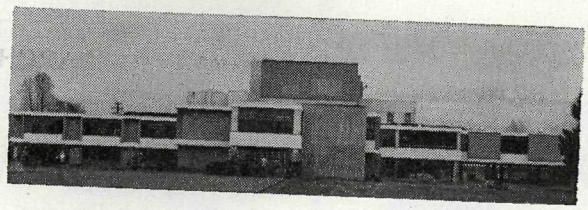


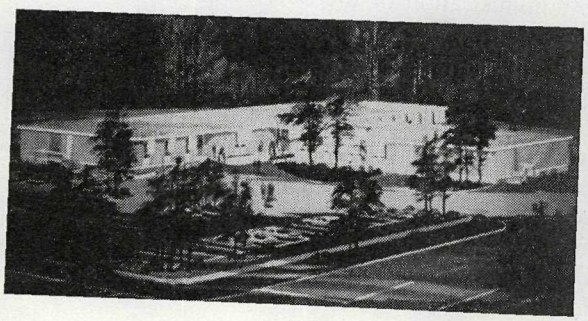
The new Lions Gate Hospital Extended-care Unit, North Vancouver. (Architects: Underwood, McKinley, Cameron, Wilson, and Associates.)



Royal Columbian Hospital, New Westminster, showing new modular units (insert).

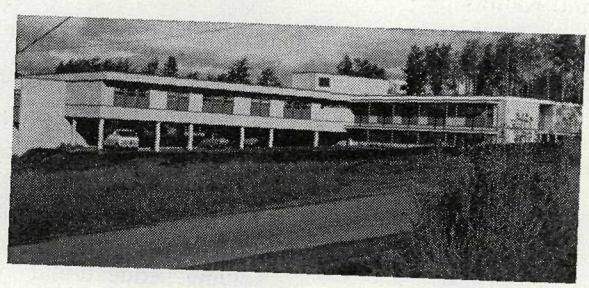
The new addition at Chilliwack General, which includes extended care, rehabilitation, and psychiatric beds.

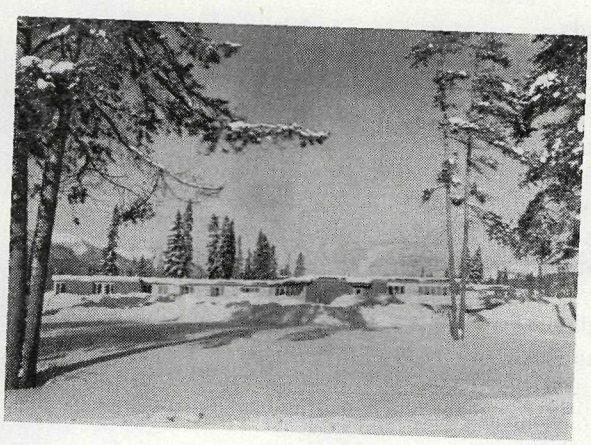




Artist's rendition of the new prefabricated Mackenzie Hospital.

Burns Lake and District Hospital with the new addition shown at left—(Architects: Wagg & Hambleton.)





Golden and District General Hospital, showing the new addition at right, which includes six extended-care beds.

DIRECTOR OF HOSPITAL CONSULTATION, DEVELOPMENT, AND RESEARCH

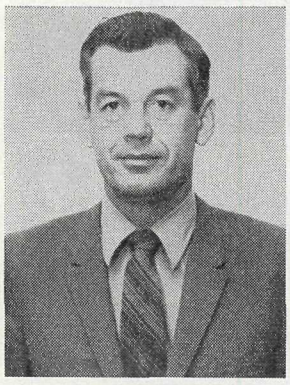
J. W. Mainguy, M.H.A.

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 18 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 the programme development for four personal-care homes to be constructed by the Provincial Government in Victoria, Vancouver, and Kamloops.

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 management. The services of the members of this Division are available to all hospitals in the areas of hospital organization and management, problem-solving, educational roles, planning, and operational research capacities. The Division is also responsible for an inspectional programme to ensure that basic standards are met, and for the licensing of private hospitals.

The staff of the Division is composed of trained and qualified administrators, nurses, management engineers, and a dietitian.

The manager is a member of the Hospital Rate Board, the Planning Group, and chairman of the Equipment Committee, while E. C. Luscombe, the senior administration consultant, provides liaison as a member on the Community Care Facilities Licensing Board, Functional Programme Review Committee, and B.C.H.A. Education Committee. These duties are in addition to his responsibilities of co-ordinating the activities of the administration consultants and the analysis and recommendations for approved staffing patterns on hospital estimates. Each of the five administrators has been assigned the consultation and inspection responsibilities for groups of specific hospitals. In addition to streamlining the Division's flow of work, it has given each hospital a definite liaison with the Service.

P. B. Langran, head of the management engineering unit, has continued to be active in the organization of regional management engineering units in the Capital Region and in Vancouver. Unit members have been actively involved in promoting understanding of management engineering among the hospitals in the Province and have co-operated with the BCHA in providing an educational programme. The unit has completed methodologies on hospital housekeeping and studies in hospital laundry and CSR operations, in addition to many other studies for individual hospitals on a variety of subjects. Two summer students were employed during 1971 and each completed a basic research study, one in housekeeping methodology and the other on the operational implications of nurseservers.

Miss E. E. Nordlund, senior nursing consultant, represents BCHIS on many nursing and nursing education committees, providing valuable liaison with the profession. During 1971 the nursing section completed a review of the level of nursing care in all private hospitals in British Columbia, in addition to their ever-growing task of providing nursing consultation for an increasing number of hospital beds in the Province.

Miss H. E. Armstrong, dietary consultant, together with Mr. Langran and dietitians from Penticton Hospital and the Federal Government, is engaged in a research project at the Penticton Hospital aimed at evaluating the efficiency and cost of a new chilled- and frozen-food method. She has also been active in the planning of new facilities, regular consultative visits, as well as taking part in an educational seminar for hospital dietary personnel.

During the year, members of this Division, in co-operation with the members of the Medical Consultant's Division, completed an extended-care programme guide which describes the basic principles of an extended-care programme; the responsibilities of the parties involved, that is, board, individual staff classifications, and volunteers, and describes in detail an organization and programme aimed at providing a high level of extended care. A total of 444 staff visits was made to acute, rehabilitation, extended-care, convalescent, and other hospitals. And, in addition, 294 visits were made to private hospitals giving nursing-home care. Also, as a necessary means of keeping abreast of changing concepts and techniques in the hospital field, personnel of the Division attended a variety of educational sessions during the year.

Research Division

D. S. Thomson, B.A., M.P.A., Director

The Research Division is responsible for advising the Service on the need for additional hospital beds and services. In order to assess the demand for new facilities, the Division carries out bed-need studies, both on an individual hospital and regional basis. These studies involve a comprehensive analysis of hospitalization data as well as economic and demographic information. The formation of regional hospital districts has brought about a greater need for planning hospital services on a regional scale, and this Division co-operates with other divisions of the Service for the purpose of providing guidelines for hospital development on a regional basis.

This Division is also responsible for compiling and maintaining statistical data relating to hospitalization

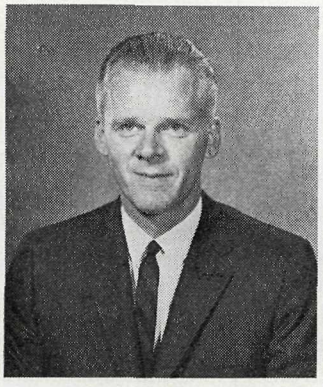
and morbidity in the Province. The admission/separation records submitted by the hospitals for each patient form the basis of this information. All diagnoses and operations are coded according to the *International Classification of Diseases Adapted* (8th revision). By use of this classification system it is possible to analyse the incidence of disease by age, sex, and geographical location as well as other variables. In connection with morbidity reporting, the Division publishes a number of annual reports. *Statistics of Hospital Cases Discharged 1970* includes the standard morbidity tables which all provinces have agreed to publish in order that national health statistics can be developed. *Statistics of Hospitalized Accident Cases,* which is also prepared annually, provides a broad analytical coverage of hospitalized accident cases by circumstance, by type of accident, and by nature of injury. A report of the *Day Care Surgery British Columbia Hospitals* is prepared in conjunction with the Medical Consultation Division for the purpose of showing the potential of this type of service. In addition to these reports the Division supplies data to many agencies both inside and outside of the Government. The demand for hospital morbidity data continues to grow and has become particularly useful in the planning of specialized hospital services. Every attempt is made to provide information for worth-while projects.

Since the change in the Criminal Code in 1969 permitting therapeutic abortions, the Division has maintained a reporting system for all therapeutic abortions performed in hospitals in the Province. The current interest in this subject has stimulated an increasing demand for information relating to therapeutic abortions.

In August 1971, D. S. Thomson returned to his position as Director of the Division after a one-year educational leave of absence.

MEDICAL CONSULTATION DIVISION

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



This Division is responsible for medical consultation within the Hospital Insurance Service, between the Service and other Departments of Government, with hospitals at all levels of care, and with regional hospital districts. Other responsibilities include liaison with other health agencies such as the British Columbia Medical Association, the British Columbia Hospitals' Association, and the University of British Columbia; the medical coding and assessing of all discharge records received from hospitals; the initial medical assessment and continuing quarterly review of patients to determine their eligibility for coverage by the Hospital Insurance Service under the extended-care programme; and medical record consultation to hospitals and related organizations.

The staff of the Division is composed of physician, physiotherapy, medical record librarian consultants, and nurses who are trained to undertake the assessment and coding of claims received from hospitals.

The Medical Consultants assist in the planning and implementation of new services in hospitals by representation on the Planning Group, the Equipment Com-

mittee, and the Functional Programme Review Committee at the Hospital Insurance Service.

The Medical Consultants provide continuing and active liaison with all health agencies, through visits to hospitals, special disease groups, societies, regional hospital districts, and professional bodies, and represent the Service as members of committees developed by these organizations. 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 Medical Consultant also represented the Service on an advisory committee established to make recommendations regarding therapeutic abortion facilities in the Greater Vancouver Regional Hospital District.

The Admission/Separation Record, which is completed for each patient admitted to a hospital either in British Columbia or outside the Province, is assessed with regard to medical eligibility for coverage, and is then coded in accordance with the "International Classification of Diseases, Adapted for Indexing Hospital Records by Diseases and Operations." Graduate nurses undertake the review and coding functions, and in areas of difficulty receive the assistance of a Medical Consultant. The coded records are then utilized by the Research Division for compiling and maintaining statistical data relating to hospitalization and morbidity in British Columbia.

Applications for admission to the extended-care programme, submitted on behalf of patients, were assessed for medical eligibility by the Medical Consultation Division. At the end of 1971, extended-care coverage was being provided to some 2,150 patients in the Province. During the year, 3,192 applications for admission to this programme were assessed for medical eligibility by the Medical Consultation Division. Additionally, 65 reviews of extended-care hospitals were undertaken to ensure that the hospitals' extended-care population continued to remain medically eligible for this benefit. During this audit review the hospital's programme is also assessed to ensure that the care which the patient receives is commensurate with current thinking in the management of chronically disabled individuals.

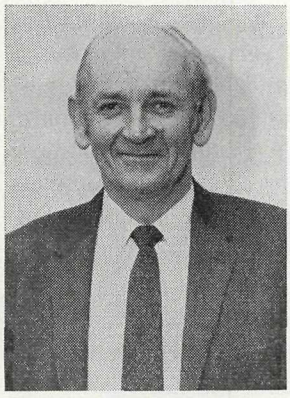
The Medical Record Consultant provided consultative advice to the Service, to hospitals visited in the Province, and participated as a member of the Provincial Education Committee of the British Columbia Association of Medical Record Librarians.

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, and the Hospitals Committee of the British Columbia Medical Association, to render assistance.

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.

ADMINISTRATION DIVISION

K. G. Wiper, Senior Administrative Officer



The Senior 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 and corporations are provided with assistance in connection with the drafting of hospital constitutions and by-laws, and their interpretation and application. Changes in hospital by-laws are 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 staff of this Division worked closely with the officials of other divisions, Government departments, and the various districts in arranging for money by-laws, temporary borrowing, and related matters.

In collaboration with the Hospital Consultation and Inspection Division, the Senior 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. The Division is also involved in the acquisition and disposal of hospital sites. 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 1971 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.

The Senior 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 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 considerable 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. During 1971, regional meetings were held in Kamloops, Prince George, Fort St. John, and Castlegar, which were attended by 159 persons representing 53 hospitals. This Section also participated in a workshop on admitting procedures held by the British Columbia Hospitals' Association in Vancouver.

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, 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 in the Lower Mainland area 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, which deals with cases arising elsewhere in British Columbia.

General Office

C. R. Leighton

One of the main responsibilities of the General Office is the handling of funds and the review of requisitions and vouchers submitted by other divisions. These include travel expenses, requisitions for supplies and equipment, grant payments to hospitals, and administrative vouchers. These are then forwarded to the appropriate branch of Government for further action. The Supervisor is responsible for gathering information from all divisions and co-ordinating this material in the preparation of the annual estimates of the Hospital Insurance Service which are submitted to Treasury Board for inclusion in the Provincial Budget. The General Office also handles the storage and dispatch of the various forms supplied by this Department to hospitals. Mail is opened, sorted, and distributed in this office and stenographic services to other offices are provided on an occasional basis.

INFORMATION OFFICE

C. N. Shave

This office is responsible for providing a basic programme of general information and public relations. Its three main areas of involvement are general public, approved hospitals, and in-service requirements.

To keep the public informed during the year, numerous press releases were prepared for the news media, dealing with hospital construction programmes, policy changes, and other items of interest. Regular editions of the *BCHIS Bulletin* were published every two months for distribution to public and private hospitals, as well as interested members of the public. (A total of 10,800 were sent out during 1971.) The *Bulletin* is an administrative aid providing detailed explanation of policy and procedures with items of interest for hospitals and our own staff. Circulation at the present time is 1,800.

A general outline of the organizational structure of the British Columbia Hospital Insurance Service was updated at the request of the British Columbia Hospitals' Association, and 1,000 copies were supplied for inclusion in their Trustees' Manual.

The *General Information* pamphlet was revised and reprinted, and over 32,000 copies were distributed to hospitals, business and industry, civic organizations, welcome-wagon agencies, and other services which come in regular contact with new residents of the Province. A pamphlet on extended care was produced as a joint effort by the Assistant Medical Consultant and the Information Officer. This is now being sent to interested parties in limited quantities. Hospital posters outlining BCHIS benefits and clarifying additional charges for private and semiprivate accommodation were updated for admitting office and reception areas of hospitals. These were sent to BCHIS Eligibility Representatives for distribution to hospitals throughout the Province.

Visits were made to the Pacific National Exhibition in July for the purpose of having our Departmental exhibit redesigned. Later, in September, a new portable display was built for the British Columbia Hospitals' Association Convention which was held in Vancouver in October. A pamphlet containing statistical data and other information of interest to administrative personnel of hospitals was prepared for distribution at the same convention, and a BCHIS information booth was set up and manned for the convenience of delegates meeting with the Minister and Departmental personnel.

A history of the British Columbia Hospital Insurance Service was completed during the year, and historical information on British Columbia hospitals was researched for the late Dr. Harvey Agnew. Descriptive material concerning new hospital facilities was prepared prior to the official opening of the facilities.

BCHIS films located in the Health Branch Film Library, which are maintained for the free use of hospitals for in-service training purposes, were used quite extensively throughout 1971. In all, a total of 88 screenings were made by hospitals.

During the year the Information Officer visited several hospitals in the Province. The discussions held proved to be very worth while, and future trips are planned.

Other duties included summarizing reports for the Deputy Minister, drafting speech material, maintaining newspaper and photograph files, writing news and feature items for the *BCHIS Bulletin,* preparing annual estimates for the Information Office, answering telephone inquiries, and replying to an ever-increasing number of written requests for information, also the compiling and initial editing of this 23rd Annual Report. In addition, there were 650 annual reports sent out, as well as several manuals and serial letters.

APPROVED HOSPITALS

General 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.
Chetwynd General Hospital, Chetwynd.
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 District 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.
Mackenzie and District Hospital, Mackenzie.
Maple Ridge Hospital, Maple Ridge.
Mater Misericordiæ Hospital, Rossland.
Matsqui, Sumas, and Abbotsford General Hospital, Abbotsford.
Michel-Natal District Hospital, Sparwood.
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, Princ 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 General 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.

* Hospitals with extended-care units.

General Public Hospitals—*Continued*

*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.
Canadian Forces Station Hospital Holberg, San Josef.
*Miller Bay Indian Hospital, Prince Rupert.
Canadian Forces Station Hospital, Masset.

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.

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).
Glendale Lodge, Victoria.

Out-patient Clinics

Houston Hospital, Houston.
The Narcotic Addiction Foundation of British Columbia, Vancouver.

* 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 1971 there were 94 public general hospitals, including two diagnostic and treatment centres, approved to accept British Columbia Hospital Insurance Service patients. Care was also provided in seven outpost hospitals, five 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 1971 there were 34 hospitals providing extended care Data for the year 1971 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 1A shows a total of 365,021 British Columbia Hospital Insurance Service adult and children patients were discharged (separated) from British Columbia hospitals in 1971, an increase of 9,572 or 2.7 per cent over 1971. This table also shows that 95.8 per cent of the total patients discharged (separated) from British Columbia public hospitals were covered by hospital insurance, compared to 95.6 in 1969 and 95.7 in 1970. Table 1B indicates that in 1971 the British Columbia Hospital Insurance Service paid public hospitals in British Columbia for 3,266,675 days of care for adults and children, an increase of 33,122 days, or 1 per cent over 1970.

As shown in Table 2A, the average length of stay for British Columbia adult and child patients in public hospitals during 1971 was 8.95 days, and the days of care per thousand population were 1,693. For comparison purposes, the data for extended-care hospitals are not included in the above observations, but it should be noted that an additional 305 days of care per thousand population were provided for these patients.

Table 2B, under "Minor Surgery Patients," includes an estimated 48,000 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	Newborn	Total	Adults and Children	Newborn	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	354,766	36,550	391,316	339,409	34,576	373,985
1970[2]	371,266	36,931	408,197	355,449	35,047	390,496
1971[3]	381,243	35,354	416,597	365,021	33,919	398,940
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	----	----	----	95.7	94.6	95.6
1970[2]	----	----	----	95.7	94.9	95.7
1971[3]	----	----	----	95.7	95.9	95.8

[1] Includes rehabilitation hospitals.
[2] Amended as per final reports received from hospitals.
[3] Estimated, based on hospital reports to October 31, 1971.

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	3,315,760	248,324	3,564,084	3,156,171	231,803	3,387,974
1970[2]	3,384,586	253,081	3,637,667	3,233,553	238,049	3,471,602
1971[3]	3,403,488	229,404	3,632,892	3,266,675	218,063	3,484,738
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				95.2	93.3	95.1
1970[2]				95.5	94.1	95.4
1971[3]				95.9	95.0	95.9

[1] Includes rehabilitation hospitals.
[2] Amended as per final reports received from hospitals.
[3] Estimated, based on hospital reports to October 31, 1971.

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	Newborn	Adults and Children	Newborn	Adults and Children	Newborn	Adults and Children	Newborn	
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	353,457	34,974	339,409	34,576	8,867	94	5,181	304	1,100
1970[1]	369,210	35,431	355,449	35,047	8,307	87	5,454	297	1,022
1971[2]	379,081	34,369	365,021	33,919	8,160	100	5,900	350	1,647
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	3,397,005	234,098	3,156,171	231,803	186,565	463	54,269	1,832	502,365
1970[1]	3,465,504	240,657	3,233,553	238,049	176,086	450	55,865	2,158	531,808
1971[2]	3,496,900	220,778	3,266,675	218,063	170,225	465	60,000	2,250	670,000
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	9.61	6.69	9.30	6.70	21.04	4.92	10.47	6.03	456.70
1970[1]	9.39	6.79	9.10	6.79	21.20	5.34	10.24	7.27	520.36
1971[2]	9.22	6.42	8.95	6.43	20.86	4.65	10.17	6.43	405.91

[1] Amended as per final reports from hospitals.

[2] Estimated, based on hospital reports to October 31, 1971. 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, 1,734; 1971, 1,693. (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 250 in 1970 and 305 in 1971. 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	389,531	220,000	609,531
1970[1]	405,663	235,000	640,663
1971[2]	415,097	265,000	680,097
Totals	6,683,754	2,799,073	9,482,827

[1] Amended as per final reports received from hospitals.
[2] Estimated, based on hospital reports to October 31, 1971.

TABLE 3—PATIENTS SEPARATED, TOTAL DAYS' STAY, AND AVERAGE LENGTH OF STAY IN BRITISH COLUMBIA PUBLIC HOSPITALS FOR BCHIS PATIENTS ONLY, GROUPED ACCORDING TO BED CAPACITY, YEAR 1971[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	365,021	194,515	85,366	47,732	29,475	7,933
Newborn	33,919	16,755	8,647	5,679	2,165	673
Patient-days—						
Adults and children	3,266,675	1,805,182	710,525	482,853	217,193	50,922
Newborn	218,063	111,178	54,021	36,340	12,887	3,637
Average days of stay—						
Adults and children	8.95	9.28	8.32	10.11	7.37	6.42
Newborn	6.43	6.63	6.25	6.40	5.95	5.40

[1] Estimated, based on hospital reports to October 31, 1971.

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 1971[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	100.00	53.29	23.38	13.08	8.08	2.17
Newborn	100.00	49.40	25.49	16.74	6.38	1.99
Patient-days—						
Adults and children	100.00	55.26	21.75	14.78	6.65	1.56
Newborn	100.00	50.99	24.77	16.66	5.91	1.67

[1] Estimated, based on hospital reports to October 31, 1971.

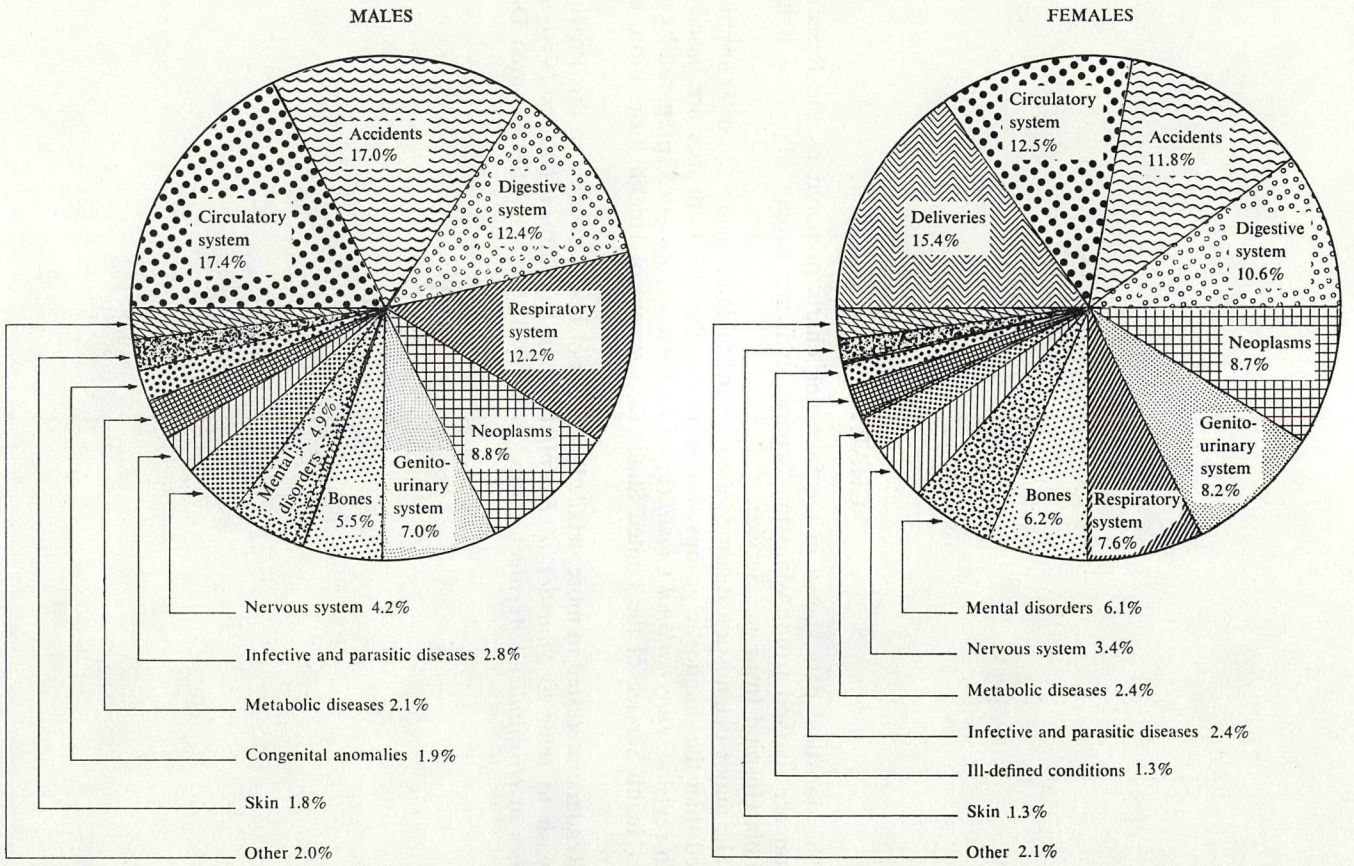
CHARTS

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.

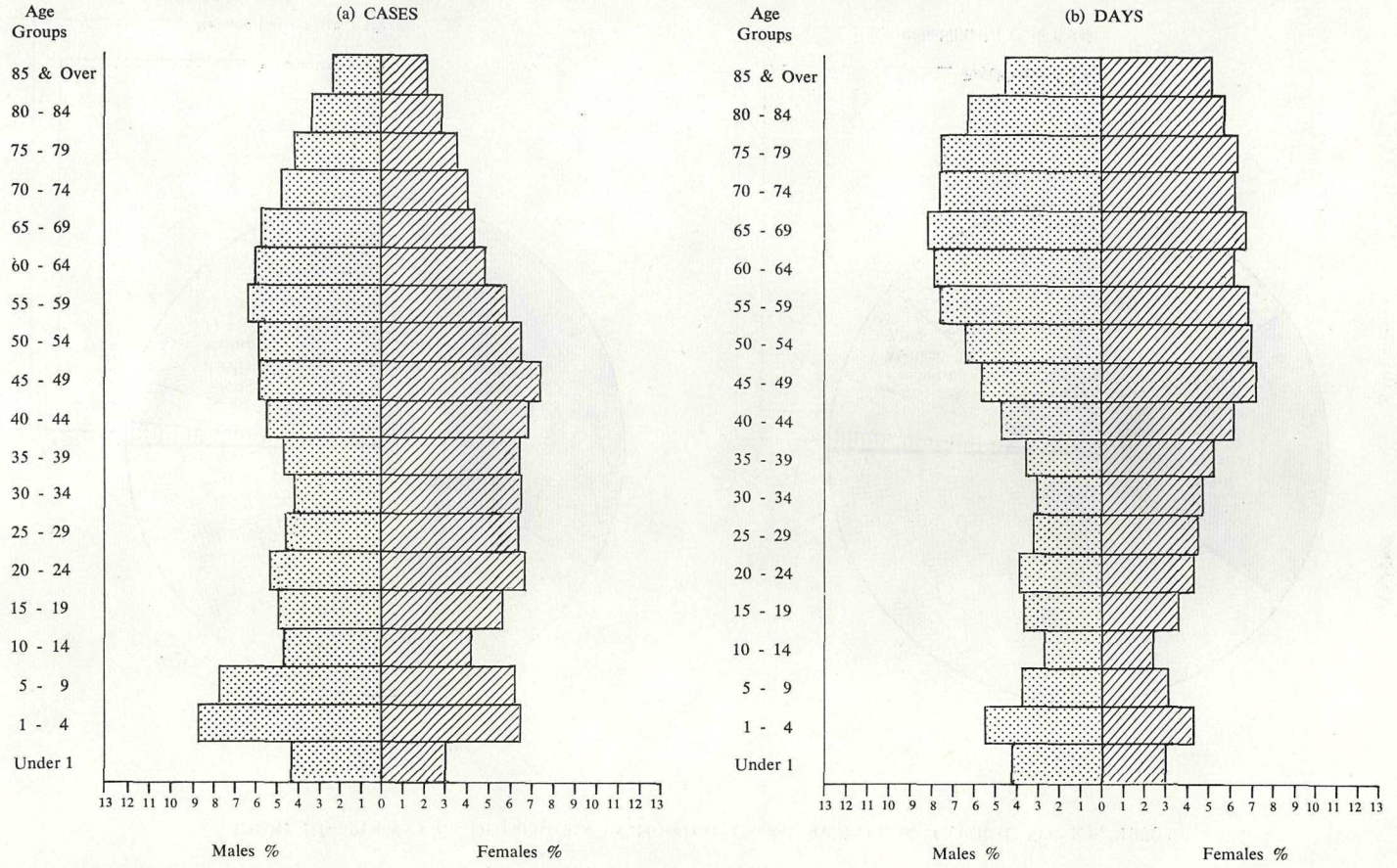
Readers interested in more detailed statistics of hospitalization in this Province may wish to refer to *Statistics of Hospital Cases Discharged During 1970* and *Statistics of Hospitalized Accident Cases, 1970,* available from the Research Division.

CHART I—PERCENTAGE DISTRIBUTION OF DAYS OF CARE* BY MAJOR DIAGNOSTIC GROUPS, 1970
(IN DESCENDING ORDER)



* Including rehabilitative care.

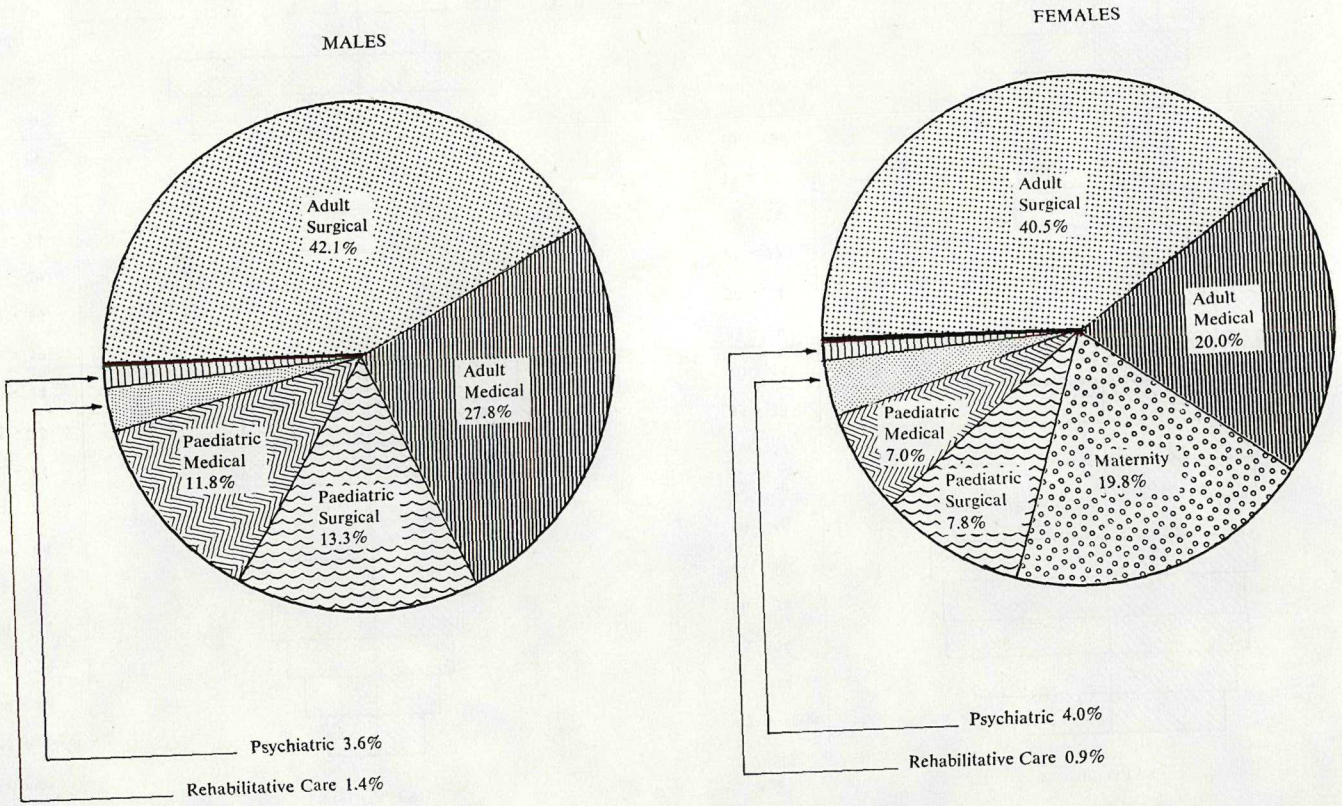
CHART II—PERCENTAGE AGE DISTRIBUTION OF MALE AND FEMALE* HOSPITAL CASES AND DAYS OF CARE,† 1970



* Group XI (Deliveries and Complications of Pregnancy, Childbirth, and the Puerperium) has been excluded, so as to bring out more clearly the comparison between males and females in respect of hospitalization not connected with the natural process of childbirth.

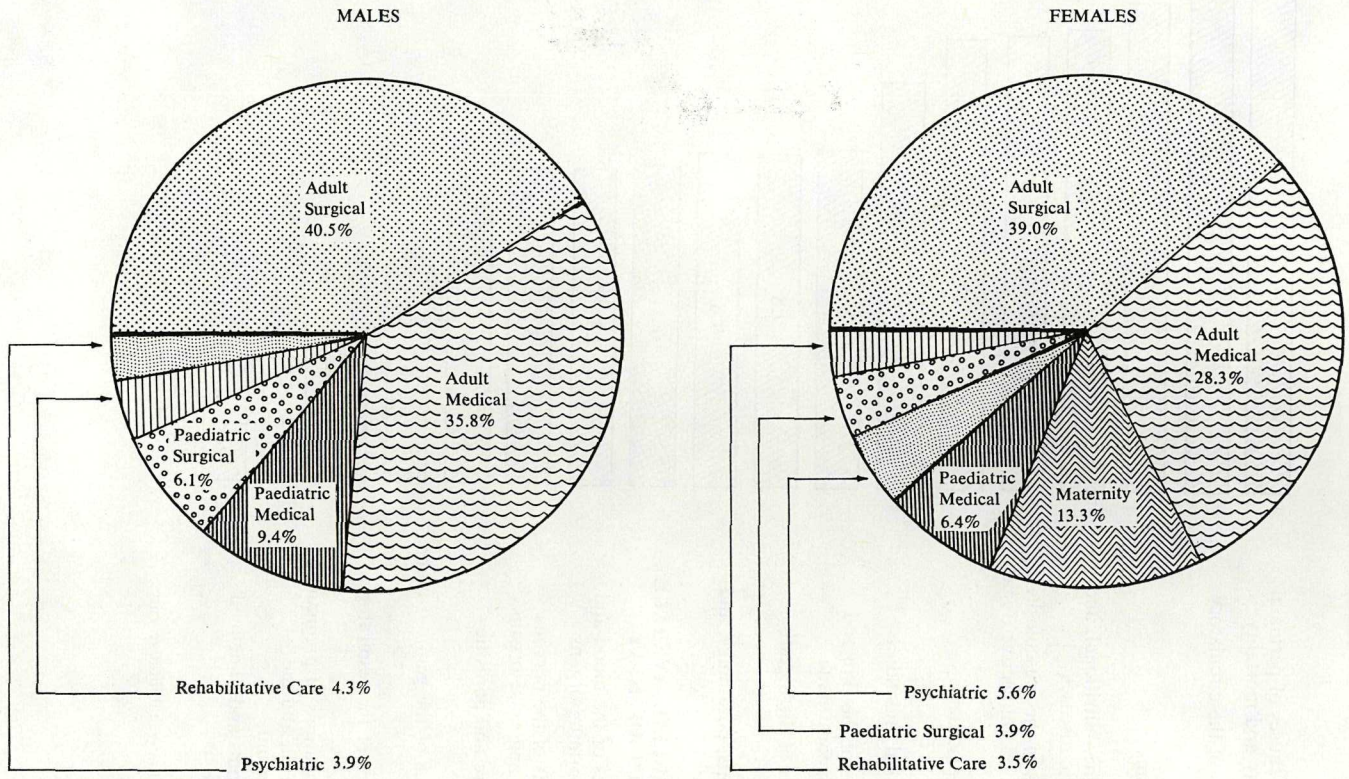
† Including rehabilitative care.

CHART III—PERCENTAGE DISTRIBUTION OF HOSPITAL CASES* BY TYPE OF CLINICAL SERVICE, 1970



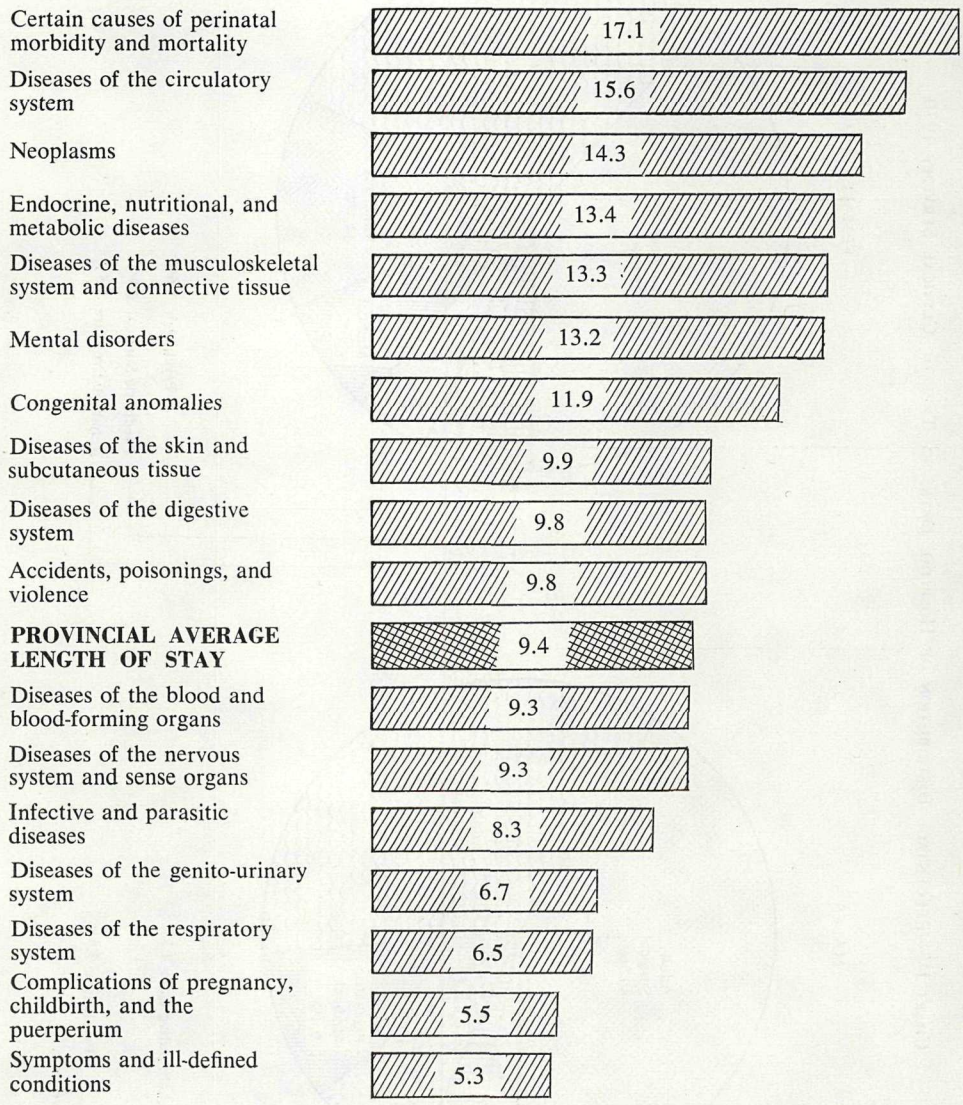
* Including rehabilitative care.

CHART IV—PERCENTAGE DISTRIBUTION OF HOSPITAL DAYS* BY TYPE OF CLINICAL SERVICE, 1970



* Including rehabilitative care.

CHART V—AVERAGE LENGTH OF STAY OF CASES* IN HOSPITALS IN BRITISH COLUMBIA, BY MAJOR DIAGNOSTIC GROUPS IN DESCENDING ORDER, 1970 (EXCLUDING NEWBORNS).



* Including rehabilitative care.

HOSPITALIZATION[1] BY MAJOR DIAGNOSTIC CATEGORIES, 1970 (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	11,134	92,178	8.3	3.0	2.6
1. Salmonella infections	000–003	157	2,561	16.3	0.0	0.1
2. Other intestinal infections	004–009	6,266	37,782	6.0	1.7	1.1
3. Tuberculosis	010–019	368	6,458	17.5	0.1	0.2
4. Streptococcal sore throat, scarlet fever, and erysipelas	034, 035	192	984	5.1	0.1	0.0
5. Acute poliomyelitis	040–043	0	0	-----	-----	-----
6. Viral encephalitis	062–066	51	775	15.2	0.0	0.0
7. Infectious hepatitis	070	841	11,921	14.2	0.2	0.3
8. Other virus diseases	044–061, 067, 068, 071–079	2,255	19,400	8.6	0.6	0.5
9. Venereal disease	090–099	210	1,490	7.1	0.1	0.0
10. Other infectious and parasitic diseases	020–033, 036–039, 080–089, 100–136	794	10,807	13.6	0.2	0.3
II. Neoplasms	140–239	21,609	309,558	14.3	5.7	8.7
11. Malignant neoplasm of buccal cavity and pharynx	140–149	297	4,915	16.5	0.1	0.1
12. Malignant neoplasm of stomach	151	505	12,453	24.7	0.1	0.4
13. Malignant neoplasm of intestine, except rectum	152, 153	999	24,163	24.2	0.3	0.7
14. Malignant neoplasm of rectum and rectosigmoid junction	154	611	15,395	25.2	0.2	0.4
15. Malignant neoplasm of other digestive organs	150, 155–159	695	16,218	23.3	0.2	0.5
16. Malignant neoplasm of trachea, bronchus, and lung	162	1,510	31,246	20.7	0.4	0.9
17. Malignant neoplasm of other respiratory organs	160, 161, 163	183	3,477	19.0	0.0	0.1
18. Malignant neoplasm of bone	170	70	1,275	18.2	0.0	0.0
19. Malignant neoplasm of skin	172, 173	421	5,129	12.2	0.1	0.1
20. Malignant neoplasm of breast	174	1,684	28,191	16.7	0.4	0.8
21. Malignant neoplasm of cervix uteri	180	799	7,788	9.7	0.2	0.2
22. Malignant neoplasm of uterus	181, 182	519	5,027	9.7	0.1	0.1
23. Malignant neoplasm of ovary	183.0	411	7,934	19.3	0.1	0.2
24. Malignant neoplasm of other female genital organs	183.1, 183.9, 184	73	1,738	23.8	0.0	0.0
25. Malignant neoplasm of prostate	185	1,126	23,225	20.6	0.3	0.7
26. Malignant neoplasm of bladder	188	1,050	12,081	11.5	0.3	0.3
27. Malignant neoplasm of other genito-urinary organs	186, 187, 189	356	7,431	20.9	0.1	0.2
28. Malignant neoplasm of brain	191	145	4,574	31.5	0.0	0.1
29. Other primary and secondary malignant neoplasms	171, 190, 192–199	716	13,961	19.5	0.2	0.4
30. Leukæmia	204–207	653	9,961	15.3	0.2	0.3
31. Other neoplasms of lymphatic and hematopoietic tissue	200–203, 208, 209	979	16,782	17.1	0.3	0.5
32. Benign neoplasm of skin	216	100	368	3.7	0.0	0.0
33. Benign neoplasm of breast	217	447	1,172	2.6	0.1	0.0
34. Benign neoplasm of uterus	218, 219	2,979	23,761	8.0	0.8	0.7
35. Benign neoplasm of ovary	220	572	4,375	7.6	0.2	0.1

[1] Includes rehabilitative care.

HOSPITALIZATION[1] BY MAJOR DIAGNOSTIC CATEGORIES, 1970 (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	285	1,254	4.4	0.1	0.0
37. Benign neoplasm of brain and other parts of nervous system	225	153	2,895	18.9	0.0	0.1
38. Other benign neoplasms	210–215, 222–224, 226–228	1,811	11,927	6.6	0.5	0.3
39. Carcinoma *in situ* of cervix uteri	234.0	1,091	7,290	6.7	0.3	0.2
40. Other neoplasms of unspecified nature	230–233, 234.1, 234.9, 235–239	369	3,552	9.6	0.1	0.1
III. Endocrine, nutritional, and metabolic diseases	240–279	6,019	80,527	13.4	1.6	2.3
41. Nontoxic goiter	240, 241	354	2,265	6.4	0.1	0.1
42. Thyrotoxicosis with or without goiter	242	225	2,584	11.5	0.1	0.1
43. Other diseases of thyroid gland	243–246	193	2,584	13.4	0.1	0.1
44. Diabetes mellitus	250	3,500	49,917	14.3	0.9	1.4
45. Other endocrine diseases	251–258	371	4,230	11.4	0.1	0.1
46. Avitaminoses and other nutritional deficiency	260–269	734	9,894	13.5	0.2	0.3
47. Congenital disorders of metabolism	270–273	178	3,231	18.2	0.0	0.1
48. Other metabolic diseases	274–279	464	5,822	12.5	0.1	0.2
IV. Diseases of the blood and blood-forming organs	280–289	2,424	22,579	9.3	0.7	0.6
49. Iron-deficiency anæmias	280	423	5,426	12.8	0.1	0.2
50. Pernicious anæmia and other deficiency anæmias	281	183	3,360	18.4	0.0	0.1
51. Other diseases of blood and blood-forming organs	282–289	1,818	13,793	7.6	0.5	0.4
V. Mental disorders	290–315	14,873	196,101	13.2	4.0	5.5
52. Alcoholic psychosis	291	1,246	13,546	10.9	0.3	0.4
53. Schizophrenia	295	1,688	34,653	20.5	0.4	1.0
54. Affective psychoses	296	1,660	26,777	16.1	0.4	0.8
55. Other psychoses	290, 292–294, 297–299	588	12,581	21.4	0.2	0.4
56. Neuroses	300	5,459	64,623	11.8	1.4	1.8
57. Alcoholism	303	1,602	9,907	6.2	0.4	0.3
58. Drug dependence	304	480	3,399	7.1	0.1	0.1
59. Other nonpsychotic mental disorders	301, 302, 305–309	2,043	26,089	12.8	0.5	0.7
60. Mental retardation	310–315	107	4,526	42.3	0.1	0.1
VI. Diseases of the nervous system and sense organs	320–389	14,544	134,526	9.3	3.9	3.8
61. Meningitis and other inflammatory diseases of central nervous system	320–324	250	4,728	18.9	0.1	0.1
62. Hereditary and familial diseases of nervous system	330–333	114	3,699	32.4	0.0	0.1
63. Multiple sclerosis	340	406	11,519	28.4	0.1	0.3
64. Paralysis agitans	342	317	9,155	28.9	0.1	0.3
65. Epilepsy	345	1,060	9,900	9.3	0.3	0.3
66. Other diseases of central nervous system	341, 343, 344, 346–349	1,129	19,983	17.7	0.3	0.6
67. Diseases of nerves and peripheral ganglia	350–358	1,172	10,537	9.0	0.3	0.3
68. Inflammatory diseases of the eye	360–369	637	4,763	7.5	0.2	0.1

69. Strabismus	373	1,476	3,559	2.4	0.4	0.1
70. Cataract	374	1,871	17,290	9.2	0.5	0.5
71. Glaucoma	375	501	3,852	7.7	0.1	0.1
72. Other diseases of the eye	370–372, 376–379	884	6,640	7.5	0.2	0.2
73. Otitis media, without mention of mastoiditis	381	3,266	21,041	6.4	0.9	0.6
74. Mastoiditis with or without otitis media	382, 383	203	1,591	7.8	0.1	0.0
75. Other diseases of ear and mastoid process	380, 384–389	1,258	6,269	5.0	0.3	0.2
VII. Diseases of circulatory system	390–458	33,450	522,935	15.6	8.9	14.8
76. Active rheumatic fever	390–392	195	3,510	18.0	0.1	0.1
77. Chronic rheumatic heart disease	393–398	943	13,324	14.1	0.3	0.4
78. Hypertensive disease	400–404	1,682	17,863	10.6	0.4	0.5
79. Acute myocardial infarction	410	4,422	87,104	19.7	1.2	2.5
80. Other ischemic heart disease	411–414	10,376	145,908	14.1	2.8	4.1
81. Other forms of heart disease	420–429	1,382	15,945	11.5	0.4	0.5
82. Cerebral hæmorrhage	431	335	8,168	24.4	0.1	0.2
83. Cerebral embolism and thrombosis	432–434	1,298	34,319	26.4	0.3	1.0
84. Other cerebrovascular disease	430, 435–438	3,335	82,511	24.7	0.9	2.3
85. Arteriosclerosis	440	814	13,557	16.7	0.2	0.4
86. Other diseases of arteries, arterioles, and capillaries	441–448	1,337	26,478	19.8	0.4	0.7
87. Pulmonary embolism and infarction	450	310	4,943	15.9	0.1	0.1
88. Phlebitis, thrombophlebitis, venous embolism, and thrombosis	451–453	959	13,108	13.7	0.3	0.4
89. Varicose veins of lower extremities	454	3,451	35,640	10.3	0.9	1.0
90. Hæmorrhoids	455	2,310	16,546	7.2	0.6	0.5
91. Other diseases of circulatory system	456–458	301	4,011	13.3	0.1	0.1
VIII. Diseases of the respiratory system	460–519	52,785	344,008	6.5	14.0	9.7
92. Acute upper respiratory infections, except influenza	460–466	9,708	63,621	6.6	2.6	1.8
93. Influenza	470–474	1,921	12,013	6.3	0.5	0.3
94. Pneumonia	480–486	9,840	112,162	11.4	2.6	3.2
95. Bronchitis and emphysema	490–492	4,844	49,533	10.2	1.3	1.4
96. Asthma	493	3,614	31,079	8.6	1.0	0.9
97. Hypertrophy of tonsils and adenoids	500	17,363	38,778	2.2	4.6	1.1
98. Chronic sinusitis	503	654	2,868	4.4	0.2	0.1
99. Deflected nasal septum	504	1,827	7,663	4.2	0.5	0.2
100. Other diseases of upper respiratory tract	501, 502, 505–508	1,367	5,682	4.2	0.4	0.2
101. Empyema and abscess of lung	510, 513	63	1,469	23.3	0.0	0.0
102. Pneumoconiosis and related diseases	515, 516	51	898	17.6	0.0	0.0
103. Other diseases of respiratory system	511, 512, 514, 517–519	1,533	18,242	11.9	0.4	0.5
IX. Diseases of the digestive system	520–577	41,501	405,042	9.8	11.0	11.4
104. Diseases of teeth and supporting structures	520–525	3,184	7,143	2.2	0.8	0.2
105. Other diseases of oral cavity, salivary glands, and jaws	526–529	556	3,299	5.9	0.1	0.1
106. Ulcer of duodenum	532	3,510	46,968	13.4	0.9	1.3
107. Ulcer of stomach, and peptic ulcer site unspecified	531, 533	1,729	23,549	13.6	0.5	0.7
108. Gastritis and duodenitis	535	1,451	8,814	6.1	0.4	0.2
109. Other diseases of œsophagus, stomach, and duodenum	530, 534, 536, 537	993	11,848	11.9	0.3	0.3
110. Appendicitis	540–543	4,467	30,903	6.9	1.2	0.9
111. Hernia, without mention of obstruction	550, 551	6,873	51,510	7.5	1.8	1.5
112. Hernia, with obstruction	552, 553	612	6,110	10.0	0.2	0.2

[1] Includes rehabilitative care.

HOSPITALIZATION[1] BY MAJOR DIAGNOSTIC CATEGORIES, 1970 (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*						
113. Intestinal obstruction, without mention of hernia	560	1,369	14,486	10.6	0.4	0.4
114. Chronic enteritis and ulcerative colitis	563	763	13,767	18.0	0.2	0.4
115. Other diseases of intestines and peritoneum	561, 562, 564–569	4,421	46,010	10.4	1.2	1.3
116. Cirrhosis of liver	571	934	18,284	19.6	0.2	0.5
117. Other diseases of liver	570, 572, 573	100	1,761	17.6	0.0	0.0
118. Cholelithiasis	574	7,638	89,789	11.8	2.0	2.5
119. Cholecystitis and cholangitis, without mention of calculus	575	1,937	18,142	9.4	0.5	0.5
120. Other diseases of gall bladder and biliary ducts	576	233	2,785	12.0	0.1	0.1
121. Diseases of pancreas	577	731	9,874	13.5	0.2	0.3
X. Diseases of the genito-urinary system	580–629	40,487	269,723	6.7	10.7	7.6
122. Nephritis and nephrosis	580–584	6,994	21,282	3.0	1.9	0.6
123. Infections of kidney	590	2,616	22,330	8.5	0.7	0.6
124. Calculus of urinary system	592, 594	3,090	24,231	7.8	0.8	0.7
125. Cystitis	595	1,829	12,570	6.9	0.5	0.4
126. Other diseases of urinary system	591, 593, 596–599	3,676	30,279	8.2	1.0	0.9
127. Hyperplasia of prostate	600	3,075	43,466	14.1	0.8	1.2
128. Redundant prepuce and phimosis	605	707	2,131	3.0	0.2	0.1
129. Other diseases of male genital organs	601–604, 606, 607	1,905	12,634	6.6	0.5	0.4
130. Diseases of breast	610, 611	1,832	6,216	3.4	0.5	0.2
131. Diseases of ovary, fallopian tube, and parametrium	612, 616	2,095	15,856	7.6	0.6	0.4
132. Infective diseases of uterus, vagina, and vulva	620, 622	1,830	11,306	6.2	0.5	0.3
133. Uterovaginal prolapse and malposition of uterus	623, 624	2,861	31,048	10.9	0.8	0.9
134. Disorders of menstruation	626	4,163	13,385	3.2	1.1	0.4
135. Other diseases of female genital organs	621, 625, 627–629	3,814	22,989	6.0	1.0	0.6
XI. Complications of pregnancy, childbirth, and the puerperium	630–678	52,785	291,875	5.5	14.0	8.2
136. Infection of genital tract during pregnancy, and urinary infections during pregnancy and puerperium	630, 635	555	3,046	5.5	0.1	0.1
137. Hæmorrhage of pregnancy	632	2,063	10,145	4.9	0.5	0.3
138. Toxæmias of pregnancy and the puerperium	636–639	1,309	7,438	5.7	0.3	0.2
139. Other complications of pregnancy	631, 633, 634	4,647	12,995	2.8	1.2	0.4
140. Abortion	640–645	6,662	22,891	3.4	1.8	0.6
141. Delivery without mention of complication	650	27,744	159,901	5.8	7.4	4.5
142. Delivery complicated by placenta previa or antepartum hæmorrhage, retained placenta, or other postpartum hæmorrhage	651–653	1,468	12,109	8.2	0.4	0.3
143. Delivery complicated by abnormality of pelvis, fetopelvic disproportion, malpresentation, or other prolonged labour	654–657	3,450	29,041	8.4	0.9	0.8
144. Delivery with other complications, including anæsthetic death in uncomplicated delivery	658–662	4,159	31,668	7.6	1.1	0.9
145. Complications of puerperium	670–678	728	2,641	3.6	0.2	0.1

XII. *Diseases of the skin and subcutaneous tissue*	680–709	5,429	53,927	9.9	1.4	1.5
146. Infections of skin and subcutaneous tissue	680–686	2,610	21,794	8.4	0.7	0.6
147. Other inflammatory conditions of skin and subcutaneous tissue	690–698	1,450	17,241	11.9	0.4	0.5
148. Other diseases of skin and subcutaneous tissue	700–709	1,369	14,892	10.9	0.4	0.4
XIII. Diseases of the musculoskeletal system and connective tissue	710–738	15,573	207,164	13.3	4.1	5.9
149. Rheumatoid arthritis and allied conditions	712	1,262	34,280	27.2	0.3	1.0
150. Osteoarthritis and allied conditions	713	1,658	30,769	18.6	0.4	0.9
151. Other arthritis and rheumatism	710, 711, 714–718	1,244	13,544	10.9	0.3	0.4
152. Osteomyelitis and other diseases of bone	720–723	1,274	26,554	20.8	0.3	0.8
153. Displacement of intervertebral disk	725	3,900	51,449	13.2	1.0	1.5
154. Other diseases of joint	724, 726–729	2,374	20,065	8.5	0.6	0.6
155. Synovitis, bursitis, and tenosynovitis	731	1,120	5,831	5.2	0.3	0.2
156. Other diseases of musculoskeletal system	730, 732–738	2,741	24,672	9.0	0.7	0.7
XIV. *Congenital anomalies*	740–759	4,981	59,192	11.9	1.3	1.7
157. Spina bifida and congenital hydrocephalus	741, 742	164	5,791	35.3	0.0	0.2
158. Congenital anomalies of heart	746, 747.0–747.2	627	6,887	11.0	0.2	0.2
159. Cleft palate and cleft lip	749	195	2,401	12.3	0.1	0.1
160. Other congenital anomalies of digestive system	750, 751	405	5,622	13.9	0.1	0.2
161. Congenital anomalies of genito-urinary system	752, 753	1,381	11,372	8.2	0.4	0.3
162. Congenital anomalies of musculoskeletal system	754–756	1,015	15,202	15.0	0.3	0.4
163. Other and unspecified congenital anomalies	740, 743–745, 747.3–747.9, 748, 757–759	1,194	11,917	10.0	0.3	0.3
XV. Certain causes of perinatal morbidity and mortality	760–779	122	2,085	17.1	0.0	0.1
164. Birth injury	764–768 with 4th digit .0–.3, 772	3	40	13.3	0.0	0.0
165. Asphyxia, anoxia, or hypoxia	764–768 with 4th digit .4, 776	39	801	20.5	0.0	0.0
166. Hæmolytic disease of newborn	774, 775	23	302	13.1	0.0	0.0
167. Immaturity unspecified	777	3	130	43.3	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	54	812	15.0	0.0	0.0
XVI. Symptoms and *ill*-defined conditions	780–796	8,363	44,557	5.3	2.2	1.3
169. Observation, without need for further medical care	793	241	1,131	4.7	0.1	0.0
170. Symptoms, senility, and ill-defined conditions	780–792, 794–796	8,122	43,426	5.3	2.2	1.2
XVII. Accidents, poisonings, and violence; supplementary classifications	800–999, Y00–Y29	51,059	502,716	9.8	13.5	14.2
171. Fracture of skull, and other intracranial injury	800–804, 850–854	6,352	46,439	7.3	1.7	1.3
172. Fracture of spine and trunk	805–809	2,467	54,150	21.9	0.7	1.5
173. Fracture of upper limb	810–819	4,382	24,592	5.6	1.2	0.7
174. Fracture of femur	820, 821	2,562	97,386	38.0	0.7	2.8
175. Other fractures of lower limbs	822–829	3,952	55,254	14.0	1.0	1.6
176. Dislocation without fracture, sprains, and strains of joint and adjacent muscles	830–848	5,616	45,261	8.1	1.5	1.3
177. Internal injury of chest, abdomen, and pelvis	860–869	926	11,442	12.4	0.2	0.3
178. Laceration, open wound, superficial injury, contusion, and crushing with intact skin surface	870–929	8,562	52,069	6.1	2.3	1.5

[1] Includes rehabilitative care.

HOSPITALIZATION[1] BY MAJOR DIAGNOSTIC CATEGORIES, 1970 (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; supplementary classifications—*Continued*						
179. Foreign body entering through orifice	930–939	511	1,963	3.8	0.1	0.1
180. Burns	940–949	1,371	21,657	15.8	0.4	0.6
181. Injury to nerves and spinal cord	950–959	169	1,783	10.6	0.0	0.1
182. Adverse effects of medical agents	960–979	3,804	22,551	5.9	1.0	0.6
183. Toxic effects of substances chiefly nonmedicinal	980–989	834	3,190	3.8	0.2	0.1
184. Complications peculiar to certain surgical procedures, other complications of surgical procedures, and other complications of medical care	997–999	3,446	32,802	9.5	0.9	0.9
185. Other effects of external causes	990–996	562	5,438	9.7	0.1	0.2
186. Special conditions and examinations without sickness	Y00–15	5,543	26,739	4.8	1.5	0.8
187. Mature infant	Y20, 22, 23, 26, 27	----------	----------	-----	-----	-----
188. Immature infant	Y21, 24, 25, 28, 29	----------	----------	-----	-----	-----
Totals	----------	377,138	3,538,693	9.4	100.0	100.0

[1] Includes rehabilitative care.

THERAPEUTIC ABORTIONS PERFORMED IN BRITISH COLUMBIA HOSPITALS

Month	1970	1971
January	44	520
February	69	572
March	80	620
April	93	557
May	134	568
June	172	599
July	277	576
August	282	609
September	358	586
October	445	617
November	456	609
December	562	657
Totals	2,972	7,090

STATEMENT OF RECEIPTS AND DISBURSEMENTS FOR THE FISCAL YEAR ENDED MARCH 31, 1971

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Administration—	
Salaries	1,007,467
Temporary assistance	12,453
	1,019,920
Office expense	68,460
Travelling expense	61,911
Office furniture and equipment	7,578
Printing and publications	2,676
Tabulating and rentals	5,289
Motor-vehicles and accessories	
Incidentals and contingencies	901
Construction and consultation fees	35,028
Technical surveys and new service development	60,177
	1,261,940
Payments to hospitals—	
Claims	178,266,296
Grants in aid of equipment	2,370,714
Grants in aid of construction	3,169,923
Total	185,068,873

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