PROVINCE OF BRITISH COLUMBIA

Department of Health

ANNUAL REPORT

1975

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1976

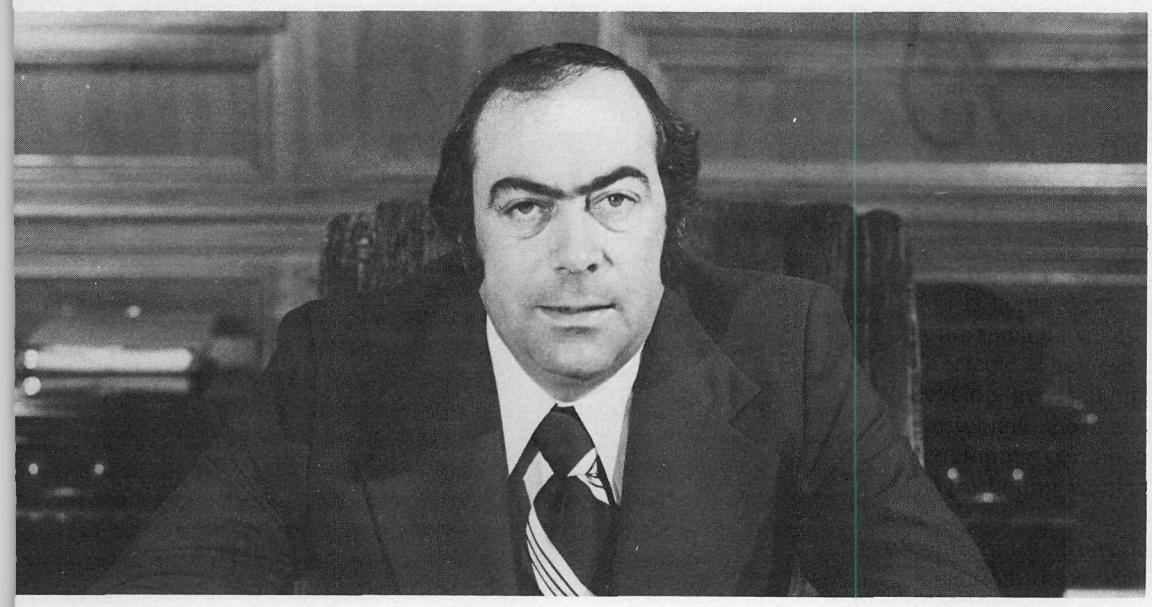
To Colonel the Honourable WALTER S. OWEN,
Q.C., LL.D.,
Lieutenant-Governor of the Province of British Columbia.

MAY IT PLEASE YOUR HONOUR:

The undersigned respectfully submits the Annual Report of the Department of Health for the year 1975.

R. H. McCLELLAND
Minister of Health

Office of the Minister of Health,
Victoria, B.C., July 2, 1976.

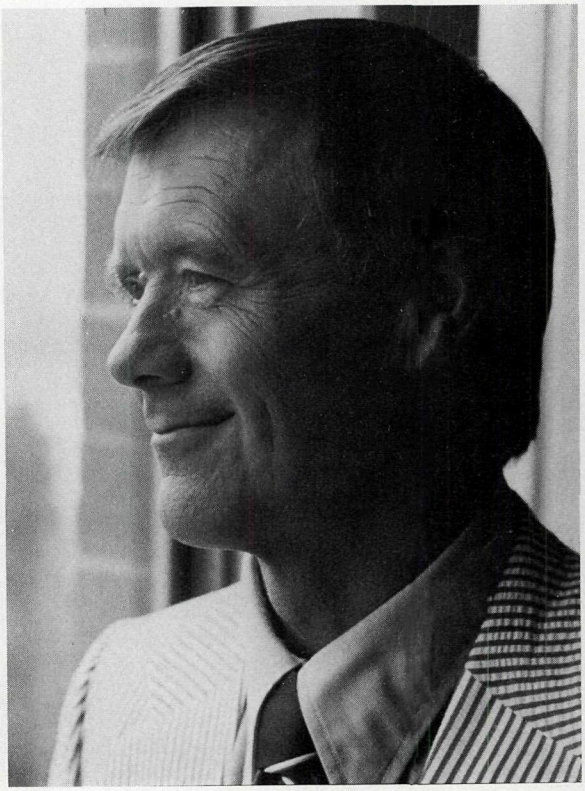


DEPARTMENT OF HEALTH,
VICTORIA, B.C., July 2, 1976.

The Honourable R. H. McClelland,
Minister of Health, Victoria, B.C.

SIR: I have the honour to submit the Annual Report of the Department of Health for 1975.

J. MAINGUY
Deputy Minister of Health



DEPARTMENT OF HEALTH

THE HONOURABLE R. H. MCCLELLAND, *Minister of Health*

J. W. MAINGUY
Deputy Minister of Health

N. S. WALLACE
Senior Financial Adviser

W. DIETIKER
Director of Data Processing

W. F. LOCKER
Director of Personnel

F. G. TUCKER
Consultant in Mental Health

J. S. BLAND
Consultant in Geriatrics

COMMUNITY HEALTH PROGRAMS

G. R. F. ELLIOT
Deputy Minister, Community Health Programs

J. H. DOUGHTY
Acting Director of Administration

W. D. BURROWES
Acting Director, Division of Vital Statistics

N. MCDONALD
Director, Division of Public Health Education

PUBLIC HEALTH PROGRAMS

K. I. G. BENSON
Associate Deputy Minister and Provincial Health Officer

W. BAILEY
Director, Division of Environmental Engineering

L. M. CRANE
Director, Division of Public Health Nursing

A. A. LARSEN
Director, Division of Epidemiology

F. MCCOMBIE
Director, Division of Dental Health Services

R. G. SCOTT
Director, Division of Public Health Inspection

P. WOLCZUK
Director, Division of Community Nutrition

G. D. ZINK
Director, Division of Speech and Hearing

SPECIAL HEALTH SERVICES

J. H. SMITH
Director, Bureau of Special Health Services

W. J. BOWMER
Director, Division of Laboratories

C. E. BRADBURY
Director, Division for Aid to Handicapped

H. K. KENNEDY
Director, Division of Veneral Disease Control

L. D. KORNDER
Director, Division of Occupational Health

F. D. MACKENZIE
Director, Division of Tuberculosis Control

MENTAL HEALTH PROGRAMS

A. PORTEOUS
Associate Deputy Minister

H. W. BRIDGE
Co-ordinator of Adult Psychiatric Services

F. A. MATHESON
Comptroller

R. H. GOODACRE[1]
Consultant in Sociology

M. M. LONERGAN
Consultant in Nursing

R. S. MCINNES
Co-ordinator of Mental Health Centres

A. G. DEVRIES
Consultant in Psychology

J. B. FARRY[2]
Consultant in Social Work

MRS. F. IRELAND
Co-ordinator of Boarding-homes

---

[1] Resigned September 30, 1975, to become Director of Research in Hospital Programs.
[2] Appointed June 1, 1975.

MEDICAL AND HOSPITAL PROGRAMS

W. J. LYLE
Deputy Minister, Medical and Hospital Programs

HOSPITAL PROGRAMS

J. G. GLENWRIGHT
Associate Deputy Minister

P. M. BREEL
Senior Director

C. F. BALLAM
Senior Medical Consultant

W. J. PETTIT
Director, Hospital Finance Division

K. G. WIPER[3]
J. D. HERBERT[4]
Director, Administrative Services

(Vacant)
Director, Hospital Consultation and Inspection Division

D. S. THOMSON[5]
R. H. GOODACRE[6]
Director, Research Division

G. F. FISHER
Director, Hospital Construction and Planning Division

MEDICAL SERVICES

G. A. STEWART
Chairman

D. H. WEIR
Assistant to the Chairman

D. M. BOLTON
Senior Medical Consultant

A. W. BROWN
Executive Manager, Plan Administration

D. H. WEIR
Chairman, Emergency Health Services Commission

P. RANSFORD
Executive Director, Emergency Health Services Commission

F. G. TUCKER
Chairman, Forensic Psychiatric Services Commission

J. DUFFY
Executive Director, Forensic Psychiatric Services Commission

J. BAINBRIDGE
Director of Government Health Institutions

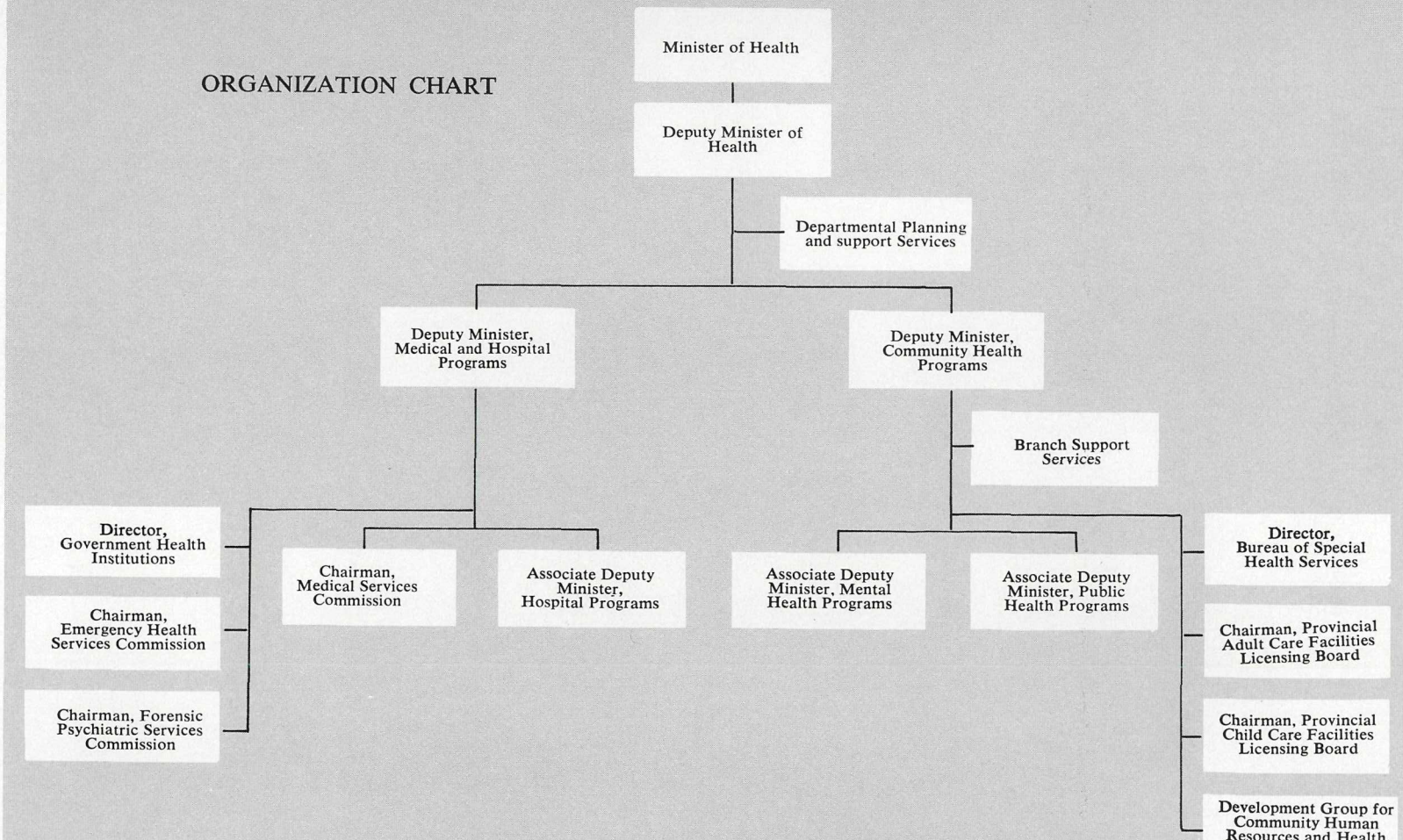
A. A. LARSEN
Chairman, Provincial Adult Care Facilities Licensing Board

M. DAHL
Chairman, Provincial Child Care Facilities Licensing Board

---

[3] Retired July 15, 1975.
[4] Appointed Director, Administrative Services, effective July 15, 1975.
[5] Resigned July 31, 1975, to become Associate Director, Cancer Control Agency of B.C.
[6] Appointed Director, Research Division, effective October 1, 1975.

ORGANIZATION CHART



[1] Responsible jointly to Department of Health and Department of Human Resources.

TABLE OF CONTENTS

	Page
Year in Review	15
Demographic Features	17
Department Highlights, 1975	17

COMMUNITY HEALTH PROGRAMS

Public Health Programs

Introduction	25
Communicable and Reportable Disease	27
Health and Our Environment	32
Specialized Community Health Programs	38
Community Public Health Nursing Services	43
Home Care Programs	47
Dental Health Services	48
Nutrition Services	50
Public Health Education	51
Vital Statistics	53
Aid to Handicapped	56
Laboratory Services	57
Community Human Resources and Health Centres	60
Action B.C.	61
Council of Practical Nurses	61
Voluntary Health Agencies	62

Tables—

1—Reported Communicable Diseases, British Columbia, 1971–75	63
2—Reported Infectious Syphilis and Gonorrhœa, British Columbia, 1946, 1951, 1956, 1961, and 1966–75	63
3—Selected Activities of Provincial Public Health Nurses, September 1974 to August 1975, Inclusive	64
4—Selected Activities of Public Health Inspectors, 1972–75, Inclusive	65
5—Number and per Cent of Children Immunized Prior to Entry Into Kindergarten (as at September 1974)	66
6—Number and per Cent of Grade V Pupils Immunized as at June 1975	66
7—Number and per Cent of Grade V Girls Immunized for Rubella as at June 1975	66
8—Pupils Referred for Health Services	67
9—Registrations, Certificates, and Other Documents Processed by Division of Vital Statistics, 1974 and 1975	67
10—Case Load of Division for Aid to Handicapped, 1975	68
11—Tests Performed by Division of Public Health Laboratories, 1974 and 1975	69
12—Licensing of Practical Nurses	70

PAGE

13—Number of Cases Referred for Hearing Assessment, by Source, Division of Speech and Hearing, 1975 70
14—Number of Cases Referred for Hearing Assessment, by Type of Evaluation, Division of Speech and Hearing, 1975 70
15—Hearing-impaired Cases, by Degree and Type of Impairment, Division of Speech and Hearing, 1975 70

MENTAL HEALTH PROGRAMS

Introduction 73
Community Mental Health Centres 75
The Greater Vancouver Mental Health Service 81
The Burnaby Mental Health Plan 82
The British Columbia Youth Development Centre 83
The Boarding Home Program 86
Consultants 88

Tables—

16—Patient Movement Trends, Mental Health Facilities, 1972–75 94
17—Patient Movement Data, Mental Health Facilities, 1975 95

MEDICAL AND HOSPITAL PROGRAMS

HOSPITAL PROGRAMS

Introduction 101
British Columbia Regional Hospital Districts Act 103
British Columbia Regional Hospital Districts Financing Authority Act 103
The Hospital Insurance Act 104
The Hospital Act 104
The Hospital Rate Board and Methods of Payment to Hospitals 105
Hospital Consultation and Inspection Division 107
Research Division 107
Hospital Finance Division 108
Hospital Construction and Planning Division 110
Medical Consultation Division 117
Administrative Services Division 119
Approved Hospitals 120
Statistical Data 122

Tables—

18—Patients Separated and Proportion Covered by Hospital Programs, British Columbia Public General Hospitals Only (Excluding Federal, Private, Extended-care, and Out-of-Province Hospitalization) 123
19—Total Patient-days and Proportion Covered by Hospital Programs, British Columbia Public General Hospitals Only (Excluding Federal, Private, Extended-care, and Out-of-Province Hospitalization) 124
20—Patients Separated, Total Patient-days and Average Length of Stay, According to Type and Location of Hospital for Hospital Programs Patients Only, and Days of Care per Thousand Covered Population 124

PAGE

21—Summary of the Number of Hospital Programs In-patients and Out-patients 125

22—Summary of Hospital Programs Out-patient Treatments by Category, 1971–75, Inclusive 125

23—Patients Separated, Total Days' Stay, and Average Length of Stay in British Columbia Public Hospitals for Hospital Programs Patients Only, Grouped According to Bed Capacity, 1975 (Excluding Extended-care Hospitals) 125

24—Percentage Distribution of Patients Separated and Patient-days for Hospital Programs Patients Only, in British Columbia Public Hospitals, Grouped According to Bed Capacity, 1975 (Excluding Extended-care Hospitals) 126

Charts—

I—Percentage Distribution of Days of Care by Major Diagnostic Groups, Hospital Programs, 1974 127

II—Percentage Age Distribution of Male and Female Hospital Cases and Days of Care, Hospital Programs, 1974 128

III—Percentage Distribution of Hospital Cases by Type of Clinical Service, Hospital Programs, 1974 129

IV—Percentage Distribution of Hospital Days by Type of Clinical Service, Hospital Programs, 1974 130

V—Average Length of Stay of Cases in Hospitals in British Columbia by Major Diagnostic Groups, Hospital Programs, 1974 (Excluding Newborns) 131

MEDICAL SERVICES COMMISSION

Introduction 135

Benefits Under the Plan 137

Services Excluded Under the Plan 139

Premium Rates and Assistance 139

Laboratory Approval 140

Professional Review Committees 140

Salaried and Sessional 140

Tables—

25—Registration and Persons Covered by Premiums and Subsidy Level, Medical Services Plan, at March 31, 1975 141

26—Persons Covered by Age-group, Medical Services Plan, at March 31, 1975 141

27—Distribution of Fee for Service Payments for Medical Services (Shareable), Medical Services Plan, 1973/74 and 1974/75 142

28—Distribution of Fee for Service Payments for Insured Services, Non-shareable Additional Benefits 142

GOVERNMENT HEALTH INSTITUTIONS 145

EMERGENCY HEALTH SERVICES COMMISSION 153

FORENSIC PSYCHIATRIC SERVICES COMMISSION 159

DEPARTMENT OF HEALTH EXPENDITURES, 1974/75

FINANCIAL TABLES AND CHART

Tables—

PAGE

29—Expenditure by Principal Categories in the Department of Health for the Fiscal Year 1974/75 163

30—Detailed Expenditure by Principal Categories in the Department of Health for the Fiscal Year 1974/75 164

Chart—

VI—Expenditure by Principal Categories in the Department of Health for the Fiscal Year 1974/75 163

YEAR IN REVIEW

1975 Annual Report of Department of Health

YEAR IN REVIEW

The year 1975 was characterized by diverse changes in the provision of services, in Federal-Provincial relations, and in Departmental organization. The following is a summary of the changes which took place in these major areas of concern:

The B.C. Hearing-aid Program was launched in September in five regional centres, with gratifying public response. The program provided hearing-aids at cost to the public and all referrals are by physician.

A combined poison control and drug information referral centre was established at St. Paul's Hospital, Vancouver, and made available to physicians and other health professionals throughout the Province. Poison control information to the public was provided through poison control centres at 59 hospitals.

Twenty major hospital construction projects were completed, costing an estimated $20 million.

An exemplary spinal cord injury unit was opened at Shaughnessy Hospital to act as the referral centre for the Province. It is believed to be one of the finest of its kind in North America.

A major nuclear medicine laboratory was opened at the Vancouver General Hospital.

Speech and language services were introduced at hospitals located in five health units. Nutrition services were expanded.

These and other highlights of the year are outlined in "Department Highlights, 1975" (page 17).

The year was one of both optimism and controversy in Federal-Provincial relations related to health. In September 1974 the provinces had unanimously rejected a new cost-sharing formula for medical and hospital care which had been proposed some time previously by the Federal Government. This formula would have related the increase in the Federal contributions to the rise in the gross national product. In January 1975, at the meeting of Federal and Provincial Ministers of Health, the Federal Minister proposed a review of interim measures, designed to bring under Federal sharing certain programs which were lower cost alternatives to high cost services. Provincial Ministers agreed and a Federal-Provincial Technical Committee was struck to work out the details.

These discussions were set back when the Federal Minister of Finance announced in June that the *Medical Care Act* of Canada was to be amended to introduce ceilings on the rate of increase in Federal sharing of the cost of physician services. These ceilings were to be 13.0 per cent in the fiscal year 1976/77, 10.5 per cent in 1977/78, and 8.5 per cent in 1978/79 and thereafter. At the meeting of Provincial Ministers of Health held in Victoria in August, the provinces unanimously protested the move, which had been made without consultation with the

provinces. It was agreed that the discussions on interim arrangements would cease until a further meeting of Federal and Provincial Ministers had been arranged. The Minister of Health of British Columbia announced at the meeting that the Federal action would cost this Province about $170 million over the next five years.

The Federal Anti-inflation Guidelines were announced in October and these could act to reduce the loss to the provinces. Talks on the proposed interim sharing arrangements had not been resumed by the year-end.

Changes in Departmental organization were made along the lines announced by the Minister in October 1974. In January, appointments were made to positions of Deputy Minister of Health, Deputy Minister of Medical and Hospital Programs, and Deputy Minister of Community Health Programs. The new organization brought to an end the previous arrangement under which the Minister had personally to co-ordinate all branches and agencies of the Department. Other senior appointments were confirmed shortly thereafter.

On December 1, the responsibility for administering Riverview, Valleyview, Dellview, and Pearson Hospitals was transferred to the Medical and Hospital Programs branch of the Department and placed under the newly appointed Director of Government Health Institutions. This was to allow Government units to be operated under conditions more closely resembling those of general hospitals and other community-operated institutions.

At the year-end, reporting arrangements for the Development Group for Community Human Resources and Health Centres were being changed so that the group would report on the health aspects of its program to the Deputy Minister of Community Health Programs, rather than direct to the Minister.

A nucleus of Departmental support services was created by transfer of positions within the Department. This involved the Senior Finance Adviser, the Director of Personnel, the Director of Data Processing, the Consultant in Mental Health, and the Consultant in Geriatrics.

The Medical Services Commission completed the immense task of amalgamating with the Government-operated B.C. Medical Plan, the operations of the Medical Services Association, and CU & C insurance plans. This resulted in a single carrier handling the medical insurance program under the *Medical Services Act* of the Province. One result was the reduction in the number of persons required to administer the program.

Control of facilities under the *Community Care Facilities Licensing Act* was improved by the establishment of two boards—one for adults and one for child care. To each board were added three additional members from the community at large.

By Order in Council 3845, of December 23, 1975, the Alcohol and Drug Commission was transferred from the Department of Human Resources to the Department of Health.

With respect to communicable diseases, it can be reported that there were no major outbreaks during the year, although the incidence of rubeola (red measles), rubella (German measles), and salmonella was higher than in 1974. Cases of diphtheria and infectious hepatitis declined considerably.

Venereal disease continued to be a major concern, with a 5-per-cent increase in notifications of gonorrhœa, and a 20-per-cent increase in notifications of infectious syphilis. Case finding and control measures were intensified and a public awareness program carried out.

DEMOGRAPHIC FEATURES

The population of the Province at mid-year approached two and a half million, the official estimate being 2,457,000, an increase of 62,000 over the 1974 figure. While this was a slightly lower growth rate than has been experienced in recent years, the numerical increase was second only to Ontario among the Canadian provinces. British Columbia's population has doubled since 1952.

The following information is based on the preliminary vital statistics of the Province for 1975:

During the year the number of births remained substantially unchanged, yielding a birth rate of 14.4 per 1,000 population, slightly below that for 1974. The proportion of these births recorded as having occurred out of wedlock was somewhat higher this year, being 12.4 per cent compared to 12.1 per cent the previous year.

The number of marriages declined slightly from 1974 to 1975, and because of the accompanying increase in population, the marriage rate per 1,000 population declined to 8.8 from 9.1 the previous year.

Deaths in British Columbia declined somewhat during 1975. The death rate per 1,000 population was 7.7, down from the figure of 8.0 for 1974 and a new record low. As in 1974, the lower death rate was reflected in each of the major causes of death.

The rate of deaths from heart disease in 1975 was only 258.6 per 100,000 population, a reduction from the 1974 figure of 263.8.

Total cancer mortality declined only slightly to 154.1 deaths per 100,000 population, compared to 155.9 in 1974. However, deaths from cancer of the lung showed a 7-per-cent increase.

Deaths from cerebrovascular disease caused about the same number of deaths in the two years being compared, the 1975 rate being 81.3 compared to the 1974 figure of 82.7.

It is gratifying to be able to report a substantial reduction in the death rate from accidents for this year. In 1974 an excessively high number of 83.3 persons per 100,000 population died from accidental causes, and while this year's figure of 74.8 is still at an undesirably high level it marks a considerable improvement. A 17-per-cent reduction in motor-vehicle fatalities contributed to the decline as did substantial declines in the number of deaths from falls and from poisonings.

The suicide rate was also somewhat lower in 1975, 16.8 suicides per 100,000 population having been recorded, compared to 17.0 in 1974.

There were fewer infant deaths this year than in 1974 and the rate was down to 14.8 per 1,000 live births from the 1974 figure of 16.1.

DEPARTMENT HIGHLIGHTS, 1975

COMMUNITY HEALTH PROGRAMS

The British Columbia Hearing-aid Program was launched in September in five regional centres with gratifying public response. The program provides hearing-aids at cost to the public and all referrals are by physician.

•

Speech/Language Services were introduced at hospitals in the Selkirk, West Kootenay, North Okanagan, Simon Fraser, and Northern Interior Health Units.

•

The control of facilities coming within the purview of the *Community Care Facilities Licensing Act* was improved by the establishment of two separate Boards, one devoting its attention to adult care facilities and the other to child care facilities. Provision was also made for each Board to have three additional members appointed from the community at large.

•

A combined poison control and drug information referral centre was established at St. Paul's Hospital, Vancouver, and made available to physicians and other health professionals throughout the Province. Poison control information to the public was provided through poison control centres at 59 hospitals.

Improved techniques were introduced into the dialysis program for patients with kidney failure. Treatment is becoming more economical and less demanding on the patient. The use of disposable artificial kidneys was introduced during the year.

•

Engineering guidelines were prepared for the design, submission, and construction of domestic waterworks systems, including private systems, and those under the jurisdiction of utilities, improvement districts, and municipalities.

•

Home care programs were expanded to cover 90 per cent of the population of British Columbia with approximately 80 per cent of the population having access to the comprehensive "hospital replacement" type of home care program.

•

Over 9,000 new mothers and 5,600 new fathers attended educational classes for expectant parents. Public health nurses made at least one home visit to almost 99 per cent of all newborn babies, in order to carry out general health assessment and appraisal, and to provide advice and counselling on child care.

•

Home visits of all types by public health nurses totalled over 333,000, a 38-per-cent increase over the previous year.

•

Almost half a million individual immunizations were performed by public health nurses and over 29,000 tests for diphtheria, tuberculosis, and other conditions were given.

•

The mobile dental units visited 24 communities which lack a resident dentist in the northern part of the Province and in the Kootenays.

•

Analysis of Province-wide dental surveys carried out since 1958 revealed significant improvements in the dental health status of children in the Province.

•

Nutrition services were expanded by the addition of five field nutritionists and one nutrition consultant. An Infant Nutrition Guide was developed and distributed to all health professionals involved in infant care and to all hospitals. Public heath education activities were strengthened by staff appointments both at headquarters and in the field, and by the provision of well-equipped central facilities for the division.

•

An estimated 12,500 patients were treated in the Province's 30 mental health centres during the year, and, in addition, professional staff provided consultative services to a variety of community agencies.

•

The Boarding Home Program, a community residential placement program for psychiatric care, was also operated in most areas of the Province, which supervised a continuing case load of approximately 1,900 mentally ill and retarded persons.

•

By the end of 1975 the Greater Vancouver Mental Health Service had six Community Care Teams operating in West End, Strathcona, Mount Pleasant-Fairview, Richmond, Kitsilano, and West Side, additionally, two teams were operating in Burnaby out of the Burnaby Mental Health Centre.

•

Venture and Vista (halfway houses for former patients of Riverview Hospital) were transferred to the Greater Vancouver Mental Health Service in April, providing 16 beds for short-term crisis patients. Riverview's Out-patient Department also came under the administration of the Service during the year, and was renamed the Broadway Clinic.

•

In October 1975 the patient load of the Greater Vancouver Mental Health Service was 2,116, compared with 949 one year previously.

•

The Burnaby Mental Health Plan continued to provide the Province's only regionalized program of decentralized comprehensive psychiatric services for adults and children. The plan included a fully utilized 25-bed acute psychiatric in-patient unit, an adult day program, adult and children's out-patient service, and consultation and educational services.

•

Twenty psychiatric nurses completed a special in-service training program in March, and commenced service in various communities. This group will provide home care for adult patients who might normally require admission to hospital.

•

MEDICAL AND HOSPITAL PROGRAMS

Gross expenditure for public general, rehabilitation, and extended-care hospitals for the year of 1975 amounted to $460 million.

•

A total of 405,598 adult and child B.C. Hospital Program patients was discharged in 1975, an increase of 11,091 or 2.8 per cent more in 1974; 95.7 per cent of all patients discharged were covered by Hospital Programs.

•

Hospital Programs paid public hospitals in British Columbia for 3,472,971 days of care for adults and children, an increase of 72,098 days or 2.1 per cent over 1974. The average length of stay was 8.56 days.

•

In 1975, 20 major hospital projects were completed, involving an estimated $20 million. Two special unit projects were the Spinal Cord Injury Unit at Shaughnessy Hospital and the Nuclear Medicine Laboratory at the Vancouver General Hospital.

•

Approval was given during the year for multi-million-dollar hospital projects, including renovations and construction at Burnaby and New Westminster, to be carried out under project management.

•

At the year-end there were 4,001 extended-care beds in the Province, and approximately 2,015 additional extended-care beds under construction or in planning stages. Five designated intermediate care homes provided a total of 663 beds.

•

During 1975 the regional hospital districts debenture sales to the B.C. Regional Hospital Districts Financing Authority amounted to $27.5 million.

•

Grants totalling $6 million were approved toward purchases of moveable and fixed technical equipment amounting to approximately $10 million. Over 6,800 applications for such grants were received from hospitals.

•

In excess of 2,000 patient accounts and over 2,550 emergency-service and minor-surgery accounts were processed daily by Hospital Programs.

•

Over 575 out-of-Province hospital accounts were processed each month, resulting in an estimated total expenditure of over $4.6 million.

•

The total expenditure for insured benefits under the Medical Services Plan increased by 20.1 per cent to $211,966,988 in 1974/75, from $176,568,498 in 1973/74. These figures included services rendered by physicians on a salaried, sessional, or contract basis, which amounted to $8,037,662 in 1973/74 and $10,209,157 in 1974/75. Total expenditures, including administrative costs, were $224,468,003 in 1974/75, compared to $185,150,292 in 1973/74.

•

The *per capita* cost of insured medical services (shared by the Federal Government) increased to $78.56 in 1974/75 from $66.52 in the previous year, based on population statistics provided by Statistics Canada. The most significant increases were in general practice, laboratory and radiology, and internal medicine.

•

The *per capita* cost of additional medical service benefits (not shared by the Federal Government) increased to $4.57 from $3.66 the previous year. The increases were principally related to optometric and chiropractic costs.

•

Increased costs under the Medical Services Plan were brought about through upward revisions to the agreed schedule of costs for medical practitioners; changes in the additional insured benefits, resulting in increased servicing; increased utilization of insured benefits; changes in the practitioner/population ratio; increased population, and increased administrative costs.

COMMUNITY HEALTH PROGRAMS

PUBLIC HEALTH PROGRAMS

Public Health Programs

In British Columbia, the first legislation to authorize a Provincial Board of Health was passed in the late 1860's, but such a Board did not actually function until almost 30 years later. Beginning in the 1890's, however, the Board exercised its authority in administering the Province's public health services and continued to do so for some 50 years. Then, in 1946, the services were given full departmental rank when the Department of Health and Welfare was created.

The branch of the present Department of Health known as Public Health Programs is charged with providing a wide range of preventive, treatment, and environmental control services and with promoting positive health. These services are made available to the public through certain centralized facilities and a network of 17 local health units covering the non-metropolitan areas of the Province. Greater Vancouver and the Capital Regional District have their own health organizations, which are not under the jurisdiction of the Provincial Health Department, but which receive certain consultative and specialized services together with financial assistance from the Provincial Government. These two administrations collaborate very closely with the Provincial Health Department in disease prevention and control, and in program implementation.

Statutory support for the operation of Public Health Programs comes mainly via the *Health Act,* and pursuant regulations, and the *Public Schools Act.* These statutes confer powers on the Minister of Health, the local Medical Health Officer, and the local Board of Health for dealing with matters of public health. The local Board of Health may be either a municipal council (covering municipal areas which may also draw up additional public health by-laws), or a union of municipalities and school districts, to administer relevant sections of the *Health Act* or pursuant regulations in areas outside municipalities.

A review of the activities of Public Health Programs is presented on the following pages:

COMMUNICABLE AND REPORTABLE DISEASE

DIPHTHERIA

It was gratifying that the upsurge in diphtheria noted in 1973 and 1974 did not continue into 1975. Only 22 cases were reported, compared to 69 the year before. There were two deaths from this disease during the year. These minor outbreaks over the past four years led to a considerable increase in childhood immunization, which, although it may not altogether prevent the spread of diphtheria, has assured that protected children will not die from this disease.

SALMONELLA

Salmonella food infection continued to be a problem, with 456 cases being reported. There is good reason to feel that the cases reported are only "the tip of the iceberg." The prevention of Salmonella infections requires the closure of many avenues of transmission. One such avenue was closed this year by new regulations which required frozen pet food, which can easily be infected with Salmonella organisms, to be treated so that it is free of organisms that cause disease in man.

INFECTIOUS HEPATITIS

Although infectious hepatitis is always present in British Columbia, it is a cyclical disease, and less than 1,000 cases were reported this year. In contrast there were nearly 1,400 in 1974 and almost 2,000 in 1971. Immune serum globulin, a by-product of human blood, prevents the development of severe illness when given to contacts of this disease. It does not prevent infection, however, and its use probably results in more cases of hepatitis than would otherwise occur, because infected persons remain well enough to move about the community. The only real means of controlling this condition is through immunization, and effective vaccine has not yet been developed. In the meantime, simple precautions, such as careful handwashing, remain the most useful control measures.

MEASLES

More than 1,100 cases of measles were reported in 1975. This was a marked increase over 1973 and 1974, when 158 and 573 cases respectively were reported. Measles is a cyclical disease and yearly fluctuation can always be expected. Measles vaccine has been available at no cost to parents for a number of years, and if every infant were protected at one year of age, there would be a great reduction in the number of cases of this disease.

Some concern has been expressed about the effectiveness of the currently available measles vaccine and studies are planned to determine whether reinforcing injections should be given during school life. Current experience in the United States indicates that measles can be almost fully eradicated if every child is immunized during infancy.

Almost 500 cases of rubella were reported, an increase of 134 from the previous year and 399 more cases than in 1973. These included 25 women who contracted rubella during the early weeks of pregnancy. The Health Department continued to provide immunization to all children, starting at one year of age, as a short-term solution to this problem, in order to reduce the risk of susceptible

mothers contracting rubella from exposure to their own children. At the same time, public health staff have intensified their efforts to assure that every girl is protected from rubella before puberty.

TYPHOID FEVER

A few cases of typhoid fever are reported every year, and in 1975 eight cases were diagnosed, none of which spread to the contacts. Milk and water are no longer significant sources of typhoid fever in this Province. Instead, older chronic carriers, and visitors or immigrants from countries where typhoid is more prevalent, are usually found to be responsible for this disease.

RHEUMATIC FEVER PROPHYLAXIS

This year there were about 800 young people receiving prophylactic antibiotics from the Health Department to prevent a recurrence of their rheumatic fever. An injectable antibiotic, Bicillin, was offered during the year, in addition to the oral antibiotics that have been in use since this program was started some 15 years ago. This permits those on the program the choice of taking a tablet twice a day or having an injection once a month.

TUBERCULOSIS CONTROL

During the last decade significant changes have been made toward the control of tuberculosis in British Columbia. These include a lower incidence of active tuberculosis; shorter hospital stay corresponding to a greater use of out-patient and anti-tuberculosis drug therapy, expanded clinic facilities, closer supervision of at-risk inactive cases, and a preventive treatment program among those at-risk, including contacts to active cases and persons with a positive tuberculin reaction.

The number of new active cases has ranged in the last 10 years from a high of 600 cases in 1967 to lows of approximately 440 cases in 1969 and 1975. The rates of active disease among those of Chinese and East Indian origin are estimated to be 10 times higher than those of other racial groups, mainly Caucasian. During 1975, daily bed occupancy averaged 70, while close to 700 cases were on anti-tuberculin drugs as out-patients.

On August 20, 1975, all Willow Chest Centre in-patients were transferred to Pearson Hospital, to prepare the centre for the second phase of renovations.

In co-operation with the Metropolitan Health Department of Vancouver, a tuberculin survey of all new Canadians registered in the schools for the first time was carried out. As a result, a number of children considered at high risk have been started on chemoprophylaxis.

VENEREAL DISEASE CONTROL

A variety of infections produce a discharge or skin lesion in the male or female, but only those which are transmitted by sexual intercourse are considered to be venereal diseases. Two of these, gonorrhœa and syphilis, are present in the Province in sufficient numbers to necessitate close attention by the Division of Venereal Disease Control.

ILLNESS
(CEREBRAL PALSY)
PSY HISTORY

Gonorrhœa

Gonorrhœa is a specific bacterial infection with an incubation period of four to five days. It produces severe symptoms of pain and discharge in the male, but few noticeable symptoms in the female. At least 80 per cent of infected women do not know they are infected and 5 per cent of infected males do not have any signs or symptoms of disease. This infection occurs mostly in young, single adults with a peak incidence at age 20 to 22. The high incidence groups in the community are alcoholic women, male homosexuals, and alienated youth.

Gonorrhœa has been increasing each year since 1969, 9,793 cases having been reported this year compared to 9,284 in 1974. As no single control measure has proven to be satisfactory, it is necessary to employ several methods. The procedures presently being used are as follows:

- The operation of a control centre from which information regarding contacts to this infection is rapidly transmitted to the local health department, so that these persons can be brought to treatment. The control centre physicians provide a consultative service regarding this infection to physicians and health departments throughout the Province.
- The carrying-out of a contact tracing program by the Division of Venereal Disease Control in Greater Vancouver and by public health nurses in health units throughout the Province provides complete coverage of the Province by contact investigators.
- The compulsory reporting of positive cases by physicians and laboratories operates throughout the Province. Physicians do not report all cases, so that this program has only a partial success. Theoretically, if every known case was interviewed for contacts and these contacts were brought to treatment, infection could be brought under control. In practice, there are psychological barriers to revealing information about casual sexual contacts, and this part of the control program has marked limitations.
- The Health Department operates many clinics throughout the Province to assist those patients with social disease who are reluctant to consult a family physician. The main Venereal Disease Clinic and the Pine Clinic are located in Vancouver. In order to provide a service to people who work and to reduce the load imposed on the Pine Clinic, the main Venereal Disease Clinic extended its hours and now remains open until 7.30 p.m., Monday and Friday evenings, and is open from 10 a.m. to 1 p.m., Saturdays. Other clinics are operated in Victoria, New Westminster, Kamloops, Prince George, Dawson Creek, Prince Rupert, and Kelowna.
- The development of a screening program for young women has been found effective in other areas. This screening applies primarily to single women between the ages of 15 and 25 located in high-incidence areas. It consists of taking a cervical culture for gonorrhœa whenever a pelvic examination is being done. However, at least 80 per cent of women infected with gonorrhœa have no symptoms of this disease and do not know they are infected. They pass infection to the male and, while the symptoms which develop generally prompt him to seek treatment, if he does not inform the female she may never know she is infected. She also runs the risk of developing complications which can affect her health or produce sterility. These young women constitute a reservoir of infection which continues to maintain the epidemic. The identification and treatment of this reservoir could markedly reduce the incidence of the disease. The reasons that it is so seldom done are twofold:

- There is a difficulty in using transport or diagnostic culture media which can be rapidly sent to a laboratory. (The latter must receive the specimen within 24 hours.)
- There is a reluctance to submit to the test because of psychological resistance to admitting that a venereal infection may be present.

- There has been direct classroom teaching, workshops to assist teachers and counsellors, production of a 16-mm film *It Takes Two,* and revision of the pamphlet *Rhythm and the Blues* in the carrying-out of an effective educational campaign in order to reduce these psychological barriers against venereal disease. A physician's kit was prepared in co-operation with the British Columbia Medical Association and details of this kit were forwarded to physicians throughout the Province. A public awareness program was carried out in the spring using advertising in newspapers and spot announcements on radio stations. For personal information, a venereal disease information Zenith line was installed.

Infectious Syphilis

While infectious syphilis remains under good control, introduction of the disease from outside the Province necessitates vigilant attention to each small epidemic which subsequently develops. The common problem is the spread of the disease by the male homosexual, a single, unattached individual who has usually acquired the infection in the west coast cities of the United States. Single men travelling to and from Mexico, and seamen, constitute somewhat less of a problem. Some of these individuals are bisexual and spread the infection into the heterosexual population. As a result of the interviewing and contact tracing, 400 people were identified as having syphilis in the Province during 1975, and of these, 179 were found to have the disease in its infectious form.

Latent syphilis—The Provincial Laboratory conducts over 700 tests a day on specimens from pregnant women, persons having routine physical examinations, and persons suspected of having a venereal infection. Syphilis may produce few symptoms and the presence of the disease may only be discovered by blood tests during its latent phase. It is necessary to continue a screening program to find these hidden cases of infection so that they may be adequately treated and prevented from developing complications.

THE PUBLIC HEALTH NURSE AND DISEASE CONTROL

The public health nurse played an active role in disease control programs and provided the following services (*see* Table 3 for details):

- 499,946 individual immunizations and 29,155 tests for diphtheria, tuberculosis, and other conditions were given at neighbourhood clinics, child health conferences, and kindergartens. This total of 529,101 individual services represents a saving to the Provincial Medical Services Plan of well over a million dollars based on the minimum rate which might be paid a physician for the same service.
- 7,931 visits were made to patients and contacts concerned with venereal disease.
- 9,062 visits were made concerning tuberculosis control.
- 8,726 visits were made for epidemiological follow-up of other communicable diseases, including infectious hepatitis.

HEALTH AND OUR ENVIRONMENT

ENVIRONMENTAL ENGINEERING

During the year the staff of the Environmental Engineering Division continued to carry out the functions assigned under the *Health Act*. These include technical and consultative support to Medical Health Officers, Government agencies, municipalities, and individuals throughout the entire Province on matters relating to water supplies, swimming-pools, sewage disposal, solid waste management, sanitation, and training of water and wastewater personnel.

Field Operations

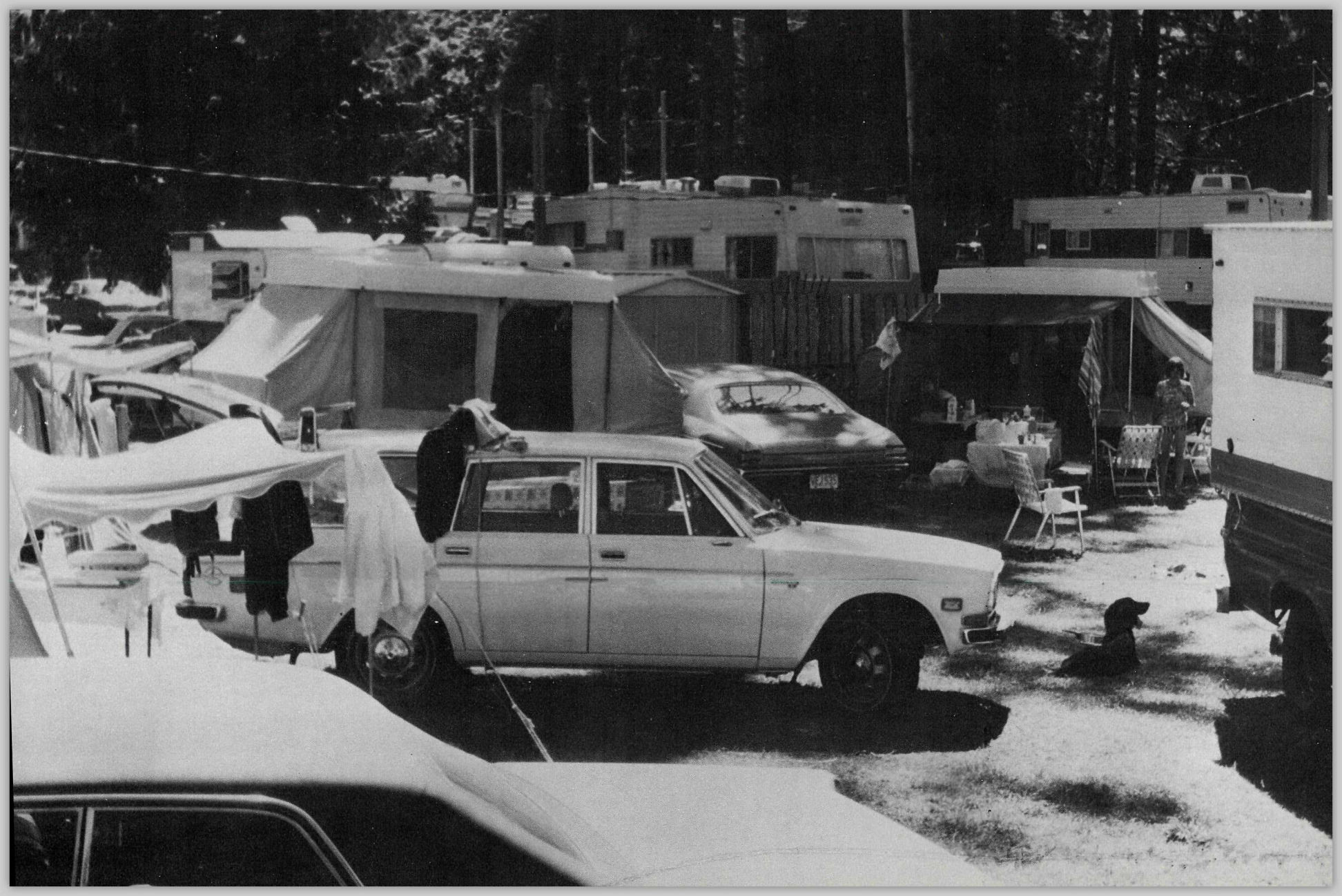
The concept, introduced in 1974, of offering greater and more direct technical support to the Medical Health Officers and their staff, by locating Environmental Engineers in the field, has been successful. District Engineers strategically located at Cranbrook, Nanaimo, Prince George, Surrey, and Vernon offer direct, rapid service to the health units, which are grouped into five regions, each containing three or four health units. District Engineers visit and assist operators of waterworks, sewage works, and swimming-pools, carry out site inspections on the installations, and consult with municipal officials.

With the addition of the five District Engineers, the need for Regional Engineers in Victoria to travel was reduced. However, engineers from Victoria visit each health unit on the average of two to three times per year. There were 82 field visits made by Victoria-based Regional Engineers in 1975.

Description of Functions

A brief description of the basic functions of the Division are as follows:

- *Waterworks*—All plans and specifications for domestic water systems, including private systems, utilities, improvement districts, and municipalities, were reviewed. (Certificates of approval from the Health Department are required before construction proceeds.) The Division has 760 recorded waterworks systems in the Province, this being 100 more than in 1974. Certificates of approval were issued to 639 applicants in 1975, 49 fewer than in 1974.
- *Sewage works*—Plans for sewage works reviewed by the Division are limited to public systems with flows under 5,000 gallons per day and not discharging into a water course. Two certificates of approval were issued in 1975.
- *Swimming-pools*—This Division reviews the plans and specifications for all swimming-pools and auxiliary facilities for compliance with the regulations. In general, compliance with the regulations ensures that physical safety and sanitation standards are met. All pools, with the exception of private pools, require a certificate of approval from the Department of Health before construction proceeds. Engineers follow up the progress of construction until the pool is complete, whereupon the jurisdiction is turned over to the local Medical Health Officer for the issuance of an annual operating permit. Eight-one certificates were issued in 1975 for the construction of new pools. This was 34 fewer than in 1974.
- *Sanitation*—The Division offered increased technical support to the Division of Public Health Inspection, primarily as a result of the appointment of District Engineers. Assistance was given on technical aspects of septic tank construction, tile for disposal fields, package sewage treatment plants, and preparation of sewage disposal regulation amendments.



- *Pollution control permits to discharge*—An inherent feature of the *Pollution Control Act, 1967* is the requirement that four other Government agencies review applications for discharges prior to the issuance of the permit. The Division, on behalf of the Deputy Minister of Health, receives all applications for discharges to land and water, solicits comments from the local health authorities, and formulates a Departmental reply. Applications for permits to discharge solid wastes are also reviewed by the Environmental Engineering Division.
- *Operator training*—The Division is active in the preparation and implementation of operator training programs in British Columbia. The delivery system for training is accomplished through three avenues:
  - Preparatory Training of eight months duration is offered at Malaspina College in Nanaimo. A staff member of the Division is a member of the Advisory Committee at Malaspina College.
  - Workshops, seminars, and schools are offered through the B.C. Section, American Water Works Association, of which the education chairman is a staff member of the Division. A five-day water and waste school for operators was attended by 140 operators. Other workshops and training sessions carried out in 1975 where the Division was responsible for the planning or was directly involved in the planning included Chlorination Workshop, two-day sessions in Richmond; Cross Connection Control Seminar, two one-day sessions in Kamloops and Burnaby; and B.C. Water & Waste School, a five-day session in co-operation with the Universtiy of British Columbia, Vancouver.
  - Correspondence courses which are suitable for use in British Columbia have been made available from other areas and the Division is contemplating the implementation of a correspondence course for waterworks personnel.

Training of swimming-pool operators is the responsibility of the Division. In previous years a series of workshops was offered throughout the Province, but this year a new concept was tried. The Division retained the services of two qualified instructors to offer a series of one-day training sessions in swimming-pool operation. Booklets on swimming-pool operations prepared by the Division were given to course participants. Eleven one-day sessions were offered at Richmond, North Vancouver, New Westminster, Chilliwack, Coquitlam, Courtenay, Prince George, Vancouver, Kelowna, Cranbrook, and Victoria.

The Division offers direct assistance and technical support to other Government agencies and participates in many specialized committees and groups.

Special Projects

Several new projects were initiated during the year. These include

- preparation of Engineering Guidelines for Design, Submission, and Construction of Waterworks Systems;
- preparation of amendments to Sewage Disposal Regulations, including a lecture series for Health Inspectors throughout the Province to disseminate the information;
- participation in the Environment and Land Use Committee's Task Force to Resolve Problems Relating to Sewage Effluent Disposal;

- development of a computerized system for the storage and retrieval of waterworks information;
- development of a training film for swimming-pool operators.

PUBLIC HEALTH INSPECTION

The major activities of the Division of Public Health Inspection are designed to provide a comprehensive environmental health program for the people of the Province. In this regard, new Sewage Disposal Regulations were approved by Order in Council in August and these contain several significant changes to safeguard the environment. The most notable are:

- Allowances are made for Ministerial Standards of Design for package treatment plants, prefabricated septic tanks, alternate sewage disposal systems, and for disposal tiles.
- Persons manufacturing or distributing a package treatment plant are required to obtain the approval of the Director of the Division of Environmental Engineering.
- The owner of a treatment plant system is required to obtain an operating permit from the Medical Health Officer. In order to obtain this permit, the owner must maintain a service contract with a package treatment plant service agent.
- The Local Board of Health is given authority to prohibit sewage discharge into tidal waters. This only applies to single-family dwellings and duplexes, as larger sewage volumes are under the jurisdiction of the Pollution Control Branch.
- Persons who are aggrieved by an order, decision, or action of the Medical Health Officer may appeal in writing to the Local Board of Health.
- The regulations provide more detailed information on how to conduct percolation tests, and include more realistic information on permissable daily sewage flows from various premises.

Sanitary Regulations

Updating of these regulations continued with recent amendments removing all reference to sewage disposal which is now covered by the sewage regulations. The amendments removed the obsolete section whereby a city municipality had to request that an Order in Council be passed to bring into effect certain pertinent clauses of the regulations.

Food Handler Training Programs

The National Sanitation Training Program for the food service industry was implemented on the Lower Mainland as a pilot project. It involved the Simon Fraser, Boundary, and Central Fraser Valley Health Units. The courses were jointly sponsored by the Canadian Restaurant Association and the local health unit and were available to all food handlers. The first of these courses was given to managers, although others attended. British Columbia Ferries are now providing this training course for their senior food service catering staff at the British Columbia Institute of Technology. Assistance is provided by public health inspectors.

Activities With Other Departments

The Division worked closely with other Government agencies involved with the protection of the environment.

These agencies included the Environment and Land Use Committee; the Pollution Control Branch; the Lands Branch; the Departments of Municipal Affairs, Housing, Highways and Public Works, and Recreation and Conservation; Health and Welfare Canada; and the Federal Department of the Environment.

Educational Activities

The Director of the Division is a corresponding member of the Board of Certification of the Canadian Public Health Association, which is responsible for conducting the examinations leading to the certification of Public Health Inspectors; and is also a member of the Environmental Technology Advisory Committee for the British Columbia Institute of Technology. Community Health Programs provided three months field training for 17 Public Health Inspector students. The field training requirements were increased to six months to provide a more comprehensive training.

Twenty-three Public Health Inspectors attended the second module of an ongoing course in communications.

OCCUPATIONAL HEALTH

The Division of Occupational Health offers a fully integrated employee health program to Provincial Government employees and provides environmental monitoring and consultative services to Governmental and non-Governmental agencies and institutions.

The Division of Occupational Health in 1975 expanded and extended the range of Occupational Health services offered to Government employees. The Division has offices in Kamloops, Prince George, Woodlands, Riverview, Victoria, and Vancouver.

Service requests are handled on a "team approach" and components of the team each deal with one of five programs:

- Physicians' Consultative Service.
- Occupational Health Nursing Service.
- Radiation Protection Service.
- Employees' Development Services.
- Employees' Fitness Program.

The physician complement increased to four with the recruitment of an additional doctor for the Victoria office. The physicians provide consultative services for community occupational health problems, service departmental requests, and provide on-the-job health service to employees.

This year, representation on interdepartmental committees was extensive. This involved close liaison with the Departments of Transport and Communication, Highways, Labour, and the Attorney-General, as well as the Pollution Control Branch, the Water Investigations Branch, B.C. Hospital Programs, and the Public Service Commission. Although pre-employment health examination of Public Service candidates has yet to be implemented, a hearing conservation program has been instituted using interval audiometry for noise-exposed employees. A flight surgeon's program has been undertaken on behalf of the Government airline pilots. Also, the structure of a Joint Union Management Committee to deal with disabled employees has been formalized and expanded.

The Occupational Health Nursing Service was further expanded and co-ordinated with nurses serving 11,858 employees during the year. This included immunization, counselling, referral to physicians, first aid, screening procedures, and education of employees.

Three nurses successfully completed an Audiometric Technicians Course sponsored by the Workers' Compensation Board. This will enable them to screen employees for hearing loss.

Employee group education remained a conscious concern of the nursing staff. Classes were held for employees in nutrition, physical fitness, body mechanics, safety, and infectious disease control.

Radiation Protection Service

The Radiation Protection Service experienced a marked increase in service demand during 1975. Much of this demand originated from the increase in the number of dental X-ray installations and the granting of more licences for radioisotope use. There are now over 500 radioisotope licences, covering several different radioactive sources.

In 1975 the Radiation Protection Service conducted

- 625 radiation surveys;
- 188 consultations and visits
- 25 talks and lectures;
- 505 radiation leak tests;
- 14 monitorings of nuclear submarine visits;
- 158 checks of water samples for radioactivity;
- 360 checks of air samples for radioactivity;
- 155 checks of microwave ovens for leakage (mostly through Public Health Inspectors).

The Radiation Protection Service completed a working draft of proposed radiation control regulations calling for registration and inspection, and establishing some basic parameters for X-ray equipment, operating procedures, and protection. The proposed regulations are being circulated among the professions and other interested parties for comment.

A research project was completed in collaboration with the Director of the X-ray Department of St. Paul's Hospital, Vancouver, on a system of personal and environmental radiation monitoring known as Thermal Luminescent Dosimetry (TLD). This dosimetry system, using small ⅛ by ⅛-inch LiF crystals is more stable and accurate over a wider range of exposures than the familar film badge monitors. The project was very successful and a report is under preparation.

The awareness that the use of certain ultrasonic devices could be a potential health hazard resulted in the development of a questionnaire that was sent to all public hospitals in the Province. These data provided an understanding of the use of the various ultrasonic units in Provincial hospitals.

Since 1958 a member of the staff of the Radiation Protection Service acted as Secretary to the Radiological Advisory Council and its several Committees. The organizational activities of the Radiological Advisory Council have expanded to become a full-time position, with most of the work done on behalf of the B.C. Hospital Programs.

In December a training program in microwave oven surveying was developed for Public Health Inspectors. This will permit the Province-wide surveying of commercial microwave installations on an alternative yearly schedule.

Employee Development Service

The Employee Development Service conducted an education and counselling program tailored to the needs of the problem employee. The accent was on alcoholism.

In liaison with a number of other departments, one-day educational sessions pertaining to the problem employee were presented at various locations throughout the Province. These sessions reached top, middle, and operative management levels and over 1,000 employees participated. A comprehensive training manual on the policy and program for problem-drinking employees was written and distributed to supervisors throughout the Public Service. Although it is still in a development phase, the results of the problem-drinking program have been very encouraging.

Representatives of the Employee Development Service were also active in addressing community groups such as the Occupational Industrial Program Counsellors, Lions Club, Workers' Compensation Board, and concerned professionals in the Richmond community.

The Employee Fitness Program was incorporated into the Occupational Health Division in April. The staff for this program is comprised of a kinesiologist, a public health nurse, and a nutritionist.

The first exercise sessions began May 5, 1975, and by the autumn approximately 300 employees had participated. The program offers a multiplicity of services to assist employees in maintaining proper physical fitness. Individually tailored fitness programs are developed on request. The service facilities at the Physical Activity Centre at 539 Superior Street, Victoria, have been modernized with the installation of carpeting, exercise mats, showers, and life-cycle bicycles. Classes are also conducted at two other locations adjacent to the Legislative Buildings precinct. Office exercise breaks have been established and approximately 140 people participated.

The program also conducts an educational service. A bimonthly fitness and health newsletter *The Square Wheel* commenced its first mailing in August. A 13-page booklet *Guidelines for Exercise Leaders,* an *Activity Plan—The "Half-as-Much" Approach,* and *Physical Activity Programs in Business and Industry—What Road to Follow?* were compiled, as well as a variety of material for counselling and class handouts.

The expansion of Community Fitness Programs was encouraged by developing a liaison among existing community fitness groups and responding to outside requests.

In summary, considerable progress was made toward the implementation of a comprehensive Occupational Health Service for the Public Service employees. Representatives of the Division have responded to increased community demands, particularly in the areas of health education, health maintenance, and environmental monitoring.

SPECIALIZED COMMUNITY HEALTH PROGRAMS

KIDNEY FAILURE CORRECTION PROGRAM

Six hospitals in the Province have a renal unit for the treatment of kidney failure. Each year more patients with this disease are kept alive and, in order to provide adequate treatment and the freedom of living at home, a home dialysis program has been developed. This program is conducted by the Medical Supply

Service of the Department, which operates a warehouse, a machinery servicing unit, and a delivery service. Patients receive their training for home dialysis at the Vancouver General Hospital, St. Paul's Hospital, or Royal Jubilee Hospital, Victoria.

Seventy-two patients in the program were on hæmodialysis and 18 on peritoneal dialysis at the end of the year. Several improvements were made in the dialysis techniques during the year, the main improvement being the development of an automatic peritoneal dialysis machine. This machine uses a concentrate which can be diluted with treated water which, in turn, will remove impurities through the abdomen of the patient. The use of the automatic peritoneal dialysis machine enables the patient to receive more thorough dialysis in less time and with less effort. This method of treatment is also more economical.

A program of completely rebuilding all hæmodialysis machines every two years was instituted.

The use of disposable artificial kidneys was introduced into the program during the year and this enabled patients to reduce dialysis time of eight to ten hours down to five or six hours, three times a week.

It takes time to finance such a change and to retrain the patients on the new technique but, by the year-end, half of the home hæmodialysis patients were on this program.

Many patients in the hospital centres cannot go on home dialysis because they do not have adequate accommodation or someone to assist them with dialysis procedures. In order to improve this situation, a program of self-care units is being instituted. The first will be located at the Division of Tuberculosis Control on the grounds of the Vancouver General Hospital, with a maximum capacity of 30 patients.

POISON CONTROL PROGRAM

A combined poison control and drug information referral centre was established at St. Paul's Hospital early in the year in excellent quarters provided by the hospital. This new centre makes available, for distribution to hospitals, information about new products that could be poisonous, and provides a specialized consultative service to physicians who are caring for cases of poisoning. There are now 59 hospitals providing poison control information to the public and it is planned to add at least two more during 1976. There were about 5,700 poisoning incidents reported this year, of which 44 per cent were accidental in nature, 8 per cent were judged to be due to the misuse of illegally obtained drugs, and the remaining 48 per cent were categorized as attempted suicide.

At the year-end discussions were taking place with the Department of National Health and Welfare which, it was hoped, would lead to the use of British Columbia-produced poison control information cards throughout English-speaking Canada. At the same time, consideration was being given to the use of microfilm in order to speed up production and distribution of new product information.

HYPOGAMMAGLOBULINÆMIA PROGRAM

This year two patients with congenital hypogammaglobulinæmia were added to the program, and 19 children and adults are now being provided with immune serum globulin on a regular basis. Because a few people have had rather severe reactions following their injection, the manufacturer now provides a specially processed immune globulin which may permit these life-saving injections to be continued indefinitely.

This program is operated jointly by the Department of Health, the Faculty of Medicine at the University of British Columbia, and the Canadian Red Cross Blood Transfusion Service. Funding and administration is provided by the Health Department, while laboratory facilities and professional consultative advice are provided by the Red Cross and Faculty of Medicine.

MERCY FLIGHTS

"Mercy flights" were again provided to transport seriously ill or injured persons by air to a hospital or other treatment centre. For this purpose, aircraft were used by the Provincial Government, the Canadian Armed Forces, the Canadian Coast Guard, and in some cases the United States Coast Guard and British Columbia Forest Products. In each case a medical assessment of the need was made by a senior medical officer of Public Health Programs, who played a prominent co-ordinating role through telephone conferences with the patient's physician, the providers of the aircraft, and the receiving hospital.

In 1975, mercy flights totalling 357 were carried out, an increase of 46 per cent over the 244 such flights in 1974. Six physicians in the Bureau are on an "on call" system to monitor requests for air evacuation of seriously ill or injured patients.

COMMUNITY CARE FACILITIES LICENSING BOARD

Administration of the *Community Care Facilities Licensing Act* is the responsibility of the Department of Health. During the year, several major changes were made in the arrangements for maintaining the quality of care in licensed community care facilities.

The ever-growing number of licensed facilities and the increasing public interest in this field made it necessary to divide the interdepartmental licensing board into separate adult care and child care boards. Each board has three additional members appointed from the community at large by the Ministers of Health, Human Resources, and Education.

The terms of reference of both boards have been enlarged and include not only the administration of the *Community Care Facilities Licensing Act* but also the planning and development of new and needed interdepartmental programs in the field of child and adult care.

Further amendments to the *Community Care Facilities Licensing Act* were made to facilitate the use of private homes for family day care without expensive renovations, and to return the enforcement of municipal by-laws to municipal officials.

The Board consultative staff is being increased by the seconding of additional staff from the Departments of Human Resources and Education. Three specialists in child care and three in adult care are required to provide guidance to operators and field staff in conducting ongoing training programs and also in answering queries from the public.

SPEECH AND HEARING SERVICES

During the year the Division continued the program, first reported on in 1973, designed to meet the needs of those in the Province who suffer from a variety of speech and hearing disorders. In addition, several significant accomplishments provided more effective services to those suffering from communication disorders:

- A Province-wide audiometer calibration service was introduced. Significant savings were realized through the program, and in addition, there is assurance that the audiometers are kept at a satisfactory operating level.

- The British Columbia Hearing-aid Program was launched in September in five regional centres serving Skeena, Northern Interior, South Central, South Okanagan, and West Kootenay Health Units, and public response was gratifying. Inquiries regarding this program were numerous.

The Provincial Hearing-aid Program was designed to provide quality services and quality hearing-aids at a fair price. The program, based on sound audiologic principles, provides hearing-aids at cost to the public. Audiologic clinics are located regionally throughout the Province and all referrals to the program are by physicians. Negotiation with hearing-aid manufacturers culminated in requisition of high-quality hearing-aids at the lowest possible price.

The first and the most important step in the rehabilitation of the hearing impaired is the evalution, selection, and fitting of optimal amplification. This step is completed by field audiologists.

Additional features of the program are as follows:

- Hearing-aids are supplied to the field through a central distribution centre. Each aid, whether new or repaired, is evaluated according to the most rigid performance standards in North America (as specified by the Government of British Columbia) before the instrument is fitted or reissued after repair.
- Assistance is given to field audiologists in a practical way. To ensure that clinical effectiveness and efficiency will result, the Division designs hearing-aid specifications which supply data pertinent to clinical application and accuracy.
- Included in an evaluation program are data such as manufacturers' co-operation, instrument delivery time, reply and response to special requests. Part of the evaluation consists of a circuit analysis of all instruments, and special instruments and jigs are designed and produced to perform tests more efficiently and accurately.
- A continuing record is kept on the condition of all measuring equipment used for evaluation of hearing-aids. This is to ensure measuring instrument stability and validity at all times.
- Repairs on the measuring equipment and on the hearing-aids are performed by Health Department personnel. Repairs to hearing-aids are completed within 24 hours, otherwise loan instruments are available. (Studies have indicated, at any given time, approximately 45 per cent of hearing-aids being used are not functioning satisfactorily.)
- All hearing-aids supplied to recipients by the Government are periodically examined electroacoustically to ensure optimal performance.
- The Government also supplies acoustic couplers, batteries, and repairs at cost.
- Other rehabilitative audiology services are available, such as hearing-aid orientation, speech reading, auditory training, speech conservation, speech pathology, language services, and counselling.

Speech-language Services

The following were included among programs conducted during the year:

- Speech-language positions were introduced at the following health units: South Okanagan (Penticton), South Central and Northern Interior.
- Speech-language positions temporarily vacated were filled at the following health units: West Kootenay, North Okanagan, Upper Fraser Valley, Cariboo, and Northern Interior.

- Speech-language services were introduced in hospitals at Selkirk, West Kootenay, North Okanagan, Simon Fraser, and Northern Interior. These programs were conducted by Community Health Programs speech pathologists.
- As of January 1, a new data collection system was introduced for speech-language assessment and treatment. It will give an indication of the effectiveness of speech-language services and will assist in cost-benefit analysis.
- The Division continued to present workshops for public health nurses, school teachers, and parent groups. The aim has been to prevent speech and language problems in the pre-school population and to assist nurses, teachers, and parents in the identification of speech-language problems and also to assist teachers in remedying minor speech-language problems. A major goal has been to extend speech-language services to remote communities throughout the Province.
- Two Division speech and hearing mini institutes were held—one in Kamloops, which dealt with administrative matters in the Division; and one in Prince George, which dealt with professional development.

VISION SERVICES

Consultative services regarding vision services were provided by the Provincial orthoptist to over 200 public health nurses, aides, and summer students. Visits were made to 11 health units and 14 branch offices.

Particular attention was paid to the detection and management of visual defects in the young child. However, the need for vision services by the remainder of the community is being reviewed.

With continued visits and demonstrations of screening methods and equipment, all health units are now using the Titmus Stereopsis Test as part of routine vision screening for kindergarten and pre-school-aged children.

Pilot studies were set up in order to determine the earliest age at which visual acuity and stereopsis could be carried out and recorded. Statistics on over 5,000 pre-school and kindergarten children were gathered and evaluated. The results proved most useful in establishing recommendations for the most effective testing equipment for general use, as well as referral levels for various age-groups.

It is anticipated that, in the near future, each health unit will be provided with a 'Learning Module' for Vision Screening. The purpose of the module is to provide public health nurses with information required to carry out parts of the vision screening program relevant to their district case loads. Early detection of eye defects is essential to prevent permanent visual damage.

COMMUNITY PUBLIC HEALTH NURSING SERVICES

Public health nursing services are available to all persons in the Province. The public health nurse is a primary health worker and is concerned with total family and community health. She brings her special skills in preventive and curative nursing to the community so that she can assist in providing the best possible health care for the people in her area, according to their special needs. She is concerned with physical and emotional health, and uses epidemiological methods to uncover potential health problems so that prevention, or care, can be arranged before treatment becomes unnecessarily costly to the taxpayer. She is also concerned with health promotion and the maintenance of maximum health of the individual and the family.

MATERNAL AND CHILD HEALTH

PRENATAL

Educational programs for expectant parents continue to be an important method used by public health nurses to bring about positive behavioural changes when parents are most receptive to learning. Through group classes and by individual counselling the public health nurse has a unique opportunity to help expectant parents build a good foundation for the enlarging family, and

- there were 550 classes for expectant parents held at health centres during the year;
- 9,093 new mothers and 5,631 new fathers attended 48,979 sessions, representing an over-all increased attendance of about 30 per cent;
- 62 per cent of the group sessions had both parents enrolled, representing a 12-per-cent increase over last year;
- 38 per cent of all expectant mothers participated and it is estimated that over 60 per cent were mothers having their first baby;
- 6,208 home visits were made by public health nurses to supplement group sessions.

INFANT AND PRE-SCHOOL

Public health nurses give special attention to the health supervision of young children, as good health patterns may be established at this time and many potential health problems prevented if detected early. Home visits, health appraisals, screening procedures, as well as health protection measures, are emphasized. In summary,

- 22,585 infants or about 99 percent of all newborn babies received at least one home visit for general health assessment and appraisal, advice, and counselling on child care;
- 36,969 home and office visits were made to infants for further follow up (the number represents a 50-per-cent increase over last year), and these visits were generally to children with suspected abnormalities or "at risk" due to unfavourable home conditions, failure to thrive, etc.;
- 26,901 similar visits were made to pre-school children;
- 17,822 infants attended child health conferences at health centres where 58,977 individual services such as counselling on general health, nutrition, health appraisals, and immunizations were given;
- 84,229 individual services of a similar nature were provided to pre-school children at child health conferences;
- 18,965 special services such as physical examinations, vision and hearing tests, and the Denver Development Screening Test were given by public health nurses at special clinics. Children showing deviation from the normal pattern were given special help by the public health nurse or referred to specialists.

FAMILY, ADULT, AND GERIATRIC SERVICES

Public health nurses provide a family health service and, through counselling and health advice, they are in a position to encourage changes in life-style which can lead to better general health for the entire family and reduce health care cost. Examples of this include discussion of obesity, exercise, nutrition, use of seat belts, cigarette smoking, and a better understanding of disease and of human relations. Regarding this,

- 333,306 visits of all types were made to homes, which is a 38-per-cent increase over last year;
- 5,095 visits were made for home assessment and appraisal of conditions related to health care;
- 15,086 visits were made for specific referral and follow-up of special conditions;
- 461 special geriatric clinics were held for elderly persons to assess health problems and provide appropriate follow-up;
- 121,694 or 50 per cent of all home visits were to persons over 65 years of age;
- 284,219 health services were rendered by telephone conversations by public health nurses with persons concerned about health problems;
- 1,108 family planning clinics were held.

PUBLIC HEALTH NURSING AND HEALTH PROMOTION

Group methods have proved especially effective in providing opportunities for discussion of health problems for persons with similar concerns. Group discussions are an excellent health education method for providing scientific and technical information to persons with common interests, and

- 1,475 sessions were held with parents of 1,062 pre-school children to discuss growth and development and parental problems;
- 28,889 school and adolescents' sessions were held with 19,564 persons in this category;
- 5,937 sessions were held with 3,358 adults, which were devoted to many general health and social problems;
- 4,757 meetings were held for health education on specific topics;
- 3,003 meetings were attended by public health nurses as official representatives of the health unit;
- 30,337 visits were made to homes or were held in the office, with health promotion objectives.

CONTINUITY OF CARE AND COMMUNITY CARE FACILITIES

Public health nurses attempt to provide continuity of care to individuals with health problems as they move within the health care system, i.e., home, physician, hospital, or other treatment and care facilities. This is accomplished by liaison and consultative visits to appropriate persons, agencies, and facilities in the community. In summary,

- 7,464 routine liaison visits were made to physicians' offices;
- 8,507 liaison visits were made to other agencies on behalf of persons being cared for by public health nurses;
- 6,623 liaison visits were made to general hospitals;
- 4,133 case conferences were held with members of the health unit staff or other disciplines;
- 390 visits were made to licensed child care facilities;
- 2,791 visits were made to licensed facilities for adults.

SCHOOL HEALTH SERVICES

Health promotion among school-age children is an inseparable part of the over-all health service to families. Through maternal, infant, and pre-school services, the public health nurse tries to ensure that all children will enter school in a

state of physical and emotional health which will enable them to grow and learn to their maximum potential. School and health personnel work together to discover "at risk" and "special needs" children as early as possible, and plan for their needs to be met. This joint approach toward ensuring each child a good start in school is enhanced by a continued increase in kindergarten enrolment and day care services.

Following are some of the services provided by 17 Provincial health units:

- Developmental screening between the ages of birth and 5 years provides an excellent opportunity to counsel parents whose children demonstrate any special need. Some 7,800 pre-school-aged children were assessed using the Denver Developmental Screening Test.
- Screening services carried out after entry to school include vision and hearing on a regular basis and screening for communicable disease or other health problems as indicated.
- 206,545 screening procedures were carried out by public health nurses and 95,760 by auxiliary workers.
- From the pupils screened the nurses selected 28,974 who required further investigation, counselling, or referral.
- 68,688 students were referred to the public health nurses for investigation of a health problem and of these 27,932 were referred by the nurse to another health resource. A breakdown of the reasons for referral is shown in Table 8.
- A major contribution of the public health nurse in the school health program is providing a liaison between school and home; 36,724 home or office visits involving school pupils or their parents were carried out by public health nurses.

MENTAL HEALTH SERVICES

The nursing consultants in mental health and public health programs are working toward co-ordination of all community nursing services. The long-range objective is to ensure an adequate input of mental health nursing consultation, at the local and Provincial level, to all generalized public health nursing and home care programs. As well as services provided for the mentally ill, the emotional needs of persons with acute or chronic physical illness, or disability, or those in crisis situations, should be recognized and care provided.

Public health nurses share with other professionals the development of a variety of special community services designed to enhance the mental health of the community, particularly that of young families. These include discussion groups for parents, crisis intervention services, programs for children with special problems and community education. In summary,

- 6,429 counselling sessions were provided by public health nurses to support families during illness, family crisis, or a period of loss;
- 9,182 visits were made concerning problems in family relationships and communication;
- 2,324 visits were made to administer medication for treatment of mental illness or supervise patients receiving medication;
- 4,288 counselling sessions were held with persons receiving follow-up care in relation to a mental illness;
- 1,975 visits were made to mentally retarded persons or their families.

HOME CARE PROGRAMS

The home care programs throughout the Province continued to provide services in the homes to persons who might otherwise be in acute hospitals, institutions, or who, without services, would be inadequately cared for. The program is available to persons of all ages except some in isolated areas of the Province.

Through the home care programs, public health nurses work with the physician in co-ordinating and providing services required by a patient. Staff of public health units provided nursing and physiotherapy services and arranged for other services such as homemakers, social workers, dietitians, medication, and equipment. Through the program, patients were admitted to a home care program on referral from their physicians. Home care programs were available to over 90 per cent of the population of British Columbia.

Highlights of the program are summarized as follows:

- Professional nursing care in the home is provided by community public health services at no cost to the patient or his family.
- Physiotherapy services are available from many public health offices at no cost, and these services are being extended.
- The Public Health Nurse Co-ordinator working with the patient's physician arranges for all ancillary services required for the patient and assumes responsibility for co-ordination of services to the patient and his family.
- Public health staff nurses made 287,428 nursing visits to home care patients during the year. This was a 44-per-cent increase from the previous year.
- "Hospital replacement" home care programs were extended to 22 areas and provided services to approximately 80 per cent of the Province's population.
- When patients are on "hospital replacement," i.e., home care in lieu of acute hospitalization, all services including medication, equipment and supplies, homemaker, orderly, laboratory services, and dietitian are paid by the Provincial Department of Health.
- Over 7,977 patients were admitted to home care programs in lieu of hospitalization. These same patients received 79,859 nursing visits, 6,904 physiotherapy visits, 25,989 hours of homemaker services and 2,428 meals-on-wheels. Medication was supplied to 4,265 patients and medical supplies and equipment to 4,423 patients.
- The average length of stay for patients on "hospital replacement" was 10.3 days and the average total cost per patient was $135.34.
- The Department of Health continues to assume full financial responsibility for the services of the Victorian Order of Nurses in Greater Vancouver and, in November, the Victorian Order of Nurses Branch in Surrey was phased into the Boundary Health Unit.

PHYSIOTHERAPY SERVICES

During the year, three full-time and twelve part-time physiotherapists provided consultive and preventive services to patients, patients' families, physicians, public health staff, hospitals, private agencies, Government departments, and the general public in nine health units (13 offices).

Services are being provided or are being developed in

- *Preventive care*—Prevention is an integral part of all physiotherapy and involves education and training in self-care procedures in order to prevent secondary complications, deterioration of existing problems, or recurrence of a treated problem. Additionally, the therapist is involved in other health

services whose primary function is prevention, such as school health, "well child," sports injuries prevention and treatment, industrial/occupational accident prevention, physical fitness, mental retardation screening and assessment, prenatal and postnatal programs, and recreation/activation programs for senior citizens and disabled groups. The services are provided through the community clinics, health care agencies, and organized community programs.

- *Treatment*—Services provided can be classed in terms of location and type of care:
  - *Acute care*—This is provided through the home care program.
  - Active rehabilitation.
  - Convalescent and chronic care.
  - Nursing-home care.

Emphasis in treatment service is placed upon the acute care group where physiotherapy is provided for patients requiring continuous care and specialized treatments. Thus the community rehabilitation therapists are involved in the treatment of a high percentage of both acute medical and surgical patients. Therapists have been involved in a wide variety of medical areas.

Home care is also provided for the non-acute patient either on a periodic basis to deal with fluctuations in his health status or following discharge after rehabilitation to ensure optimum functioning in the home setting.

- *Maintenance and follow-up services*—These services provide continuous care for patients suffering from chronic disease processes who may benefit from intermittent therapy programs. These programs usually involve periodic treatment or supervision by the physiotherapist over many years and may include continuous assessment, special training programs, specialized procedures, and the provision and constant re-evaluation of aids and devices necessary for independence. This program is expected to reduce hospital readmissions and help patients live a reasonably normal life in the community.
- The final role of the physiotherapist in the community is that of adviser to members of the health care team, particularly where the multidisciplinary approach has been taken. Physiotherapists act as consultants and advisers to local universities, colleges, and schools, community and health care agencies, industry, health care institutions, Government departments, other health personnel, and particularly members of the physiotherapy profession. An important aspect of the advisory service is the therapists' function in advising on features needed in public buildings and facilities to avoid architectural barriers to the disabled.

DENTAL HEALTH SERVICES

In the spring of 1975 the Government of British Columbia announced that it was planning the introduction of a comprehensive preventive and curative dental program for children. Furthermore, it stated that the responsibility for the organization and administration of the program would be that of the staff of the Division of Preventive Dentistry. The name of the Division was thereupon changed to "Division of Dental Health Services" as this title appeared to be more appropriate.

Later in the year the report of the Children's Dental Health Research Project was jointly released by the Minister of Health and the President of the College of

Dental Surgeons of British Columbia, as co-sponsors of the project. During the balance of the year discussions were held between the two parties in an endeavour to reach an agreement on the most efficient delivery system for the treatment services. However, it was mutually agreed that whatever delivery system was adopted would require a considerable number of additional auxiliary dental personnel. Therefore, an appointment was authorized for an additional consultant to the Division to be responsible for the organization of the training of auxiliaries and for planning the future needs for in-service and extra-mural education of all personnel of the Division. At the close of the year, finalization was incomplete.

During the year, progress was made in the improvement of conditions in dentally under-serviced areas. The following summary explains:

- In Masset and in Queen Charlotte City, dental clinics were provided by the communities with financial assistance from the Government of British Columbia. Dentists were recruited by the College of Dental Surgeons of British Columbia. At the close of the year a similar facility was being constructed in Mackenzie.
- Secondly, in the summer of 1974, there was an acute shortage of dentists in Prince Rupert and no suitable rental accommodation was available. Therefore, it was arranged that the City would provide, service, and prepare a site for a large mobile home, to be constructed and equipped to specifications by the Department and purchased by the Government of British Columbia to provide living accommodation and a two-operatory dental clinic. This was leased during 1975 on a 12-month basis to a dentist and his wife, a dental hygienist.
- During 1974, to improve the quality of treatment services provided on a fee-for-service basis by dental externs visiting communities without a resident dentist, two large, specially designed motor home-type vehicles had been purchased and equipped as two-chair dental offices. As a result, commencing in the early summer of 1975, five mobile dental units visited 12 northern communities. In the fall, these units visited 12 similar communities in the Kootenays and at the close of the year the mobile clinics moved to northern Vancouver Island to provide similar services.

With the assistance of grants-in-aid from the Department of Health, preventive dental services of high calibre continued within the Capital Regional District and Metropolitan Vancouver, which areas are not covered by Provincial health units.

Five regional dental consultants initiated and supervised all dental health programs in 17 health units. The programs were considerably improved and strengthened by the appointment to the headquarters of the Division of a consultant dental hygienist. A one-week in-service training program was organized and attended by 40 employees of the Division. Subjects presented and discussed included objectives, evaluation and cost effectiveness of programs, personnel management, and techniques appropriate to the various programs.

In the health unit areas, the dental consultants, dental hygienists, and dental assistants concentrated most of their time and efforts on the 3-year-old birthday card programs and dental health programs in the schools.

The birthday card program was modified during the year in negotiation with the College of Dental Surgeons of British Columbia. Formerly, at no charge to the parents, 3-year-olds were provided with an examination, appropriate advice on dietary habits and oral hygiene practices, X-rays, if necessary, and the topical application of a dental caries-preventing solution. The fees paid to dentists for these services had remained unchanged for 10 years, and rather than expend the additional funds required to meet the current fee schedule, it was decided to forego

the X-ray and topical application features in favour of strengthening other dental health programs. During the year, some 10,000 3-year-olds of this Province benefited.

School dental health programs were carried out in those areas where dental auxiliary personnel were available. These were very considerably strengthened during the last month of the year when the total number of dental hygienists increased from five to nine. These personnel were supported by 18 dental assistants, 12 of whom were certified and registered.

To evaluate the effectiveness of all dental health programs in British Columbia, three Province-wide dental surveys have been carried out in the periods 1958–60, 1961–67, and 1968–74. The combined results of the third series were tabulated and analysed during 1975. It is encouraging to report significant improvements in the dental health status of the children of the Province during the period. For example, the average number of permanent teeth attacked by dental caries has decreased in each age-group between 7 and 15 years. Specifically, the average 15-year-old in the first series of surveys had 12.4 such teeth but only 10.0 as recorded in the third series. Furthermore, of these teeth, at the time of the examination, 4.8 had untreated carious lesions and at the latter series only 2.8 were untreated. That treatment coverage had significantly improved was also demonstrated by the fact that whereas 16.8 per cent of the children aged 7 to 15 years were shown in the first surveys as having no untreated carious teeth, this percentage had increased to 32.0 in the third series. The percentage of children receiving orthodontic treatment doubled during this period. However, it is still disturbing to note the high percentage of children with poor oral hygiene and consequently a relatively high ratio (26.3 per cent) with evidence of inflamed gingivæ (gums). Also noted is a similar ratio (27.7 per cent) with "severe" malocclusion for whom orthodontic treatment would most likely be highly desirable.

In addition to the 1,332 dentists registered and licensed to practise in British Columbia at the close of 1975, there were also 295 dental hygienists and 656 certified dental assistants, having increased since 1974 from 256 and 552 respectively. In 1975, close to one third of the total population were beneficiaries of dental care plans. In communities where the ratio of such beneficiaries was high and the ratio of population to dentists was also high, serious difficulties arose, since the demand for dental services considerably surpassed the total services the resident dentists could provide. It is evident therefore, that the needs for dental services must be decreased by active and effective dental health programs throughout the Province and the availability of dental services must be increased, especially by the education and efficient utilization of more well-trained para-dental personnel.

NUTRITION SERVICES

With an increase in staff, the availability of nutrition services was expanded. Five field nutritionists and one nutrition consultant were added for a total of nine staff members in the Division.

Nutrition programs were implemented Province-wide and in individual health units to meet three main priorities—promotion of sound nutrition knowledge, implementation of nutrition education programs, and increased emphasis on the role of nutrition in preventive health. On a Province-wide basis, programs included

- *Nutrition Buyline,* a nutrition column carried by 53 newspapers;
- infant nutrition education workshop for public health nurses representing each health unit;

- conferences with physicians in 10 different centres in the Province to discuss current nutrition topics, in particular, Health Department policy regarding instruction about infant feeding;
- regional nutrition workshops to meet the needs of individual health units;
- nutrition education and food service workshops for staff of residential community care facilities and day care centres;
- production of a 15-minute film entitled *Why Nutrition* to stress the importance of nutrition education in day care centres;
- production and revision of a number of nutrition pamphlets.

In health units with nutritionists (Cariboo, South Central, South Okanagan, Central Fraser Valley, Simon Fraser, and Boundary), examples of the programs in which the field nutritionists were involved are

- nutrition in the schools, including nutrition education, student food habit surveys, assistance to school lunch programs, and projects to remove non-nutritious food from school vending-machines;
- programs to special groups, e.g., nutrition counselling on an individual basis, and nutrition presentations, to the elderly;
- participation in ongoing health unit programs, e.g., prenatal nutrition classes and counselling "at risk" pregnant women;
- provision of nutrition displays for food fairs and exhibitions;
- assistance to self-help weight-reduction groups;
- in-service nutrition education program for health unit staff;
- television and radio appearances to promote sound nutrition information.

As in previous years, an extensive summer student employment program was conducted by the Division. The projects included a survey of the eating habits of East Indians living in the Boundary Health Unit; development of nutrition teaching aids for public health nurses; a weight-reduction program for adolescent girls; nutrition pamphlets for parents of pre-school children; a repeat assessment of the nutrition knowledge, attitudes, and practices of public health nurses in British Columbia.

A notable project was the development of an *Infant Nutrition Guide*. This book is to be distributed to all general practitioners, pædiatricians, nutritionists, public health nurses, schools of medicine, nursing, and nutrition, and hospitals in the Province. The objective of this publication is to promote one policy regarding instruction about infant feeding practices. Workshops and conferences for professionals, and pamphlets for parents, will accompany the release of the guide.

PUBLIC HEALTH EDUCATION

For the Division of Health Education, 1975 was a year of significant development and growth. Highlights of the Division's development include the appointment of a Director, staff appointments in Health Units and the Division, and a move to new, well-equipped, office accommodation.

In keeping with the Department's over-all goal of developing a modern health care system responsive to the needs of the people, the Division re-examined its role and established new objectives. These objectives focus on the increased emphasis that all health agencies are giving to health promotion strategies aimed at alteration of life-styles.

Briefly, the Division's goals are to administer the health education delivery system for the Department of Health by providing technical advice, services, and educational materials for health department programs, branch, division, and health unit staff, and the general public

- by organizing and developing a health education resources centre for the production and distribution of audio-visual materials on health and health-related subjects, and evaluating the usefulness and effectiveness of materials—
  - library services, including a film library (35 mm, 16 mm, Super 8); a videotape library; and a resource library (books, journals);
  - audiovisual production and services including film (35 mm, 16 mm, Super 8); television and videotape recording; radio spots, editing, mixing; visual materials (artwork, photography, transparencies, and displays); sound (slide/filmstrips); printed matter (pamphlets, posters, flipcharts); and the purchase and supply of audiovisual equipment to health units;
- by forecasting and developing health education manpower requirements at professional and paraprofessional levels and by providing for educational supervision and professional development;
- by providing effective liaison with other Government departments (Provincial and Federal) and with voluntary health, welfare, and education agencies in order to co-ordinate interorganizational planning and programming;
- by developing health education projects and activities in co-operation with the traditional providers of health education, i.e., schools, media organizations, Government and voluntary agencies, health institutions (hospitals and clinics), and occupational health programs;
- by providing funding for the health education component of the programs of other divisions.

FIELD OPERATIONS

Five health educators were employed with health units and one health educator was assigned to the Division of Venereal Disease Control to develop and co-ordinate health education activities. Highlights of their year's work include

- the Family Health and Fitness Festival at the Coquitlam Sports Arena, attended by 4,000 people, was a co-operative project sponsored by Simon Fraser Health Unit, the Parks and Social Recreation Department, and the Local School Board;
- community organization activities include membership on advisory boards to school districts at Vernon and Armstrong, organization of a regional chemical dependency committee in the Comox Valley, and establishment of an Upper Island Health Education Council;
- VD Awareness Campaign utilizing newspaper advertisements, radio spot, and posters, and preparation and distribution of a VD Awareness Kit for physicians;
- school health education involvement was through participation in Family Life Education programs, smoking education, and input into the health curriculum;
- media organizations were generous in their allocation of public service time on radio, TV, and in the press for dissemination of health information.

VITAL STATISTICS

The Division of Vital Statistics undertakes a wide variety of duties involved in administering the *Vital Statistics Act,* the *Marriage Act,* the *Change of Name Act,* and Part II of the *Wills Act.* These duties are carried out through the central vital statistics offices in Victoria, a branch office in Vancouver, and 103 district offices and suboffices throughout the Province.

In addition, the Division provides a centralized statistical service to Community Health Programs, and to certain other Government departments and voluntary health agencies, through a Research Section in Victoria and a Research Office in Vancouver.

REGISTRATION SERVICES

Table 9 indicates the numbers of the main types of documents processed under the above-mentioned Acts in 1974 and 1975, and reflects several significant trends:

- There was an increase in the number of birth registrations over 1974. This continued last year's upward trend following several years of declining births.
- The number of wills notices registered under the *Wills Act* again increased, although at a lesser rate than in recent years.
- The recent upward trend in numbers of name changes under the *Change of Name Act,* following the broadening of the Act in 1972, was unabated in 1975.
- The number of divorce decrees, which has risen steadily since the liberalization of the Federal *Divorce Act* in 1968, turned more steeply upward in 1975.
- The demand for certificates and other types of documentation continued to increase substantially, and would have been greater but for the 40-day national mail strike in the fall.

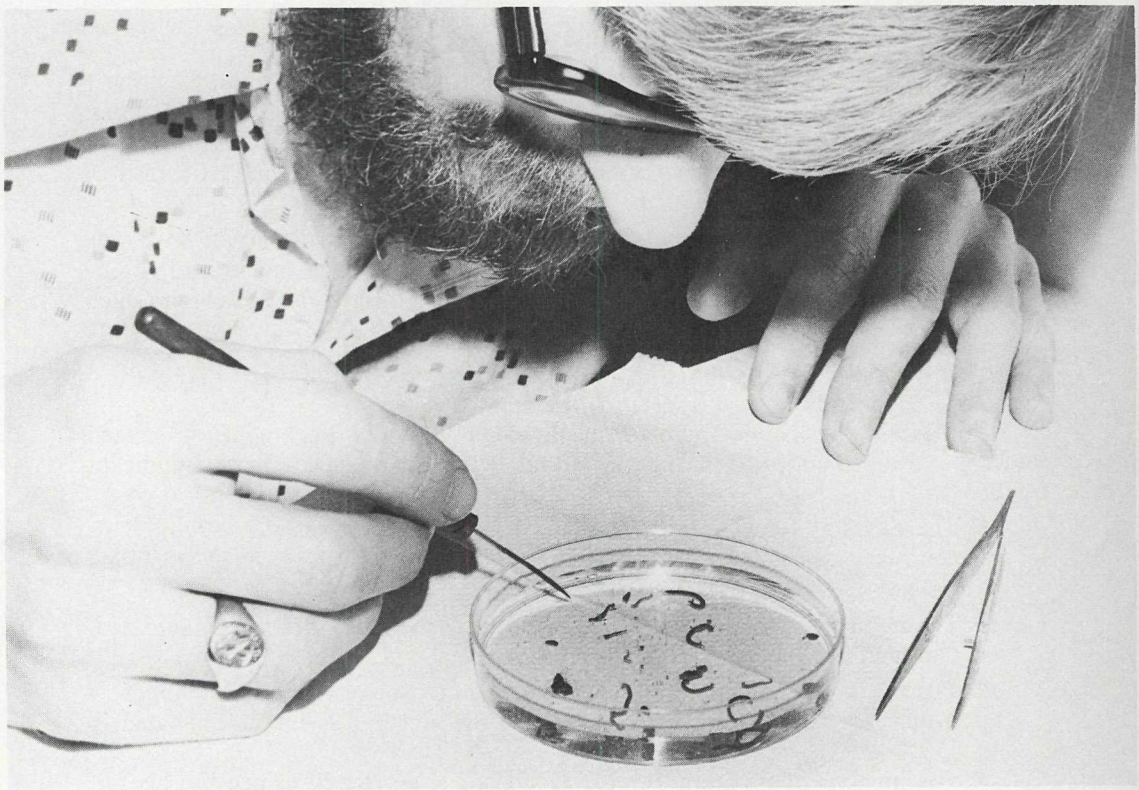
BIOSTATISTICAL SERVICES

Various recent developments within the Department have stimulated the initiation of new research projects, with a resulting increased demand on the Division's Research staff in Victoria and Vancouver.

The Health Surveillance Registry (previously the Registry for Handicapped Children and Adults) accepted about 3,000 new cases during 1975. The Department of Human Resources co-operated with the Registry in instituting a program for registering handicapped adults in receipt of the Handicapped Persons Income Allowance. From this source approximately 2,800 adult registerable cases were ascertained and are being processed. A continuing procedure for the reporting of similar cases is being worked out with the Department of Human Resources.

Over 2,000 cases, ascertained from birth, stillbirth, and death registrations, hospital separation forms, and other sources were added to the file of congenital anomalies.

The Registry makes extensive use of consultants who are experts in the fields of genetics, pædiatrics, and cancer. In addition to direct assistance in the day-to-day operation of the Registry these consultants were active in international conferences and workshops related to the work of the Registry.



The Cancer Register is a specialized entity within the framework of the Health Surveillance Registry. Further success was achieved during the year in securing the co-operation of pathologists throughout the Province in submitting pathological reports to the Cancer Register.

The Division assisted the Central Cytology Laboratory of the Cancer Control Agency in the analysis of data derived from about 440,000 cervical smears taken from women screened for cervical cancer. As from January 1975 the responsibility for mechanical processing of these records was assumed by the Computing and Consulting Services Branch of the Department of Transport and Communications, thereby terminating the service rendered by this Division since 1956. The Division, however, continues to undertake the analysis and interpretation of the annual data, and general statistical consultation.

Registry staff continued to work closely with the Cancer Control Agency of British Columbia (previously the B.C. Cancer Institute) and to process the records of the agency relating to malignancies at the treatment facility in Vancouver.

Statistical consultative advice and data processing services were provided to the Division of Dental Health Services. Assistance was also given in the development of a new recording form and revised methodology for the continuing series of dental field surveys. The new form is designed to provide more comprehensive information on the levels of caries experience and restorative or corrective treatment.

The Division participated actively in the work of the Perinatal Program Committee of the B.C. Medical Association, which was formed in 1974. One Research Officer has served as a member of the committee since its inception, and another was appointed as a statistical consultant during 1975. A number of special

tabulations relating to maternal and child health in this Province were prepared for the use of the Program Committee.

The Division continued to co-operate with the Child and Maternal Health Division of the Department of National Health and Welfare in the maintenance of a national congenital anomalies surveillance program. Lists of anomalies ascertained from physicians' notices of births were submitted to Ottawa throughout the year, and assistance was given in the critical examination of the resulting data.

A Research Officer of the Division continued to represent Community Health Programs on the interdepartmental Metric Committee. He assisted in the work of subcommittees on training and cost analysis, and in developing a program of basic education for all Health Department employees in the essentials of the metric system.

The services rendered to the Division of Tuberculosis Control for many years entered a new phase in 1975 with the computerization of the Division's punch card records. Assistance was given to a physician attached to that Division, in the statistical evalution of all newly diagnosed cases of tuberculosis from 1950 to date.

The Research Section co-operated with the statistician attached to Mental Health Programs in the processing of statistics relating to patients of residential institutions and those treated at day care centres. Arrangements were made for transferring to the Department of Human Resources the main responsibility for processing statistics relating to three institutions for the retarded, which were transferred during the year to that department's jurisdiction from the Health Department.

Services were given to the Community Care Facilities Licensing Board in maintaining statistics of the operation of personal care homes and day care centres for children. The transfer of the punch card files of these records to computer tape has facilitated prompt response to the requirements of the Board for up-to-date information.

The patient records relating to the expanding Special Home Care Projects were processed, and summary data supplied to the Division of Public Health Nursing. Assistance was given to a Public Health Nursing Consultant in preparing a report, based on a study completed in 1974, on the effectiveness of the physician/public health nursing liaison program.

In collaboration with the Medical Genetics Department of the University of British Columbia, the Division initiated a computerized record linkage program based upon the pioneer work of Dr. H. B. Newcombe at the Chalk River Nuclear Laboratories of Atomic Energy of Canada Limited. The project involves the linking of British Columbia vital and health records into individual and family histories. By this means a wide variety of health-related studies, otherwise impracticable, can be made possible, while the confidentiality of individual records is rigidly maintained. The project is under the immediate direction of a geneticist who previously worked with Dr. Newcombe on the Chalk River project.

A new aspect of the Division's work assumed importance in 1975, namely, the provision of consulting services in relation to behavioural studies. Notable examples were a design of questionnaires to measure behavioural changes in children resulting from a program of Parent Study Groups in the Courtenay area; and a study undertaken by the REACH agency, which involved the assessment of a tape presentation designed to allay concern among the elderly about hospital admission.

The Division's Research Section maintained statistical services to the Divisions of Epidemiology, Venereal Disease Control, Environmental Engineering, Public Health Inspection, Speech and Hearing, and to the consultant in Public Health Nutrition, in the editing and processing of records, and in statistical consultation.

The Mechanical Tabulation Section continued to undertake much of the Division's requirements for processing of data, including the requirements of the Research Section, as well as the extensive demands for preparation of indexes and statistical data arising from the Division's legal registration functions.

Substantial progress was made in 1975 in the computerization of the Division's data processing system, with a view to replacing the existing outdated unit record equipment by a computer terminal connected to the central installation of the Computing and Consulting Services Branch, Department of Transport and Communications. Because of the number and variety of the statistical series to be converted, the process is likely to take another year or two to complete, depending on the availability of technical staff.

During the year, initial discussions were held with representatives of other branches of the Department regarding the development of a computerized data system for the entire Health Department.

AID TO HANDICAPPED

The year was one of consolidation rather than expansion. Many new programs aimed at providing more and better services for the handicapped and those who have been described as "disadvantaged" have been developed under various Federal and Provincial Government auspices. A major part of the responsibilities of Aid to Handicapped Consultants in the Province has been the promotion and development of means by which services within a community can be co-ordinated to the advantage of disabled people who are served by the Aid to Handicapped Programs.

The advent of the new programs has resulted in a considerable increase in the amount of time required for discussions and meetings to ensure that adequate liaison is maintained with no loss of co-ordination.

In Greater Victoria Region, for instance, a "Co-ordination of Services for a Deaf and Hard of Hearing" committee was set up. The Committee was chaired by a representative of Integrated Services for Child and Family Development and was made up of representatives of many professional services which deal with the deaf and hard of hearing. The Aid to Handicapped Consultant in the region acted as liaison with school counsellors and others. This creates a better awareness of the services available to the deaf and hard of hearing in the community.

The Consultant in Greater Victoria was also involved in the program that resulted in the publication of a book listing public buildings and recreational facilities accessible to handicapped individuals.

In the Upper Vancouver Island Region, which includes Powell River and part of the Sunshine Coast, a Consultant was involved with the Department of Labour and the Department of Manpower in a joint Federal/Provincial program known as the Community Employment Strategy Program. This is aimed at finding ways to reduce barriers and open up job opportunities for chronically unemployed and handicapped people. A number of active projects were developed under the auspices of this program in the Nanaimo-Parksville area. The Consultant was also responsible for the development of a group which dealt with the needs of a number

of students who, because of educational, mental, and physical handicap, would experience more than average difficulty in making the transition from school into employment.

The Committee included the Director of Special Education Services, the Director of Malaspina College Study School Centre, and representatives from the Canada Manpower Centre.

In the South Fraser Region, which extends from Delta eastward to Hope, the Aid to Handicapped Consultant was involved in the development of several community projects, some of which envisage the setting-up of workshops for the disabled. It is hoped that, if regular gainful employment cannot be predicted for certain of the disabled, at least a useful and satisfying activity may be planned.

The Northwest Region, in which major centres are Prince Rupert, Terrace, Kitimat, and Smithers, was staffed with a Consultant. Much developmental work to ensure the co-ordination of community facilities and programs was required.

Other highlights of the Division's work were that

- working relationships were established with various agencies in the Skeena Health Unit Area, including the B.C. Vocational School at Terrace where many clients were referred over the past year for practical assessment programs and training, and Northern Training Centre at Smithers; programs included assessment, practical training in farm work, social orientation and experience, and workshop activities;
- Aid to Handicapped Committees were involved with new agencies and programs that have started up in the Health Unit Area over the past year, including Osborne Guest Home, Terrace (a boarding-home primarily set up for persons with some degree of mental impairment); Audiological Services, Terrace (an Audiologist was appointed to the Skeena Health Unit during the past year and many clients were referred for assessment and follow-up);
- the B.C. Vocational School in Terrace was transformed into a combination of Vocational School and Community College in September, allowing for an increased scope of training courses to be available to clients in the area;
- in May a local physician in Terrace was appointed Medical Consultant to the Terrace Aid to Handicapped Committee and provided medical consultation at monthly meetings and acted as a liaison between the committee and the doctors of the community concerning various medical aspects of an individual's rehabilitation plan.

LABORATORY SERVICES

During the year much time was spent in planning new programs and new accommodation for the Provincial Laboratories. In May, in preparation for building new facilities at the British Columbia Medical Centre (BCMC) Shaughnessy site, the Environmental Analysis Group (TEAG) Ltd. submitted to the Department of Public Works a study titled "Recommendations on Management Decisions, Preliminary Design Requirements, and Functional Program for Physical Facilities for the Vancouver Laboratory of the Provincial Health Laboratories." By the end of July the Deputy Minister of Health authorized establishment of a joint committee comprising representatives from the Provincial Laboratories, the Bureau of Special Health Services, the Department of Public Works, and B.C. Medical Centre, to undertake detailed planning for the new facilities closely integrated with, and sharing services with, the facilities for clinical microbiology at the centre.

The year marked the move of the Nelson Branch Laboratory to the Kootenay Lake District Hospital, Nelson. The new plan envisaged providing work space large enough to meet the anticipated needs of the three southeastern Health Units—Selkirk, West Kootenay, and East Kootenay.

The work load rose from 600,000 tests in 1974 to 637,000 in 1975, reflecting the steadily increasing demand for service in recent years.

Methods for improving the speed of providing Provincial public health laboratory service were studied. It was concluded that regular delivery-courier services between cities throughout the Province and the Main Laboratories in Vancouver would cut down the delay in receiving specimens and returning reports. Accordingly, South Central and Northern Interior Health Units were selected for a pilot study, with expansion to other health units in the future. Use of telecommunications for reporting laboratory results also received consideration. Since the operation of the Provincial Laboratories must be computerized, initial studies were begun.

BACTERIOLOGY SERVICE

Diphtheria

During the 12 years 1956 to 1967, only 15 patients with upper respiratory diphtheria were recorded in British Columbia. In the four years 1968 to 1971, 143 new upper respiratory tract infections with *Corynebacterium diphtheriæ* were recorded. In the four years 1972 to 1975, the number of isolations of the disease reached 709. Of these, 493 were located in the upper respiratory tract and 217 in the skin (one patient had simultaneous respiratory and cutaneous infection).

Enteric Diseases

By culturing close to 18,000 stool specimens, almost 1,000 new cases of enteric bacterial disease were diagnosed: Salmonellosis (420), shigellosis or bacillary dysentery (270), and acute gastroenteritis of children (300). Nine isolations of typhoid fever were diagnosed bacteriologically. During the year, culture of 270 specimens from nonhuman sources yielded 66 strains of Salmonella, indicating how widespread these pathogenic micro-organisms are in the environment.

Food Poisoning

During the investigation of 144 incidents of suspected food poisoning, microbial agents were identified on only 10 occasions: *Staphylococcus aureus* (5), *Clostridium perfringens* (4), and *Salmonella typhimurium* (1). In one incident a child developed mushroom poisoning after eating *Amanita pantherina*. In four incidents the provisional diagnosis was botulism, but the final diagnoses were hysteria; overdose of Anacin (five tablets) and "Coke"; reaction to benztropine mesylate; and hernia.

Tuberculosis

While the demand for microscopic examination for tubercle bacilli and for mycobacterial cultures of exudates and material other than sputum increased substantially, the increased demand for sputum culture was modest. Requests for drug susceptibility tests on mycobacterial cultures remained at more than 1,000. Ethambutol was added to streptomycin, isoniazid, and para-amino salicylic acid in routine susceptibility tests. Some 300 mycobacterial cultures, other than Mycobacterium tuberculosis, were investigated and mycobacterial strains of eight different species were identified.

Venereal Diseases

The laboratory aspects of the diagnosis and control of gonorrhœa and syphilis are reported elsewhere. Use of the Automated Reagin Test (ART) as the screening test for syphilis was continued successfully.

Whooping Cough

In 1971, culture of prenasal and postnasal swabs replaced cough plates in the laboratory diagnosis of whooping cough. In the five-year period 1971 to 1975, Bortella pertussis was isolated on 33 occasions from 214 swabs.

WATER MICROBIOLOGY

Water samples, collected from drinking-water sources, recreational waters, and waters subject to pollution, were received from Governmental agencies at three levels—Federal, Health and Welfare Canada and Agriculture Canada; Provincial, Pollution Control Branch, Water Investigations Branch, Fish and Wildlife Branch, and Health Units of the Department of Health; and municipal, municipalities throughout the Province. The laboratory procedures carried out included total coliform test, fæcal coliform test, tests for fæcal streptococcal group, standard plate count, and identification of algæ.

VIROLOGY SERVICES

Rubella

The epidemic of German measles (rubella) which began early in 1974 continued throughout 1975. This epidemic largely affected a population of unimmunized adolescents and adults. About 90 per cent of the 1975 laboratory-tested patients were 16 years of age or older, the reason for this being that the immunization program introduced in 1970 was directed primarily at pre-school and elementary-school children up to the age of 12 years.

Although an average of only 14 cases of rubella were laboratory proven per year in the nonepidemic period, in 1974 the number of such cases was 200, and in 1975, 588.

Among those whose blood is being tested, special emphasis is directed to pregnant women, newborn infants, and other contacts to proven cases.

Other Virus Diseases

The 200 other viruses indentified in 1975 included influenza A (70), herpes (45), measles (44), mumps (10), and at least 10 other viruses. The epidemic strain of influenza virus in British Columbia was type B in 1974 and type A Port Chalmers in 1975.

TROPICAL AND PARASITIC DISEASES REFERENCE SERVICE

The Tropical and Parasitic Diseases Reference Service, operated by the Provincial Laboratories, provided advice and consultation on preparation for travel to the tropics and on diagnosis and treatment of tropical and parasitic diseases acquired by returning travellers and immigrants to Canada. Of particular interest was the increased demand for examination of blood films for malarial parasites (from 36 in 1974 to 194 in 1975). Of the 96 patients investigated, 76 had malaria parasites in

the peripheral blood. At the same time the demand for examinations for intestinal parasites increased substantially from 15,750 in 1974 to 18,300 in 1975. For the treatment of tropical and parasitic diseases, exotic drugs, not available commercially in Canada, were supplied for the treatment of 42 patients with parasitic diseases such as malaria, trichuriasis, filiariasis, and schistosomiasis.

COMMUNITY HUMAN RESOURCES AND HEALTH CENTRES

The Community Human Resources and Health Centres is a project jointly supported and financed by the Department of Human Resources and the Department of Health. It has three main objectives—

- Community involvement.
- Integration of services.
- Emphasis on prevention.

A task force, called the Development Group for Community Human Resources and Health Centres, acts as a link between the two Government departments and the Community Human Resources and Health Centres. Composed of six professionals from different disciplines, their functions include management and consultation.

There are now five Community Human Resources and Health Centres, each with an elected Board of 10 to 15 members. For the most part the facilities are complete, having frequently involved only the renovation of existing structures.

The basic services being integrated by the centres include social services, public health nursing services, primary medical care, and mental health services. The Orders in Council were passed in December, setting up the Boards and transferring to them the statutory powers for social services, public health nursing services, and mental health services. There are just over 100 multidisciplinary staff in the five centres, with about one third of those to be seconded from their respective departments. Each centre, administered by a Board-hired co-ordinator, was beginning to develop multiservice teams.

In the 1975/76 fiscal year the total operating budget for the centres was $842,967, the Department of Health portion being $716,965.

- Houston Community Human Resources and Health Centre is located in a one industry community of 3,000, and now provides primary medical care, public health nursing, social services, and psychological services.
- Granisle Community Human Resources and Health Centre in this mining community of 2,400 now provides primary medical care, social services, part-time public health nursing, and is attempting to arrange for dental care.
- Boundary Community Human Resources and Health Centre (Grand Forks Area) services a poulation of 9,500 in a large geographic area of approximately 100 by 60 miles. The centre has one Board and administrator with three different locations, Rock Creek, Greenwood, and Grand Forks. Services include primary medical care (Rock Creek), social services, public health nursing, mental health services, and some probation services.
- James Bay Community Human Resources and Health Centre, serving a population of 10,000, the only urban centre in the project, is with a community school. The services offered by this centre include community medical care, social services, day care, family life program, drug program,

and volunteer services. The centre also acts as a base for probation services, public health nursing, and out-reach programs for manpower and mental health.

- Queen Charlotte Islands Community Human Resources and Health Centre services an isolated population of 4,600 in the four separate locations of Sandspit, Queen Charlotte City, Port Clements, and Masset. There is one regional Board and a common administration, and services include primary medical care, public health nursing, social services, dental care, physiotherapy, youth preventive programs, and senior citizen visiting. Plans are now under way to include the services of the United Church Hospital in Queen Charlotte City.

ACTION B.C.

In 1974 a nonprofit organization known as Action B.C. was set up under the *Societies Act* and funded by the Department of Health. The objective of the organization was "to promote positive health through increased physical activity and good nutrition." During 1975, Action B.C. concentrated its work in three major areas—schools, industry, and the community.

At the Pacific National Exhibition Fair and during the subsequent daily program for schools at the PNE, over 19,000 students were involved in an obstacle course and in Action B.C.'s children's step-test.

One-hour-a-day physical activity programs for each child were initiated by Action B.C. in two elementary schools in Prince George, and these will be expanded to many more schools in that city and elsewhere in 1976.

The two-year industrial activity program designed by Action B.C. for the Vancouver main office staff of Cominco was started in the fall of 1975 and has had a consistently high participation rate of over 70 per cent. Action B.C. is continuing to plan, motivate, and provide the leadership for similar programs for many other companies throughout the Province.

Community activities and events have provided Action B.C. with the opportunity to contact people in all walks of life and to bring to them an awareness of the potential for an enhanced quality of life. Through the use of the Canadian Home Fitness Test, developed by Recreation Canada, Action B.C. has tested and advised over 10,000 adults, more than any other province. The results of this simple step-test, designed as an indicator of cardiovascular fitness, has enabled Action B.C. to recognize the pressing need for life-style change which has been the main focus of our activity counselling sessions.

With the ever-growing interest shown by both professional and public in the area of preventive health, Action B.C. will continue to act as a catalyst and motivating force to help bring about the changes urgently required in our life-style.

COUNCIL OF PRACTICAL NURSES

The British Columbia Council of Practical Nurses, under the authority of the *Practical Nurses Act,* has completed 11 years of its mandate under this Act. The 10 members of the Council are appointed by Order of the Lieutenant-Governor in Council on the basis of nominations by

- the Minister of Health (two members);
- the College of Physicians and Surgeons of B.C. (one member);

- the Registered Nurses' Association of B.C. (two members);
- the Minister of Education (one member);
- the British Columbia Hospitals' Association (one member);
- the Licensed Practical Nurses Association of B.C. (three members).

During these 11 years, 76 general meetings of the Council were held, as well as a great many standing and special committee meetings. During Council meetings over the years, 12,248 applications for licensure were received; the disposition of these is given in Table 12. Consideration was given to graduates of B.C. College and Hospital Programs and to a large number of applicants from outside British Columbia and Canada.

Responsibility for the preparation, administration, and marking of all practical nurse testing was transferred to the Council by the Department of Education at the end of this year. To prepare for this function it was necessary to add a part-time clerk to the Council's staff.

The Council continues to work closely with the Department of Education through the Council member nominated by that Department, and this year with the British Columbia Medical Centre through a staff member of its Education Committee who attends meetings of the Council as an observer. This addition co-ordinates the licensing and new testing functions with the educational responsibilities of the BCMC.

VOLUNTARY HEALTH AGENCIES

During 1975 the Department of Health continued to give financial support to a wide range of voluntary health agencies. In general, these agencies cater to persons suffering from chronic debilitating conditions who have special needs beyond the scope of health services routinely available, and to certain disadvantaged socio-economic groups in the population. Over $2,000,000 in grants were awarded to these agencies for the 1975/76 fiscal year.

Table 1—Reported Communicable Diseases, British Columbia, 1971–75

(Rate per 100,000 population)

	1971		1972		1973		1974		1975	
	Number of Cases	Rate	Number of Cases	Rate	Number of Cases	Rate	Number of Cases	Rate	Number of Cases	Rate
Amœbiasis	1	0.2	1	0.1	.....	.....	2	0.1	1	0.1
Brucell	.....	.....	.....	.....	.....	.....	.....	.....	1	0.1
Diarrhœa of the newborn (*E. coli*)	64	2.9	60	2.7	29	1.3	52	2.2	49	2.0
Diphtheria	11	0.5	11	0.5	51	2.2	69	2.9	22	0.9
Dysentery, type unspecified	126	5.7	72	3.2	34	1.5	91	3.8	97	3.9
Food infection—										
Salmonellosis	548	24.9	415	18.5	320	1.39	302	12.6	456	18.6
Unspecified	8	0.4	73	3.2	36	1.6	7	0.3	33	1.3
Food intoxication—										
Staphylococcal	6	0.3	16	0.7	25	1.1	.....	.....	.....	.....
Botulism	.....	.....	5	0.2	.....	.....	2	0.1	.....	.....
Hepatitis—										
Infectious	1,954	89.0	1,894	84.3	1,755	75.8	1,381	57.7	962	39.2
Serum	(1)	(1)	26	1.2	25	1.1	11	0.5	10	0.4
Leprosy	1	0.1	.....	.....	1	0.1	.....	.....	1	0.1
Meningitis—										
Bacterial	17	0.8	34	1.5	47	2.0	43	1.8	33	1.3
Viral	45	2.0	22	1.0	20	0.9	12	0.5	16	0.7
Pertussis	91	4.2	102	4.5	102	4.4	66	2.8	49	2.0
Poliomyelitis	.....	.....	.....	.....	1	0.1	.....	.....	.....	.....
Q. fever	.....	.....	1	0.1	.....	.....	.....	.....	.....	.....
Rubella	1,168	53.2	84	3.7	77	3.3	342	14.3	476	19.4
Rubeola	200	9.1	97	4.3	158	6.8	573	23.9	1,149	46.8
Shigellosis	241	11.0	202	9.0	212	9.2	203	8.5	184	7.5
Streptococcol throat infection and scarlet fever	306	13.9	454	20.2	836	36.1	789	32.9	739	30.1
Trichinosis	.....	.....	.....	.....	1	0.1	.....	.....	.....	.....
Tularæmia	.....	.....	.....	.....	1	0.1	.....	.....	.....	.....
Typhoid and paratyphoid fever	5	0.2	13	0.6	3	0.1	6	0.3	8	0.3
Western equine encephalitis	.....	.....	7	0.3	.....	.....	.....	.....	.....	.....
Totals	4,792	218.2	3,587	159.7	3,734	161.3	3,951	165.0	4,286	174.4

1 Infectious and serum hepatitis combined.

Table 2—Reported Infectious Syphilis and Gonorrhœa, British Columbia, 1946, 1951, 1956, 1961, and 1966–75

Year	Infectious Syphilis		Gonorrhœa	
	Number	Rate[1]	Number	Rate[1]
1946	834	83.0	4,618	460.4
1951	36	3.1	3,336	286.4
1956	11	0.8	3,425	244.9
1961	64	3.9	3,670	225.3
1966	71	3.8	5,415	290.8
1967	72	3.7	4,706	242.0
1968	68	3.4	4,179	208.6
1969	45	2.2	4,780	232.0
1970	76	3.6	6,070	285.2
1971	73	3.4	7,116	325.7
1972	98	4.4	7,921	352.5
1973	101	4.4	8,955	386.6
1974	146	6.1	9,284	387.6
1975[2]	174	7.1	9,793	398.6

1 Rate per 100,000 population. 2 Preliminary.

Table 3—Selected Activities of Provincial Public Health Nurses, September 1974 to August 1975, Inclusive[1]

Expectant parents—	
Class attendance by mothers	31,757
Class attendance by fathers	17,222
Prenatal home visits	6,208
Postnatal home visits	15,226
Child health—	
Infants—	
Conference attendance	58,977
Nursing visits	55,954
Service by auxiliaries	1,646
Pre-school—	
Conference attendance	84,229
Nursing visits	26,901
Service by auxiliaries	12,769
Special assessments of infants and pre-schools	18,965
School—	
Screening test by public health nurse	206,545
Follow-up by public health nurse	28,974
Service by auxiliaries	95,760
Conferences with students	33,222
Conferences with staff	89,292
Home and office visits	36,724
Adult home and office visits (age 19–64)	111,018
Geriatric home and office visits (over 65)	121,694
Geriatric clinics	461
Family planning clinics	1,108
Family services—	
Total visits to homes	255,718
Professional services by telephone	284,219
Immunizations—	
Smallpox	92,751
Poliomyelitis	159,408
Basic series of diphtheria, pertussis, and tetanus	161,376
Rubella	26,224
Rubeola	20,082
Other (mostly reinforcing doses)	40,105
Total doses	499,946
Tests—tuberculin, diphtheria, and other	29,155

[1] Services provided by public health nurses under the jurisdiction of the Health Department, Public Health Programs, and do not include services provided by Greater Vancouver, New Westminster City, or the Capital Regional Health Services.

Table 4—Selected Activities of Provincial Public Health Inspectors, 1972–75, Inclusive

Type of Inspection or Activity	1972	1973	1974	1975 (Estimate)
Inspection—				
Food premises—				
Eating and drinking places	5,022	9,668	10,051	11,435
Food stores	1,622	1,962	2,558	2,288
Other	775	1,064	1,512	2,066
Factories	337	437	561	415
Industrial camps	260	280	305	354
Community care[1]	1,703	2,442	3,139	2,804
Schools	498	546	1,013	497
Summer camps	212	274	300	338
Housing	1,741	1,603	1,672	1,710
Mobile-home parks	1,566	1,946	2,199	2,195
Camp-sites	1,718	1,567	1,344	1,531
Other housing	454	418	600	770
Hairdressing places	384	365	370	420
Farms	345	387	400	395
Parks and beaches	366	318	352	470
Water and waste investigation—				
Swimming-pools—				
Inspection	1,298	1,801	2,094	3,106
Samples (pools and beaches)	1,343	1,516	1,153	2,006
Surveys (sanitary and other)	449	518	430	447
Waste disposal	797	917	890	798
Public water supplies—				
Inspection	1,305	1,516	1,496	1,982
Samples	4,975	5,716	5,370	6,778
Private water supplies—				
Inspection	2,042	2,431	2,665	2,940
Samples	2,551	2,692	3,717	3,362
Pollution and survey samples	1,003	1,543	563	829
Private sewage disposal	17,554	22,585	26,251	24,117
Municipal outfalls and plants	438	528	480	415
Plumbing	399	772	686	814
Land use investigation—				
Subdivisions	6,307	5,395	6,140	5,398
Site inspections	10,685	11,719	14,786	14,819
Nuisance investigation—				
Sewage	3,376	3,440	3,361	3,604
Garbage and refuse	1,963	1,870	2,107	1,964
Other (pests, etc.)	2,524	2,740	2,776	2,898
Disease investigation	338	314	541	875
Meetings	3,109	3,225	3,330	2,258
Educational activities	1,234	1,535	1,479	1,415

[1] Includes boarding-homes, youth hostels, day-care centres, hospitals, and other institutions.

Table 5—Number and per Cent of Children Immunized Prior to Entry to Kindergarten (as at September 1974)

	Greater Vancouver		Capital Region		Remainder of Province[1]		Total	
Total children in kindergarten	9,270		2,569		21,194		33,033	
Type of Immunization	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Smallpox	5,023	54.2	2,046	80.0	11,143	52.6	18,212	55.1
Diphtheria, pertussis, and tetanus	6,372	68.7	1,883	73.0	14,579	68.8	22,834	69.1
Poliomyelitis	5,959	64.3	1,819	72.0	14,189	67.0	21,967	66.5
Rubeola (measles)	5,262	56.8	1,718	67.0	13,387	63.2	20,367	61.7

[1] Figures for New Westminster and Coquitlam (School Districts Nos. 40 and 43) not available.

Table 6—Number and per Cent of Grade V Pupils Immunized as at June 1975

	Greater Vancouver		Capital Region		Remainder of Province		Total	
Total pupils in Grade V	11,223		3,705		29,975		44,903	
Type of Immunization	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Smallpox	7,311	65.1	2,762	75.0	21,902	73.1	31,975	71.2
Diphtheria and tetanus	9,468	84.4	3,284	88.0	26,068	87.0	38,820	86.5
Poliomyelitis	9,405	83.8	3,293	88.0	25,528	85.2	38,226	85.1
Rubeola (measles)	7,687	68.5	1,737	47.0	13,732	45.8	23,156	51.6

Table 7—Number and per Cent of Grade V Girls Immunized for Rubella as at June 1975

	Greater Vancouver	Capital Region	Remainder of Province	Total
Total girls in Grade V	5,380	1,721	14,366	21,467
Immunized for rubella	4,766	1,486	11,757	18,009
Per cent immunized	88.6	86.3	81.8	83.9

Table 8—Pupils Referred for Health Services

Reason for Referral	Capital Region[1]		Area Served by Health Department[2]	
	Referred to Public Health Nurse	Referred by Public Health Nurse for Further Care	Referred to Public Health Nurse	Referred by Public Health Nurse for Further Care
Vision	2,330	1,357	25,543	13,655
Hearing	1,402	444	10,727	3,086
Speech	188	136	1,805	.....
Emotional	716	332	5,233	2,221
Skin conditions	1,332	515	6,882	2,477
Other	2,409	843	18,498	5,488
Totals	8,377	3,627	68,688	27,932
Percentage of enrolment	17.7	7.7	18.2	7.4

[1] Total enrolment, 47,390. [2] Total enrolment, 376,440.

Table 9—Registrations, Certificates, and Other Documents Processed by Division of Vital Statistics, 1974 and 1975

	1974	1975 (Preliminary)
Registrations accepted under *Vital Statistics Act*—		
Birth registrations	35,393	35,570
Death registrations	19,847	18,860
Marriage registrations	21,673	21,570
Stillbirth registrations	317	410
Adoption orders	1,704	1,880
Divorce orders	6,328	7,250
Delayed registrations of birth	410	380
Registrations of wills notices accepted under *Wills Act*	34,570	37,300
Total registrations accepted	120,242	123,220
Legitimations of birth effected under *Vital Statistics Act*	249	180
Alterations of given name effected under *Vital Statistics Act*	282	250
Change of name under *Change of Name Act*	1,715	1,890
Documents issued by the Central Office—		
Birth certificates	78,194	79,340
Death certificates	9,085	8,970
Marriage certificates	8,220	8,600
Baptismal certificates	3	20
Change of name certificates	1,881	2,000
Divorce certificates	263	230
Photographic copies	10,143	10,800
Wills notice certifications	12,609	12,530
Total documents issued	120,398	122,490
Nonrevenue searches for Government departments by the Central Office	11,941	11,200
Total revenue earned	$488,599	$527,940

Table 10—Case Load of Division for Aid to Handicapped, 1975

Cases under assessment or receiving services, January 1, 1975		1,116
New cases—		
Referred to Aid to Handicapped Committees in Vancouver Metropolitan Region and North Fraser Region (11 committees)	589	
Referred to Aid to Handicapped Committees outside Vancouver Metropolitan Region (36 committees)	713	
Referred from other sources	34	
Total new cases		1,336
Cases reopened (all regions)		328
Total cases provided with service in 1975		2,780

Cases Closed During 1975

Rehabilitated—			
Employment placement made by—			
Canada Manpower	69		
Aid to Handicapped	20		
Self	205		
Other	144		
Total placed in employment		438	
Job placements not feasible, restorative services completed		232	
Not rehabilitated—			
Severity of disability	219		
Unable to locate clients	128		
Other	418		
Total not rehabilitated		765	
Other reason—			
No disability	8		
No vocational handicap	11		
Deceased	21		
Total other reasons		40	
Total cases closed in 1975			1,475
Cases remaining in assessment or receiving services, December 31, 1975			1,305

Table 11—Tests Performed by Division of Public Health Laboratories, 1974 and 1975

Item	1974			1975		
	Main	Nelson	Victoria	Main	Nelson	Victoria
Bacteriology Service						
Enteric Section—						
Cultures—						
Salmonella/Shigella	14,431	340	4,746	14,391	261	4,653
Enteropathogenic *E. coli*	3,159	.....	1,102	3,500	.....	1,365
Food poisoning	219	.....	8	246	.....	31
Miscellaneous Section—						
Cultures—						
C. diphtheriæ	6,942	139	7,666	4,047	25	3,295
Hæmolytic Staph./Strep.	4,309	426	.....	4,393	184	1
Miscellaneous	17,440	253	54	25,636	273	13
Fungus	3,437	.....	.....	3,528	.....	.....
N. gonorrhœæ	15,709	.....	7,145	16,988	128	8,865
Smears—*N. gonorrhœæ*	105,353	2,396	955	101,798	2,692	1,713
Animal virulence	480	.....	20	308	.....	20
Tuberculosis Section—						
Cultures—*M. tuberculosis*	29,992	.....	2,219	31,807	.....	2,154
Smears—*M. tuberculosis*	22,157	6	2,185	24,588	4	1,768
Sensitivity tests	1,099	.....	.....	1,050	.....	.....
Atypical mycobacteria	295	.....	.....	313	.....	.....
Animal inoculation	568	.....	2	604	.....	3
Parasites—						
Fæces	15,749	.....	2,706	18,318	.....	3,004
Pinworm swabs	1,125	42	.....	1,156	61	.....
Water Microbiology Section—						
Presumptive/Confirmed coliform test	28,694	3,382	3,820	32,113	3,361	3,695
Completed coliform test	2,385	496	96	2,214	490	602
Fæcal coliform test	7,251	.....	609	7,959	.....	379
Fæcal streptococcal test	376	.....	.....	113	.....	.....
Standard plate count	2,819	.....	19	2,931	.....	.....
Other tests (algæ, shellfish)	4	.....	.....	2	.....	.....
Serology Section—						
Syphilis—						
Screening	181,292	2,126	17,349	182,225	.....	18,096
Confirmatory	9,285	.....	.....	12,739	.....	.....
ASTO	8,958	.....	908	8,196	.....	968
Widal, Brucella, Heterophile-antibody	5,315	189	693	4,971	.....	864
Immunofluorescence	1,973	.....	.....	3,784	.....	.....
Toxoplasmosis	248	.....	.....	306	.....	.....
Virology Service						
Virus isolation—						
Tissue culture	2,071	.....	.....	4,418	.....	.....
Rubella	140	.....	.....	660	.....	.....
Embryonated egg	210	.....	.....	619	.....	.....
Hæmadsorption	126	.....	.....	6	.....	.....
Serological identification—						
Hæmagglutination inhibition—						
Rubella	35,831	.....	.....	51,783	.....	.....
Other viruses	2,091	.....	.....	2,804	.....	.....
Complement fixation	4,406	.....	.....	7,198	.....	.....
Neutralization	2,124	.....	.....	521	.....	.....
Totals	538,083	9,795	52,251	578,233	7,479	51,489
Combined totals	600,129			637,201		

Table 12—Licensing of Practical Nurses

(Disposition of applications received since inception of program in 1965 to October 31, 1975)

Received				12,248
Approved—				
On the basis of formal training		7,421		
On the basis of experience only—				
Full licence	396			
Partial licence	876			
		1,272		
			8,693	
Rejected			1,765	
Deferred pending further training, etc.			1,421	
Deferred pending receipt of further information from applicants			297	
Awaiting assessment at October 31, 1975			72	
				12,248
Number of licences issued to October 31, 1975				7,921
Number of practical nurses holding currently valid licences at October 31, 1975				6,150

Table 13—Number of Cases Referred for Hearing Assessment, by Source, Division of Speech and Hearing, 1975

	Referral Source				Total
	Physician	PHN	Mental Health	Other	
Number of referrals	1,624	709	16	272	2,621

Table 14—Number of Cases Referred for Hearing Assessment, by Type of Evaluation, Division of Speech and Hearing, 1975

	Type of Evaluation					Total
	Initial Assessment	Re-assessment	Hearing-aid Evaluation	Rehabilitative Audiology	Other	
Number of cases	2,056	409	79	37	40	2,621

Table 15—Hearing Impaired Cases, by Degree and Type of Impairment, Division of Speech and Hearing, 1975

Type of Impairment	Degree of Impairment				Total of Each Type
	Mild	Moderate	Severe	Profound	
Conductive	426	152	24	0	602
Sensorineural	191	308	208	53	760
Mixed	21	57	41	8	127
Totals of each degree	638	517	273	61	1,489

MENTAL HEALTH PROGRAMS

Mental Health Programs

On October 12, 1872, just 14 months after British Columbia's entry into Confederation, Mental Health Programs had its beginnings when the Royal Hospital in Victoria was designated as the first Provincial Asylum. The management of the institution was placed under the jurisdiction of Mental Health Services in the Provincial Secretary's Department, where it remained until 1959, at which time it was transferred to the Department of Health and Welfare and became known as the Mental Health Branch.

With the change in name to Mental Health Programs in 1975, as part of the reorganization of the Department of Health, the branch transferred the operation of the various mental health institutions to the Division of Government Health Institutions, and became solely responsible for the development of mental health services at the community level.

A review of the year's operations of the various community services throughout the Province appears on the following pages:

COMMUNITY MENTAL HEALTH CENTRES

Mental health centres have been established in 30 British Columbia communities. The function of each centre is to develop, in co-operation with existing resources within the community, a variety of services designed to meet the specific mental health requirements of the area served.

Mental health centres are located in the following communities: Abbotsford, Burnaby, Chilliwack, Courtenay, Cranbrook, Duncan, Fort St. John, Kamloops, Kelowna, Langley, Maple Ridge, Nanaimo, Nelson, New Westminster, Penticton, Port Alberni, Port Coquitlam, Powell River, Prince George, Prince Rupert, Saanich, Sechelt, Squamish, Surrey, Terrace, Trail, Vernon, Victoria, Whalley, and Williams Lake.

A centre is staffed by a team of experts in mental health and may include a psychiatrist, a psychologist, psychiatric social workers, mental health nurses, and other professional personnel.

The majority of the centres provide the following services in varying proportions:

- Direct treatment services for adults and children.
- Consultative services to physicians, health, welfare, educational, and correctional agencies.
- Educational programs, both professional and nonprofessional.
- Special programs such as the supervision of the long-term patient, preventive programs, boarding-home care, special group homes, etc.

Members of a mental health centre may make periodic visits to outlying districts of the area served by the centre, primarily to provide diagnostic assessment, consultation, and referral services. This travelling clinic usually utilizes facilities provided by the local health units, and sees patients on an appointment basis who have been referred by the family doctor or the district public health or welfare services. When necessary, after seeing the patient, the clinic may refer the patient back to the family doctor, in some cases to school authorities, or on occasion may recommend admission to a residential treatment facility. Treatment by the clinic team is usually given in close co-operation with the family doctor, the health unit, or other agency.

Following rapid expansion of mental health centres throughout the Province over the past five years, 1975 was characterized by a reorganization of administrative support services to ensure a continued co-ordination of services and planning. In order to facilitate better liaison between the centres and Victoria headquarters, it was proposed to appoint a Director for each region. Pending final approval for appointing permanent directors, existing personnel were asked to assume this responsibility for specific regions.

Regional reports of the community mental health centres follow:

LOWER MAINLAND REGION

The Lower Mainland Region is comprised of mental health centres located in Sechelt, Squamish, New Westminster, Whalley, Surrey, Langley, Port Coquitlam, Maple Ridge, Abbotsford, and Chilliwack. During the year, these centres treated over 2,800 patients. Direct services to patients accounted for nearly two thirds of the time of the mental health teams. In addition to these direct services,

the centres provided consultation to various community agencies dealing with emotionally disturbed clients. Staff were increased through the introduction of 12 community psychiatric nurses who provided home care for the adult patient who might otherwise require admittance to hospital. These nurses were placed on teams which were responsible for an admission and treatment program for the seriously disturbed adult, utilizing the facilities of Riverview Hospital. This program was in effect in New Westminster, Whalley, Surrey, Port Coquitlam, Maple Ridge, and Langley. Psychiatric services were available in all team locations except Squamish and Chilliwack. In both direct services and in consultation, centre staff worked closely with local physicians, community public health programs, Department of Human Resources, the schools, the local hospital, Probation, the Courts, and many other local groups.

Examples of the types of special projects in which the regional centres became involved during the year, follow:

In *Abbotsford,* under the joint sponsorship of the mental health centre and Fraser Valley College, a variety of workshops, seminars, and study sessions, called the Adult Development Program, was developed. The program offered an ongoing opportunity for clients referred to the centre, as well as the public at large, to participate in a learning experience at the centre. The popularity and benefit of this approach was soon felt by the greatly increased numbers of people participating, who would not likely attend the mental health centre for traditional therapy.

The *Langley* team co-operated with the weekly drop-in program at a local church, for a group of elderly persons from several boarding-homes. At the centre itself, a weekly drop-in was held for former Riverview Hospital patients.

In *Maple Ridge* a training course was designed for volunteers in the crisis centre, to become lay family counsellors. Emphasis was placed on training interested community groups to offer counselling for family problems, or acute emotional crisis situations, in their early stages.

A professional staff member in *Sechelt* was actively involved in an interagency group, which was developing a youth treatment home to serve eight youths between the ages of 6 and 15.

A summer play therapy program was sponsored by the *Squamish* Centre as a means of dealing with its large case load of children. Three university students were assigned to act as group therapists, assisted by high school students. The program brought about marked improvements in the social behaviour of the children.

The *Surrey* Centre was asked to provide field work experience for students from the School of Social Work at UBC, Royal Columbian Hospital, B.C. Institute of Technology, Vancouver City College (Langara Campus), Douglas College (Surrey Campus), and Western Washington State University at Bellingham.

The *Whalley* team was instrumental, with others in the community, in the establishment of a co-ordinated drug and alcohol project. Funds were received from the Alcohol and Drug Commission for a community development worker and counsellor.

OKANAGAN THOMPSON KOOTENAY REGIONS

The Okanagan Thompson Kootenay Regions are served by mental health centres situated in Kamloops, Vernon, Kelowna, Penticton, Nelson, Cranbrook, and Trail. Satellite operations were maintained through these centres by way of travelling clinics to Merritt, Ashcroft, Revelstoke, Keremeos, Salmon Arm, Cawston, Osoyoos, Hedley, Golden, Fernie, Sparwood, Kimberley, Creston, Castlegar, Salmo, Nakusp, New Denver, Riondel, Grand Forks, and Rossland.

During the year, 2,576 patients received treatment under mental health centre auspices throughout these regions, a slight increase over the 2,564 seen the previous year. In all, direct services, i.e., direct patient contact, accounted for roughly 60 per cent of the total time of the professional staff within these regions, the balance being devoted to indirect services, namely, the development of supportive mental health related services, community education, and agency consultation, etc. Although the individual centres varied widely in terms of patient groupings served, the over-all picture indicated that services to the moderately disturbed adult and child were in heaviest demand.

By the year-end most of the centres were operating with full complements of staff. In terms of personnel availability, Kamloops, Vernon, Cranbrook, and Trail suffered from a lack of necessary psychiatric input to meet service demands. Recruitment of psychiatrists appeared to be a longstanding problem in certain parts of these regions.

The following represent some of the special projects in which individual centres became involved throughout the year:

In *Kamloops,* drop-in centres for both boarding-home operators and long-term patients were initiated. The Clinical Classroom program for seriously disturbed children was continued. A summer camp program was developed for 42 long-term residential patients, and an employment program for a select group of residential psychiatric patients was instituted.

An independent-living home was initiated by Boarding-home Program staff of the *Vernon* Centre for a select group of residential psychiatric patients. Summer students conducted socialization groups for children lacking in social skills, activity therapy programs for boarding-home residents, and participated in a research program involving children with special problems.

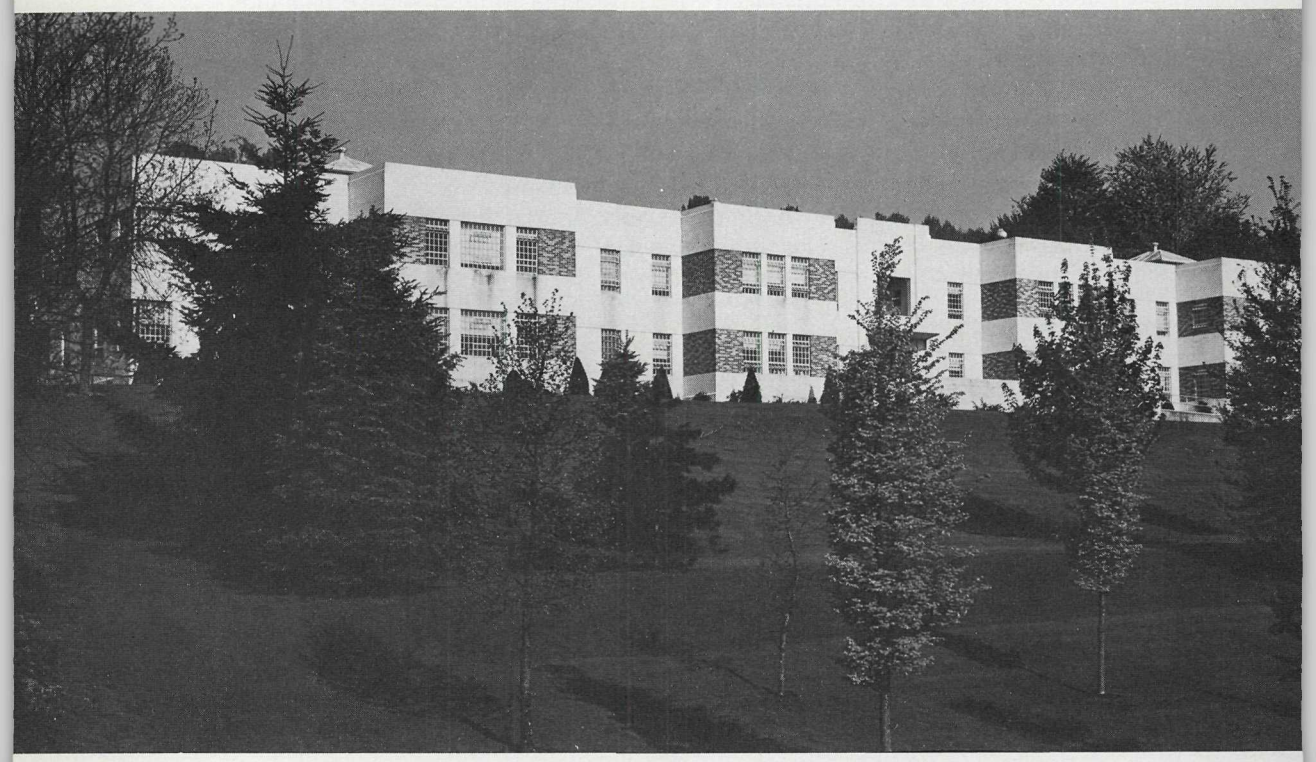
In *Kelowna,* the Boarding-home Social Worker initiated a highly successful activity program for residential psychiatric patients over the summer months. Consultation services were extended to the newly opened Kelowna Women's Centre, Child Care Centre, and the Street Worker Program. Adult Education programs were developed in response to requests from the Kelowna Homemakers' Association and the Home Care Nursing Program. One of the centre's psychiatrists was appointed to the B.C. Forensic Commission; and consultative services were extended to the Community Court System and the RCMP.

The *Penticton* Centre involved summer students in a follow-up study on Human Services available to the Penticton area. This updated the comprehensive "Penticton Profile" of 1970. Summer students also offered recreational activity and support to residential psychiatric patients and senior citizens in the Summerland area. A work experience program for the retarded was initiated and supervised, and disadvantaged youth in the Keremeos-Cawston area were served by a summer recreational program. Consultation by centre staff continued to be provided to the South Okanagan Human Resources Society, Aid to the Handicapped, Penticton Alternate School, Youth Guidance Councils, Homemaker Services, Street Workers, among others in the Penticton area.

Summer students were involved in six community-based projects in *Nelson.* Mental health centre staff worked actively with the Justice Development Commission with a view to initiating an in-depth drug dependency survey, and later, the establishment of an alcohol and drug preventive and treatment program for the Kootenays. Training facilities were provided for student nurses and health service workers (Welfare Aides). Parent Effectiveness Training courses were extended to a large number within the community. Centre personnel continued to

provide consultation to a variety of community services, including the Nelson Community Services Centre, Youth Activities Society, and the Kootenay Society for the Handicapped.

Child-rearing workshops were conducted for the general public by the *Cranbrook* Mental Health Centre in conjunction with a local parents' organization. The centre's psychologist was involved as board member and volunteer trainee for the newly formed Mental Health Society Drop-in Centre. Centre staff were instrumental in helping to organize and train community lay counselling groups in Kimberley and Golden. Weekly educational functions were conducted for a Grandmother Surrogate group. The East and West Kootenay Boarding-home Social Workers conducted regular boarding-home operation workshops.



Group programs for women discharged from mental health facilities were initiated by the *Trail* Mental Health Centre. Summer students provided 30 children with important social and recreational activities. In co-operation with the CMHA, an LIP program was instigated employing child care workers to work with seriously disturbed children. Consultation services by centre staff were extended to public health nurses, teachers, family court workers, college and high school counsellors, social assistance workers, and professionals in other communities. Advisory functions continue to be extended to the CMHA, Kootenay Alcoholism Society, Association for Community Planning, Selkirk Social Service Aide and Nursing programs, Big Brothers, and many other community organizations. Boarding-home Program staff were involved in the development of a semi-independent apartment facility in Castlegar. Three research projects were conducted throughout the summer months—a community mental health attitude survey, a study of the Trail Alternate School program, and a survey of client evaluations of centre services.

Throughout the Okanagan Thompson Kootenay Regions, population growth was extensive. Accompanying this dramatic growth was a corresponding increase in service demands on the mental health delivery system.

With staffing complements originally designed to serve less than half the current population, many of the mental health centres were no longer in a position to keep pace with community demands. To continue to provide a high standard of care through the mental health centres, it will be necessary both to relate future staffing requirements more closely to the escalating population figures, and to define more precisely the program priorities.

NORTHERN BRITISH COLUMBIA REGION

Community Mental Health Programs in Northern British Columbia are provided by staff from the Fort St. John, Prince George, Williams Lake, Prince Rupert, and Terrace Mental Health Centres. All centres operate as much as possible on an open-door policy in which an attempt is made to accommodate requests for mental health related services. Due to limitations on facilities and staff, the demands for service on the existing centres were very heavy. Fortunately, a number of other agencies also provide related services, or different aspects of the same service, and a close liaison existed with these agencies. In addition, active support by other community groups and local government was often provided. Community volunteers played an increasingly active role in assisting mental health centre staff. Staffing in northern parts of the Province continued to pose somewhat of a problem, in that vacancies in some locations were difficult to fill. It was the general policy to provide periodic services by staff members from either the nearest mental health centre or from facilities on the Lower Mainland, in those areas in which it was not possible to locate a full-time local mental health centre. Efforts were being made to obtain a documentation of the various mental health related needs in the communities throughout the northern region, in order to facilitate future planning.

Services which were provided by the individual mental health centres reflected the differences in mental health needs in the respective communities. In *Fort St. John,* special programs involved persons with personal crises, those who had acute problems in interpersonal relationships, and those who had been hospitalized for mental health related problems. Special programs were also provided for children, native Indians, and in the area of forensic care.

The *Prince George* Mental Health Centre emphasized individual, group, marital, and family programs. A liaison was being developed with the newly established psychiatric ward at the Prince George Regional Hospital, with emphasis on both in-patient involvement and out-patient follow-up. High priority programs by the *Williams Lake* area staff included communication between parent and child, adults and children with special mental health problems, and a variety of programs for various community groups. In *Terrace,* many program activities were shared with other community resources such as Human Resources, Public Health, Probation Services, Education, Justice Council, volunteers, law enforcement, ministers, crisis workers, and service clubs interested in mental health activities. Other priority programs included services for adults and follow-up and support services. In *Prince Rupert,* mental health programs of special interest included services for individuals, couples, families, and liaison with other agencies, especially Human Resources, Education, Probation, and Public Health.

VANCOUVER ISLAND REGION

On Vancouver Island, and the adjacent Powell River area, mental health centres are located in Victoria, Saanich, Duncan, Nanaimo, Port Alberni, Courtenay, and Powell River. These teams admitted over 2,300 patients to service in 1975. Direct services to patients accounted for nearly two thirds of the time of these teams. In addition to direct services, centre staff provided consultative services to a number of community agencies dealing with emotionally disturbed clients. Five community psychiatric nurses were added to the regional staff. These included three nurses placed in the Victoria and Saanich centres to assist patients released from the Eric Martin Institute of Psychiatry, and one each added to the Nanaimo and Port Alberni centres. In this region, local psychiatric services were available and many of the areas were virtually self-contained for the treatment of the seriously disturbed adult. In direct service and in consultation, the teams worked closely with local physicians, community public health programs, Department of Human Resources, the schools, the local hospital, Probation, the courts, and numerous other local groups.

With major assistance from the *Courtenay* Mental Health Centre, the Comox Valley Mental Health Society opened a halfway house in Courtenay during the year, serving patients released from the hospital's psychiatric unit, and accepting people directly from the community who needed a period of supportive care.

The psychiatrist and psychologist of the *Duncan* team provided daily consultation and support to the psychiatric unit at the Cowichan District Hospital. A great deal of effort went into the establishment of the unit, which was providing a viable service at the year-end.

During the year the *Nanaimo* mental health team, in co-operation with the Canadian Mental Health Association, expanded the functions of the Nanaimo Contact Program to include a drop-in clinic for parents of young children; an activity centre for psychiatric patients; and a co-operative venture in day-care programming for patients of the Nanaimo Regional Hospital.

The *Port Alberni* Centre provided a program of group therapy for approximately 50 patients. In addition, the centre had an extensive volunteer program, both to assist with therapeutic groups and individual services, with nearly 50 persons in volunteer training. Space for these programs was provided in the centre, in four community churches, and in the local school.

Powell River staff gave a great deal of assistance to the community resources society, in the establishment of an office and the selection and hiring of a full-time co-ordinator. This group helped to develop a family life association to train a core group of counsellors.

The *Saanich* Centre assisted in the development of the Saanich Peninsula Guidance Association, the Citizens Counselling Centre, and Cornerstone (an activity centre for severely emotionally handicapped people).

In *Victoria,* the addition of two community psychiatric nurses to the centre enabled them to develop a closer working relationship with the Eric Martin Institute of Psychiatry and with physicians in the community. More service was being given to clients in their own homes. A further development was the integration of some of the out-patient services offered by the Eric Martin Institute and the centre.

THE GREATER VANCOUVER MENTAL HEALTH SERVICE

The basic mandate of the Greater Vancouver Mental Health Service, which was to provide treatment and offer an alternative to hospitalization for the seriously emotionally disturbed adult, essentially remained unchanged in 1975. The addition of Family and Children's Workers to some of the community care teams meant that services could be provided to patients' families and children.

By the end of 1975 the Greater Vancouver Mental Health Service consisted of six community care teams operating in the West End, Strathcona, Mount Pleasant-Fairview, Richmond, Kitsilano, and the West Side. Additionally, two teams were in operation in Burnaby, administered by the Central Office but under the operational control of the Burnaby Mental Health Centre. During the year the Riverview Out-patient Department was transferred to the GVMHS. It was renamed the Broadway Clinic and has enabled the Service to develop an integrated net of community mental health facilities in Greater Vancouver. Venture and Vista were also transferred to this administration on April 1. Acquiring Venture provided the GVMHS with 16 beds for short-term crisis patients. Vista continued in its former role as a rehabilitative residence for female psychiatric patients.

In comparison to 1974, the number of patients in treatment increased dramatically. In October 1974 the GVMHS patient load was 949; at the same date in 1975 there were 2,116* patients being treated by the teams.

The Evaluation and Planning Division carried out a number of *ad hoc* studies during the year, which greatly assisted the Central Office in planning the development of future services. For example, the Division carried out a study of the on-call system, and came up with recommendations which resulted in a more effective and economical service. A manual was compiled for the use of senior personnel, which included the pertinent demographic data and social indicators for each service area of the city.

The field work emanating from the students' summer research project was completed, and at the year-end the results were in the process of being written up. Studies were being completed in the following areas:

- Patient satisfaction.
- Referral sources.
- Housing and nutrition.
- Recidivism.
- Crossroads (Richmond).
- Riverview Hospital admissions.

Priority was being given to developing a management information system for the Service. It was imperative that operating data be available to both the Central Office and the teams, for evaluation and planning purposes.

During the year, collective agreements were jointly negotiated with the Registered Nurses' Association of B.C. and the Registered Psychiatric Nurses' Association of B.C., which were tailored to the needs of the Service, rather than simply conforming to the contracts negotiated by the Public Service Commission. For nonunionized employees, the Service followed the master agreement negotiated between the Public Service Commission and the B.C. Government Employees' Union.

* Excludes two Burnaby teams.

An employee evaluation system was in the process of being introduced throughout the Service, and the form and procedures which were to be used were being developed by a task force composed of team members.

The Community Care Team Audit Committee, chaired by Dr. J. Miles of the UBC Health Sciences Hospital, met regularly throughout the year. The committee rotated its meetings throughout each team. Patient records were reviewed and appropriate comments made in writing to the Team Co-ordinator. During the last year, three suicides were investigated.

A task force report was completed during the year, and a final position statement regarding clinical policies was to be issued to the teams in the immediate future. The task force did an excellent job of ensuring that sound clinical practices were emphasized, and yet a degree of flexibility was preserved, based on the uniqueness of the community care team concept.

Citizen participation in the Service continued to be disappointing. Several key citizens played a vital role in the Board of Management, and in keeping several of the Citizens' Advisory Committees intact and functioning well. Generally speaking, however, it was difficult for the majority of the teams to develop and maintain a viable citizens' component. The Citizens' Council, which was the overall representative body of the Citizens' Advisory Committees, was developing a frame of reference for both itself and the local committees. The council was also developing ways of stimulating citizen interest in each service area.

The GVMHS continued to develop a close liaison with the local hospitals, and there was an arrangement between the West Side Team, the Health Sciences Hospital, and Vancouver General Emergency to screen and admit any patient requiring hospitalization to the Health Sciences Hospital from the West Side service area.

A similar arrangement was negotiated between the Broadway Clinic and Shaughnessy Hospital for the east area of the city. In effect, this meant that patients residing in this area, if requiring hospitalization, would be referred to local hospitals rather than the Crease Unit of Riverview Hospital.

It was hoped that a similar understanding could be arrived at with the West End Team, Strathcona Team, and St. Paul's Hospital. As local hospital beds became available, it was anticipated that all but the patient who was unmanageable in a local hospital could be cared for within the city.

THE BURNABY MENTAL HEALTH PLAN

The Burnaby Mental Health Plan, commonly referred to as Burnaby Psychiatric Services, continued to provide the Province's only integrated and comprehensive urban program of psychiatric resources for adults and children.

In-patient Service—There was greatly increased utilization of the 25-bed acute psychiatric in-patient unit in 1975, and by the beginning of November the unit was operating at full capacity. The unit provided Burnaby residents with effective in-patient treatment and worked very closely with the community care teams to ensure optimum care.

Adult Day Programs—A major development in the Adult Day Program area occurred during the year with the opening in October of a second Adult Day Program in newly renovated space. This program was developed in close cooperation with the existing Day Program (which continued in essentially the same format), the In-patient Unit, and the community care teams. It was designed to

provide a more gradual, longer-term, social and occupational rehabilitation program for the severely disabled individual who was unable to tolerate the more demanding atmosphere of the original program, yet who required more than just out-patient interviews.

Adult Out-patient Services—The three community out-patient psychiatric teams worked hard to deal with larger and more severely disturbed case loads. Additional approaches introduced during the year included assertiveness training groups, a number of activity groups for the severely handicapped, development of new, specialized boarding-homes in co-operation with the Boarding-home Social Worker, and a wealth of co-operative contacts with new community resources.

Children's Out-patient Services—The Children's Out-patient Department continued to provide consultation services to Burnaby schools, and out-patient assessment and treatment services for children and families, although the demand consistently exceeded the capacity of the staff. The Children's Day Program received much needed furnishings and equipment, and was also operating to capacity.

Consultation and Educational Services—The previous extensive range of consultation and education services to the community was complemented during the year with the addition of a nursing consultation service to Burnaby General Hospital, psychological consultation services to the Burnaby General Hospital Extended-care Unit, and to the Dogwood Lodge intermediate care facility, as well as a number of staff presentations to other organizations by request. Student placements for nurses, psychologists, social workers, and occupational therapists were increased by the addition of medical interns from the Royal Columbian Hospital who received their required psychiatric training in the facility. Each area of the program held one or more workshops during the past year to examine and develop their own programs. A number of staff attended various meetings or workshops offered by local professional and educational groups, or visited other Lower Mainland Psychiatric Services.

THE BRITISH COLUMBIA YOUTH DEVELOPMENT CENTRE

The British Columbia Youth Development Centre, referred to as The Maples, is located in Burnaby, and provides a variety of services, all of which are part of the comprehensive consultation and treatment program dealing with psychological, social, and learning problems in children and adolescents under the age of 17 years. After an initial screening, each child is interviewed and assessed at the centre. It is here that the treatment program for each individual is developed. In most cases, the family of the disturbed child will participate in the assessment, treatment, and educational process. The program that is offered may include out-patient attendance, a day program, or living-in accommodation.

These services are provided by two units, each with its own professional staff and Director—the Psychological Education Clinic, providing special services for children with learning problems; and the Residential Unit, which provides living-in accommodation for 45 boys and girls in separate residences.

The staff of The Maples is comprised of professional workers, including psychiatrists, psychologists, child care counsellors, teachers, nurses, and others who are trained in the mental health field.

A report of the two units follows:

RESIDENTIAL TREATMENT UNIT

During the year the treatment philosophy of the Residential Unit had to be adjusted and co-ordinated to meet the needs of the patient clientele, because the focus of treatment became concentrated on the more severely emotionally disturbed adolescent, as opposed to the more delinquent type.

Staff reorganization provided for psychiatric, social work, and senior supervisory child care counsellors, to be placed in each of the three cottages, the day centre, and the intake and assessment team. This staffing pattern allowed each treatment area certain flexibility and autonomy as regards treatment, and ensured that supervision and job training for line staff could be concentrated and intensive. By the year-end the unit had an almost full staff and was operating all programs.

Weekly training programs reviewed and discussed all aspects of child care, personality growth and development, diagnosis, treatment methods, first aid, and other aspects pertaining to the care and treatment of disturbed adolescents.

The training programs also accepted field placements from various students attending university classes. For example, social work students, nurses, art and crafts, and recreational personnel and child care counsellors from the University of Victoria and Douglas College spent from one week to one year working clinically within the Residential Unit, gaining practical experience. During the year the unit also had a psychiatric resident from the University of British Columbia completing a child psychiatry residency.

In the year under review, staff concentrated on treating the more seriously disturbed adolescent, and his or her family. Once assessed, the child was either recommended for referral back to the community, for residential treatment, or the Day Centre program. When admitted, the child became involved in cottage life with peers and staff, which included child care counsellors, social workers, and psychiatrists. Emphasis was placed on helping the child resolve the difficulties which necessitated admission; on promoting self-growth and individual responsibility; on enhancing learning and other skills by attending school, activities, vocational and craft classes; and on socialization by slowly reintroducing him back into the community.

As for the future, thought could be given to extending the services to include a closed facility where the children with more difficult management problems could receive treatment. Provision could also be made for the development of an adequately staffed out-patient and aftercare service, so that all aspects of the child's difficulties could be treated from start to finish in one place, specifically designed, with trained professional staff. With heavy emphasis already placed on training, such a comprehensive adolescent service would add immeasurably to the needs of the community. It would also afford other agencies opportunities for additional training of their present and prospective staff.

The experience of the past 18 months at the Residential Unit was important, not only in terms of treating disturbed adolescents and the training of staff, but it also afforded people with varied professional backgrounds the opportunity to learn from each other, and to co-ordinate their treatment ideas and philosophies.

What also became apparent was the significant role played by the child care counsellor in the over-all care and treatment of the adolescent and his family. Such recognition should be expanded so that training for child care counsellors could become standardized, and professional status achieved.

THE PSYCHOLOGICAL EDUCATION CLINIC

The Psychological Education Clinic offered programs in two major areas which could be described broadly as prevention and treatment. The preventive program is for those children in the public schools whose behaviour and learning disabilities made further work with the child by the school impossible. Schools have a variety of back-up services available to them, and the usual course was for assistance to come from that source. However, there are some situations when a solution is not possible and a referral to remove the child is made either directly to The Maples, or to the local mental health centre. At that time, the clinic's involvement becomes one of working out a program that will allow the child to remain within the school. At times the consulting was on behavioural contacting or providing a neuro-psychological and learning disability assessment. Consultation is also provided to individual children, or to the classroom teacher, in an effort to maintain these children in their schools.

The preventive program took place in many geographical areas throughout the Province through a travelling clinic. The clinic also set up workshops for a variety of community groups, primarily in the area of behaviour modification, and offered courses on parenting and child management.

The other dimension to the clinic was The Maples School, which had six classrooms and a staff of teachers and psychologists who worked together to assist the children and their families. The ages of the children ranged from 6 to 13, with their problems being a combination of learning difficulties and emotional disturbance. The average length of stay was one year, ranging from six months to over two years. There was a follow-up of the children for one year after they left. The children and staff attend camps of one week's duration each year.

During the year the clinic became more involved with training programs, and three teachers were placed in the school for a one-year period, after which time they would return to their school district better prepared to provide a service for the disturbed child. The clinic provided a one-month training program for four teachers, and provided them with both didactic and experiential sessions. The clinic also offered a practicum for graduate students in clinical and developmental psychology.

THE BOARDING HOME PROGRAM

Mental Health Programs has developed a Boarding Home Program which provides supervised personal care and attention to meet four very important needs within the community. First, it is for those individuals who require some care but for whom admission to one of the mental health facilities is not considered to be necessary. The program is also available for the long-term patient who is discharged from hospital but continues to require minimal care and who has nowhere else to go. Thirdly, the Boarding Home Program can be utilized as a means of temporary assistance for relatives who are caring for a mentally disordered individual in their home, and who need a respite from the stress endured in such situations. And finally, its services may be used by discharged patients who need a place in which to live while taking rehabilitation training.

A review of the program's activities for 1975 follows:

For the Boarding Home Program, 1975 was essentially a year of consolidation and planning for the future. The placement program proceeded at the same rate as in other years, with 641 placements made into some 296 boarding-homes. At the end of the year there were approximately 1,914 persons in boarding-homes under supervision of Mental Health Programs.

During the year, 210 residents were discharged from the program to more independent forms of living arrangements, such as returning to their family, partial or full employment, or co-operative group-living arrangements. Approximately 134 residents were returned to institutional or psychiatric facilities in general hospitals for further treatment.

Improvement was achieved in such areas as individual rehabilitation, the development of a few independent group-living resources, and an excellent summer activity program.

Summer students were employed as activity assistants through the Province, and the program continued to offer field placements for students from Welfare Aide training programs. Two summer students completed a survey of Mental Health boarding-home residents in relation to their capabilities for employment. Action was pending on this project, which had the long-range goal of the establishment of an industry in British Columbia designed to employ marginally employable persons with a variety of abilities.

A well-organized and innovative summer activity program was carried out jointly by the Boarding Home Program staff of several communities in the Lower Mainland, as an alternative to a camping program. The boarding-home operators of the East Kootenays took their residents, together with other retarded persons living in the community, on a three-week camping tour of British Columbia. In other areas of the Province, short camping programs were arranged for boarding-home residents. Staff considered this activity one of the most therapeutically productive available to them.

A highlight of the year was the opening of two unsupervised group-living homes, and one apartment, for ex-residents of boarding-homes. The residents who moved to these facilities were managing all aspects of their household operation. In addition to the development of feelings of pride and self-worth they achieved, it also represented a considerable saving in public funds allocated to the care of the handicapped person. The development of these resources in the initial stages was facilitated by interest and grants of money from several voluntary service organizations in the community, such as the Canadian Mental Health Association, the Association for the Mentally Retarded, Kinsmen, and the Canadian Legion.

Except in a few specific areas, year-end indications were that the Mental Health Boarding Home Program had peaked in its need for the personal care level of beds. Development of the intermediate level of program became the priority, together with further development of the independent group-living resource for clients who no longer required supervised boarding-home care.

The approximate distribution of placements made and the case load of the Boarding Home Program in 1975 were as follows:

	Placements Made, 1975	Case Load, December 31, 1975
Region 1 (Kootenays)	27	111
Region 2 (Okanagan-Thompson)	204	618
Region 3 (Fraser Valley)	202	792
Region 4 (Skeena)	27	21
Region 5 (Greater Vancouver)[1]	23	70
Region 6 (Cariboo-Peace River)	6	21
Region 7 (Georgia Strait)	93	175
Region 8 (South Vancouver Island)	59	106
Totals	641	1,914

[1] Burnaby and North Vancouver were the only municipalities of the Greater Vancouver area where placements were made through the Mental Health Boarding Home Program.

CONSULTANTS

The senior administrative offices of Mental Health Programs are located in Victoria, and the staff consists primarily of consultants in the various mental health disciplines. Their varied responsibilities include the provision of consulting services to the field staffs; conducting studies regarding the Province's needs in terms of facilities, programs, and treatment services; maintaining liaison with other governmental, community, and nonprofit agencies; co-ordinating the recruitment of professional personnel; the provision of continuing educational seminars and workshops; and involvement in research projects.

A brief report of the work undertaken by each of the disciplines during the year follows:

ADULT PSYCHIATRIC SERVICES

The organizational changes in the Health Department in 1975 did not significantly alter the work requiring the attention of the Co-ordinator of Adult Psychiatric Services. The need for psychiatric consultation at senior levels was so great that the activities of the Co-ordinator tended to be controlled by the demands of emergency situations and temporary priorities.

The Co-ordinator continued to be involved in the work of the Board of the Community Care Services Society, the governing body of the Riverview Hospital, and served on the Graduate Training Program Committee in Psychiatry at the University of British Columbia.

He provided an assessment of medical applicants for the Public Service Commission, and maintained a close liaison with the Registrar of the College of Physicians and Surgeons.

During the year the institutions were fully staffed with physicians and psychiatrists, with the exception of Riverview Hospital which had many psychiatric vacancies. Recruitment to the Public Service was slow, and only a few private psychiatrists were persuaded to locate in unserviced areas of the Province.

With the Co-ordinator's assignment to Mental Health Programs, there was a tendency for activities to be focused more narrowly upon those aspects of community psychiatry which fall within the specific frame of reference of the mental health centres. Contact with the institutions, psychiatric wards of general hospitals, and other groups dealing with mental health was substantially reduced.

The bulk of the work load involved a considerable number of meetings with mental health centres, calls for consultation by administrators and psychiatrists, and a variety of specific psychiatric problems requiring solution. Clinical consultation on a one-day-a-week basis to the Sechelt Mental Health Centre was maintained.

NURSING CONSULTATION SERVICES

During the year the provision of nursing consultation services was directed toward (*a*) the completion of projects undertaken the previous year; (*b*) developments in psychiatric nursing education and services; and (*c*) the changing role of mental health-psychiatric nursing consultation, in view of organizational changes in the Health Department.

The Community Psychiatric Nursing Program Project had been designed to prepare basically trained nurses for community psychiatric nursing positions in mental health centres; to assess the effectiveness of the educational program developed for these nurses; and to describe the role responsibilities of these nurses

after three months in the field. The project findings showed that (*a*) the program was effective in training a selected group of nurses for a new job and a new role; (*b*) after three months, the job and role were expanding in scope; and (*c*) the addition of these 20 nurses to 13 mental health centre teams made a definite impact on the centres' ability to deliver local community mental health services.

A study of the Role and Training Needs of Psychiatric Aides, supported by the Minister of Health and the British Columbia Government Employees' Union, was initiated in February 1974 and completed in April 1975. The report provided information, and made recommendations, concerning the functions and training requirements of psychiatric aides in Government service.

The state of psychiatric nursing education in the Province was studied by the Registered Psychiatric Nurses Educational Advisory Committee. It reported that approximately 1,000 additional psychiatrically trained nurses were required to maintain existing services in Government facilities, community programs, and the psychiatric services of general hospitals; that the only existing basic psychiatric nursing education program in the Province, at the British Columbia Institute of Technology, was producing an average of 60 new graduates a year. It was anticipated that the British Columbia Medical Centre, through its Nursing Manpower Committees, would be seeking to resolve this deficiency in the availability of nurses trained in the specialty of psychiatric nursing.

The Education Centre at Essondale continued to be administered by the Consultant in Nursing. Its facilities were used for a variety of workshops, seminars, meetings, and classroom courses by 56 groups comprising 4,182 persons, for a total of 210 sessions. Major users of the centre were Riverview Hospital, the British Columbia Institute of Technology, the Royal Columbian Hospital, Mental Health Programs, and the University of British Columbia. Its library facilities of 1,200 volumes and numerous journals and pamphlets were used by 11,000 individuals. Several proposals for the future use of the Education Centre facilities were under consideration at year-end.

Nursing consultation was provided to the psychiatric hospital nursing services and community mental health programs of the Health Department; to the mental retardation services of the Department of Human Resources; to community nursing education programs of the Department of Education; to various components of the Public Service Commission; and to professional health care organizations.

As the year was drawing to a close, preliminary steps were being taken to study the feasibility of expanding the availability of mental health-psychiatric nursing consultation as a resource service to the other programs of the Department of Health.

SOCIOLOGY CONSULTATION SERVICES

During the year the Consultant in Sociology acted as Regional Program Director for 10 Lower Mainland mental health centres. Work emphasis was on the six centres adjacent to Riverview Hospital, whose responsibility it was to screen referrals to the hospital and, when admission was indicated, to admit and treat patients on the ward, and ensure adequate follow-up upon discharge.

An analysis of the results of the Vancouver Psychiatric Home Treatment Research Project continued throughout the year, and a number of papers were prepared. One such paper, "Hospitalization and Hospital Bed Replacement," by Goodacre, Coles, MaCurdy, Coates, and Kendall, appeared in the *Canadian Psychiatric Association Journal,* vol. 20 (1975), pp. 7–13. A further report, "The Evaluation of Hospital and Home Treatment for Psychiatric Patients," by Coates,

Kendall, MaCurdy, and Goodacre, was presented at the 1975 annual meeting of the Canadian Psychiatric Association.

Program development and planning for community mental health facilities in the Lower Mainland accounted for approximately 80 per cent of the Consultant's time. The balance was devoted to commitments generated through membership on the Community Care Facilities Licensing Board; the *Ad Hoc* Committee on Long Term Care; the University of British Columbia Department of Psychiatry/Health Department Liaison Committee; and the Psychiatric Services Subcommittee of Hospital Programs Planning Group, which reviewed and recommended on applications from general hospitals for psychiatric in-patient beds and day hospital programs. The Consultant was also chairman of the Statistical Subcommittee of the Riverview Hospital Planning Committee, established to develop a patient categorization instrument as a basis for determining staffing and physical plant requirements for the hospital.

Effective October 1, 1975, the Consultant in Sociology transferred from Mental Health Programs to Hospital Programs, to become Director of their Research Division.

PSYCHOLOGY CONSULTATION SERVICES

In 1975 the Consultant in Psychology became Acting Regional Director for Northern British Columbia, which includes the mental health centres in Fort St. John, Prince George, Williams Lake, Terrace, and Prince Rupert. One of the aims of regionalization was to make a more detailed analysis of mental health related needs of the various communities within a particular region, and the types of services needed to deal with these needs. Another objective was to review the priority of services, in order to continue to provide the most effective services in any one region with the resources available. Special assignments which related to these objectives, and which involved the Consultant in Psychology during the year, included:

- Participation in a Minister's Committee on the Role and Training Needs of Psychiatric Aides: This committee was appointed to review training programs for psychiatric aides in Government facilities and other programs in the Province where psychiatric aides are employed, and to make recommendations for the training of psychiatric aides so that they may effectively carry out their role in the care of the mentally ill and retarded.
- The Community Profile Study: This study was aimed at collecting basic data about the various communities in British Columbia, in order to provide a profile which could be used for the better evaluation of health needs, as well as for a variety of other purposes.
- The Integrated Services Project: Personnel from the Departments of Health, Human Resources, and Education were seconded to this project to provide integrated services for children and families in the Greater Victoria region. These included assessment and diagnostic services for children with mental health related problems; back-up treatment support for existing treatment facilities for children; and treatment programs for both children and their families in communities where such services are not available. In conjunction with the project staff, an analysis was made of the needs of children in the project's catchment area, the number of children at risk in the various need categories, and the types of services which best could be provided by the project in relation to these factors.

- Crisis Intervention Emergency Services: With the co-operation of the various crisis centres in the Greater Vancouver area, a study was made of crisis intervention emergency services, staffing, training, and administrative procedures common to this type of operation.

MANAGEMENT ANALYST CONSULTATION SERVICES

During the year the activities of the Management Analyst were focused primarily on community mental health, and two major projects were undertaken in this area:

The project of highest priority was the development of a new information system for community mental health. This system was designed to

- provide management and case information on a regular basis;
- maintain a collection of base data from which to initiate research projects;
- facilitate data access, allowing rapid response to requests for information;
- streamline clerical procedures;
- speed up processing through the use of automation and the scheduling of activities.

The various components of the system, some of which were manual procedures and some of which involved computer processing, were to be implemented in stages.

Assistance was provided to the Greater Vancouver Mental Health Service to carry out a study and make recommendations on the standardization of forms and procedures used in the administration of the community care teams. Recommendations resulting from the study included the introduction of some new standard forms and procedures; the preparation of a procedures manual; the centralization of the printing and distribution of forms and stationery, and the purchasing of all supplies; the implementation of a forms control system; improvements to the methods of transmitting information within the service; and the addition of a Records Consultant to the Head Office staff.

The Management Analyst continued to be responsible for the design of new forms and procedures for both mental health centres and the residential facilities.

Assistance was also provided in the development of the Survey of Service, which was carried out in the mental health centres, and in the preparation of a research study in the Boarding Home Program under the summer student project.

The Management Analyst represented Mental Health Programs on the Department of Health Information Task Force, and continued to provide liaison with the Division of Vital Statistics, and Computer and Consulting Services of the Department of Transport and Communications, with regard to data processing.

SOCIAL WORK CONSULTATION SERVICES

The position of Social Work Consultant was filled June 2, 1975, with the appointment of John B. Farry. As Acting Regional Program Director for the Kamloops, Vernon, Kelowna, and Penticton Centres, virtually one quarter of the Consultant's time was devoted to the policy and program concerns within this region. In this connection, he also participated in the planning and implementation of the Autumn 1975 Regional Meeting (a program hosted by the Kelowna Mental Health Centre which combined both business and educational interests).

An evaluative study of the Boarding Home Program was conducted by the Consultant with a view to providing guidelines for its future directions. Items which were under particular scrutiny included the relationship of the Boarding

Home Program to the mental health centres, case load limitations, future funding considerations, staffing, and morale. The Boarding Home Study was being reviewed by the Mental Health Programs Planning Committee at the year-end.

Numerous requests for reclassification on the part of psychiatric social workers at all levels, in combination with a long overdue need to review the entire series, prompted the establishment of a Series Review Study Committee under the chairmanship of the Consultant. The specific objective of this Committee was to study current inconsistencies in the present psychiatric social worker series, and submit recommendations which more accurately reflected the current professional functions of social workers in the field.

During the year the Consultant was made responsible for developing a comprehensive program in continuing education for the mental health centres. The committee struck for this purpose combined regional as well as disciplinary representation, and contained plans for future liaison with institutional, university, and other established continuing educational programs.

The Consultant also served on a number of committees, such as the Planning Committee, Program Advisory Committee, Community Care Facilities Licensing Board, and the committee involving Human Resources, Education, and Health which addressed itself to Special Needs for Special Children.

STATISTICS AND MEDICAL RECORDS

During 1975, this section continued to standardize and computerize the data collection systems. The use of canned computer programs (e.g., the Statistical Package for the Social Sciences), improved the retrieval of information in terms of accessibility and content variability. As a result of this change in retrieval methods, numerous extensive requests for data were fulfilled, and more detailed tabulations were included in the Annual Statistical Report.

The realignment of responsibilities, as well as the increased work load within Mental Health Programs (comprised of 41 out-patient units and four in-patient units), necessarily demanded a more concentrated effort on behalf of the statistical staff. Areas focused on and improved were submission schedules, submission procedures, accuracy of submissions, storage of the master index, and storage of data on computer. In addition, the data systems for the residential facilities were maintained. Maintenance involved liaison with the medical records staff and with the Division of Vital Statistics, providing consultation services, and fulfilling requests for data.

The statistical system for Woodlands and Tranquille was officially transferred on April 1, 1975, to the Department of Human Resources. Consultation services were provided throughout the transfer and were continued afterward.

A monthly average of 2,300 statistical forms for Mental Health Programs, and approximately 400 statistical forms for the residential facilities, were edited by the statistical staff, before being processed by the Division of Vital Statistics.

Three new units (Secure, Vista, and Venture), under the administration of the Greater Vancouver Mental Health Service, were incorporated into the statistical system. In addition, the Riverview Out-patient Department (the Broadway Clinic) came under the administration of GVMHS and was incorporated into the statistical system. One unit, the Victoria Integrated Services for Child and Family Development, was removed from the system.

Routine statistical reports were generated throughout the year, including the Preliminary Patient Movement Report; the Monthly Statistical Bulletin; the 1974 Annual Statistical Report; the Annual Statistics Canada Preliminary Report; the

Annual Statistics Canada Returns from Institutions, Psychiatric Units of General Hospitals and Outpatient Programs; and the Statistics Canada Outpatient Monthly Report. The Annual Statistical Report was changed to reflect the reorganization of the Department of Health, and the report was expanded in terms of information content and presentation, i.e., percentages and graphs.

Regional and Provincial meetings were organized to include discussions regarding medical records, clerical procedures, and the statistical system. Visits were made to most of the mental health centres and community care teams, in order to assess the quality of records and upgrade record-keeping standards, to streamline clerical procedures, to reduce statistical backlogs, and to provide orientation to clerical staff. The Medical Records Consultant, who was transferred from Vancouver to Victoria during the year, evaluated and reported on the medical records systems within GVMHS.

Several specific projects were undertaken during the year, focusing either on providing management information or on streamlining the current data systems. The following are examples of some of the projects: a Survey of Service was conducted to assess the type and amount of service delivery; attempts were made to develop policies on the transfer and destruction of patient records; a follow-up procedure was instituted to assess the success of the referral procedure from Riverview Hospital to the mental health centres and community care teams; the development of a statistical system for the Forensic Psychiatric Services was initiated; and a therapist index card procedure was designed to provide information for Statistics Canada and to serve as a method for reviewing case loads.

Table 16—Patient Movement Trends, Mental Health Facilities, 1972–75

Mental Health Facilities	Yearly Sum of Entries[1] From—			Resident or Case Load		
	Oct. 1972 to Sept. 1973	Oct. 1973 to Sept. 1974	Oct. 1974 to Sept. 1975	End of Sept. 1973	End of Sept. 1974	End of Sept. 1975
All mental health facilities	11,553	13,901	15,630	12,309	15,234	17,332
Hospital programs	2,443	2,529	2,388	3,010	2,630	2,361
Riverview	1,911	2,024	1,950	1,976	1,643	1,381
Geriatric facilities	532	505	438	1,034	987	980
Valleyview	421	413	332	656	645	645
Dellview	86	72	88	180	174	178
Skeenaview	25	20	18	198	168	157
Mental health programs	9,110	11,372	13,242	9,299	12,604	14,971
Total in-patients	37	153	352	23	27	46
Burnaby	.....	110	301	.....	10	18
BCYDC	37	43	51	23	17	28
Total out-patients	9,073	11,219	12,890	9,276	12,577	14,925
All mental health centres	8,120	9,295	9,904	8,175	10,821	12,267
Abbotsford	15	253	226	15	231	305
Burnaby	524	807	1,015	567	776	1,002
Chilliwack	527	412	344	465	333	334
Courtenay	331	243	246	126	281	338
Cranbrook	157	117	297	144	63	224
Duncan	264	291	349	315	523	486
Fort St. John	93	107	314	74	199	492
Kamloops	330	350	253	343	392	352
Kelowna	328	464	377	399	634	787
Langley	.....	235	226	.....	210	348
Maple Ridge	476	398	415	687	768	737
Nanaimo	224	327	356	296	447	411
Nelson	267	419	358	471	672	1,013
New Westminster	265	222	200	263	258	231
Penticton	201	261	294	241	260	379
Port Alberni	417	482	417	247	286	298
Port Coquitlam	263	319	377	210	230	265
Powell River	320	259	222	294	366	302
Prince George	121	188	159	133	257	286
Prince Rupert	72	234	293	66	149	134
Saanich	304	242	287	458	512	555
Sechelt	.....	128	147	.....	74	109
Squamish	.....	69	87	.....	58	104
Surrey	388	278	360	411	535	614
Terrace	385	401	308	124	202	146
Trail	226	194	218	218	225	304
Vernon	628	759	779	733	1,097	760
Victoria	613	535	442	605	374	447
Whalley	357	285	467	258	398	430
Williams Lake	24	16	71	12	11	74
All community care teams	675	1,772	2,834	872	1,652	2,537
Blenheim House (July 1974)[2]	.....	.....	95	.....	.....	76
Broadway Clinic	557	492	420	773	709	659
Kitsilano	.....	215	349	.....	156	293
Mount Pleasant	.....	279	340	.....	150	185
Richmond	.....	185	187	.....	145	214
Secure (April 1975)[2]	.....	.....	53	.....	.....	48
South Vancouver (July 1974)[2]	.....	.....	226	.....	.....	210
Strathcona	.....	178	542	.....	142	325
West End	118	274	198	99	247	248
West Side	.....	149	424	.....	103	279
BCYDC (out-patient)	278	152	152	229	104	121

[1] For the residential facilities this includes permanent transfers, admissions from community, and returns from leave and escapes.

[2] Month Centre/Team commenced reporting.

Table 17—Patient Movement Data,[1] Mental Health Facilities, 1975

Mental Health Facilities	Entries				Exits				
	Total	Direct Admissions	Returns From Leave	Permanent Transfers	Total	Discharges	Leaves	Permanent Transfers	Deaths
All mental health facilities	16,013	15,652	349	12	14,432	12,997	1,016	13	326
Hospital programs	2,350	1,997	348	5	2,678	1,254	1,090	9	325
Riverview	1,971	1,648	319	4	2,224	1,192	936	9	87
Geriatric facilities	379	349	29	1	454	62	154	....	238
Valleyview	299	270	28	1	333	42	138	....	153
Dellview	65	64	1	....	87	7	16	....	64
Skeenaview	15	15	.....	....	34	13	.....	....	21
Mental health programs	13,663	13,655	1	7	11,754	11,743	6	4	1
Total in-patients	374	366	1	7	357	346	6	4	1
Burnaby	323	315	1	7	311	300	6	4	1
BCYDC	51	51	.....	....	46	46	.....	....	.....
Total out-patients		13,289				11,397			
All mental health centres		9,900				8,839			
Abbotsford		281				198			
Burnaby		1,056				852			
Chilliwack		290				408			
Courtenay		322				188			
Cranbrook		345				169			
Duncan		358				499			
Fort St. John		354				40			
Kamloops		238				214			
Kelowna		349				257			
Langley		226				108			
Maple Ridge		417				504			
Nanaimo		373				384			
Nelson		338				162			
New Westminster		217				260			
Penticton		284				225			
Port Alberni		392				381			
Port Coquitlam		397				326			
Powell River		220				285			
Prince George		166				134			
Prince Rupert		266				326			
Saanich		314				289			
Sechelt		161				101			
Squamish		73				26			
Surrey		373				321			
Terrace		305				296			
Trail		182				32			
Vernon		626				916			
Victoria		449				457			
Whalley		434				471			
Williams Lake		94				10			
All community care teams		3,216				2,354			
Blenheim House (July 1974)[2]		86				25			
Broadway Clinic		438				470			
Kitsilano		368				221			
Mount Pleasant		302				286			
Richmond		196				142			
Secure (April 1975)[2]		106				7			
South Vancouver (July 1974)[2]		265				102			
Strathcona		770				569			
West End		232				230			
West Side		453				302			
BCYDC (out-patient)		173				204			

[1] Table compiled from actual data through September 1975, and projected for the remainder of the year. (NOTE—In case of centres/teams opened in 1975, table compiled on basis of available data for 1975.)

[2] Month centre/team commenced reporting.

MEDICAL AND HOSPITAL PROGRAMS

HOSPITAL PROGRAMS

Hospital Programs

Prior to the introduction of the British Columbia Hospital Insurance Service on January 1, 1949, the Province had been interested in developing a comprehensive program for many years. In 1932 the findings of a Royal Commission had recommended that a compulsory health insurance maternity plan be considered, and in 1936 a Health Insurance Act had been placed on the statutes but never proclaimed. In 1937, British Columbians voted in favour of a health insurance referendum, held in conjunction with a Provincial general election. Finally, in 1948, the *Hospital Insurance Act* was passed, establishing a Hospital Insurance Service which provided coverage for acute care in approved general hospitals.

In March 1975 the name of the service was changed to Hospital Programs, as part of a reorganization of the Department of Health.

The following pages contain individual reports of the divisions which comprise the administrative structure of Hospital Programs, and brief reviews of pertinent legislation:

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 formula which provides substantial financial assistance from the Provincial Government toward the capital cost of hospital projects.

Each regional hospital district, subject to the requirements of the Act, is able to pass capital expense proposal 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, the district is able to raise any funds immediately required by temporary bank borrowing on a uniform basis. Periodically the Regional Hospital Districts Financing Authority (*see* below) provides long-term financing by purchasing debentures issued by districts, thus enabling regional hospital districts to repay their temporary bank borrowings.

Each year the Provincial Government pays through Hospital Programs from the Hospital Insurance Fund its share of the amortization cost in accordance with section 22 of the Act and each district raises, by taxation, the remainder of the annual amortization cost required to retire the debentures which are held by the Financing Authority.

Under the sharing arrangements, the Province pays annually to, or on behalf of each district, 60 per cent of the approved net cost of amortizing the district's borrowings for hospital construction projects, after deduction of any items which are the district's responsibility, such as provision of working capital 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 hospital projects, 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 regional hospital district is responsible for co-ordinating and evaluating the requests for funds from hospitals within the district, and for adopting borrowing by-laws, subject to approvals and conditions required under the Act, in respect of either single projects or an over-all program of hospital projects for the district.

In 1975 the Act was amended to increase the discretionary amount which a regional hospital district can raise annually for unforeseen capital expenditures, if specified by the Minister, to $200,000, or the product of one quarter of a mill.

BRITISH COLUMBIA REGIONAL HOSPITAL DISTRICTS FINANCING AUTHORITY ACT

This Act established a Provincial Government authority similar to the one set up 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*.

In 1975 the purposes of the Authority were expanded to permit assistance to medical and health facilities and community, human resources, and health centres and any other community, regional or Provincial facilities for the social improvement and welfare of the community or the general public good. Also, the Authority was permitted to purchase debentures from incorporated bodies other than regional hospital districts provided they are authorized under any Act or their charter or their memorandum of association to issue debentures for the financing of projects permitted under the Act.

THE HOSPITAL INSURANCE ACT

The Hospital Programs of the Department of Health operate under the authority of the provisions of this statute which also authorizes the establishment of the Hospital Insurance Fund, from which grants are made to hospitals and regional hospital districts toward operating expenses and capital costs.

- Generally speaking, every permanent resident who has made his home in British Columbia during the statutory waiting-period is entitled to benefits under the Act.
- Reimbursement to public general hospitals is based on an approved annual budget; for accounting purposes *per diem* rates are used, 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 Hospital Programs from the Hospital Insurance Fund 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.
- The wide range of in-patient and out-patient benefits provided under the Act is described on the following pages.
- Qualified persons who are temporarily absent from British Columbia are entitled to certain benefits for a period of 12 months following their departure from the Province.
- In addition to the payment toward operating costs, paid to hospitals as described above, hospitals and regional hospital districts receive grants of up to 60 per cent of approved costs of construction or acquisition of hospital facilities, one third of the cost of minor movable equipment, 75 percent of the cost of major diagnostic equipment, and 100 per cent of the cost of equipment which results in proven savings in operating costs.

THE HOSPITAL ACT

One of the important functions of Hospital Programs is the administration of the *Hospital Act*. The Deputy Minister of Medical and Hospital Programs 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:

- Public hospitals: Nonprofit hospitals caring primarily for acutely ill persons.
- Private hospitals: This category includes small public hospitals, most of which are operated in remote areas by industrial concerns primarily for their employees, and licensed nursing-homes which are not under hospital insurance coverage.
- Rehabilitation and extended-care hospitals: These nonprofit hospitals are primarily for the treatment of persons who require long-term rehabilitative and extended hospital care.

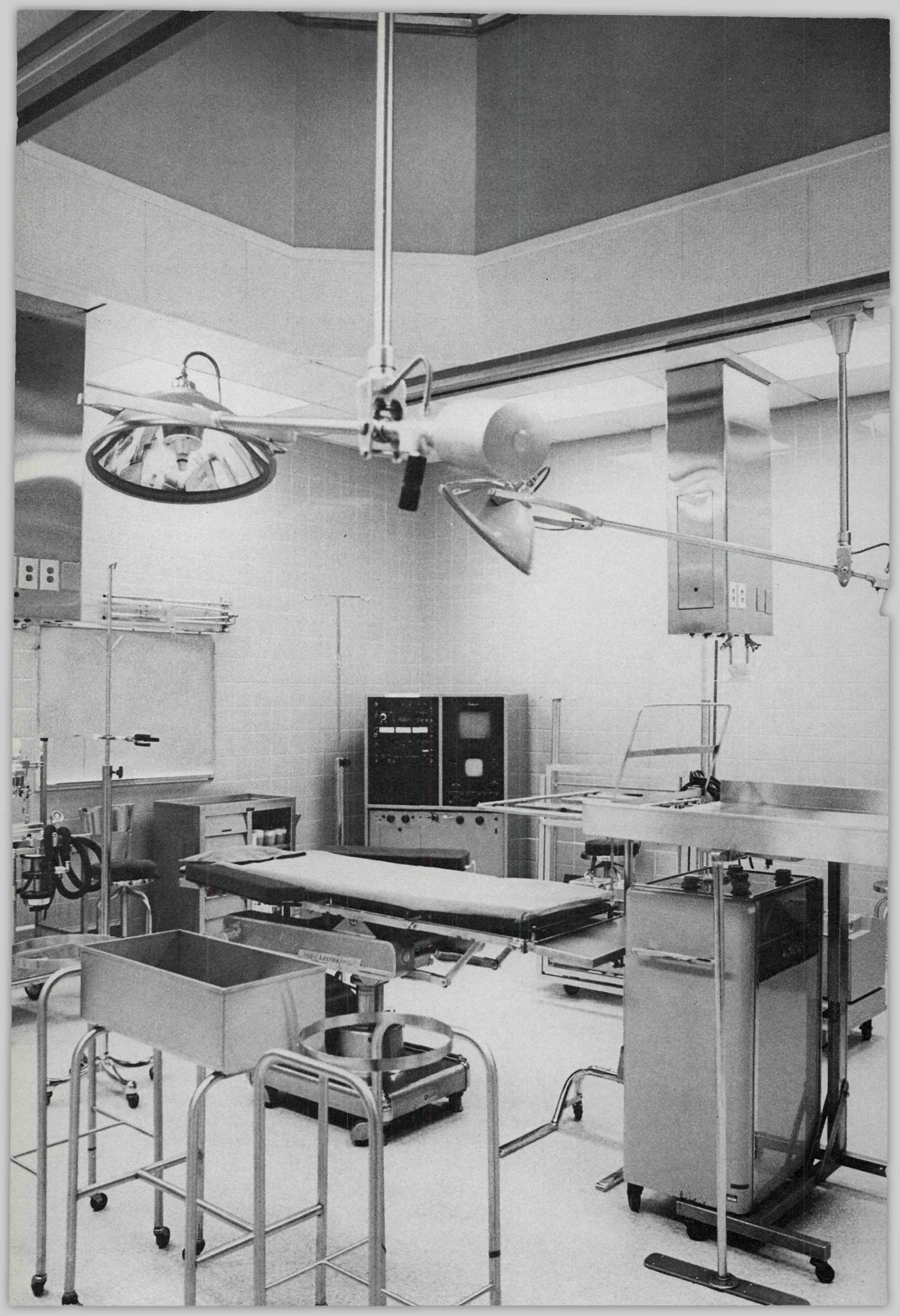
THE HOSPITAL RATE BOARD AND METHODS OF PAYMENT TO HOSPITALS

The Hospital Rate Board, appointed by Order in Council, is responsible for advising the Deputy Minister in regard to hospitals' operating budgets and 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 the total of 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 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 in-patient hospital accounts incurred in British Columbia are the responsibility of the British Columbia Hospital Programs Division. 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 Programs. Qualified patients are charged $1 per day, which is deductible when calculating payments to hospitals from the Division. 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.



HOSPITAL CONSULTATION AND INSPECTION DIVISION

This Division provides consulting services to public and private hospitals in all aspects of hospital organization, operation, and management. It is responsible for an inspectional program to ensure that minimum standards of care, safety, and licensure are met.

The services of the Division are provided by a staff consisting of consultants in hospital administration, biomedical engineering, dietary, laboratory, social services, management engineering, nursing, and X-ray.

During 1975, consultant services in biomedical engineering and radiology were added to the staff of the Division and provided a valuable new service to hospitals of the Province.

PRIVATE HOSPITAL VISITING

The year 1975 saw a marked increase in consultation and inspection service to private hospitals. In addition to team visits, most private hospitals in the Province received visits from consultants in nursing and administration. It is intended that this approach to the inspection of private hospitals will be continued in 1976.

PARTICIPATION IN EDUCATIONAL PROGRAM

Two consultants of the Division became participants in the GAMAT program. GAMAT was developed by the British Columbia Health Association to provide education for hospital society trustees and emphasizes their role and responsibilities. The GAMAT team has 12 members representing the Government, Administration, Medicine, the Association, and Trustees.

PUBLIC ADMINISTRATOR

During 1975 the Division was required to provide a member of the staff to act in the capacity of public administrator for a hospital society in the Province. In this role he provided direction to the institution while a reorganization of the hospital board and society affairs took place.

CONSULTATION AND INSPECTION

The ongoing work of consultation and inspection, which was carried out during the year, involved 149 visits to private hospitals, 137 visits to general hospitals, and participation in other activities such as Federal-Provincial meetings and task forces in hospital administration, nursing, dietetics, and pharmacy; attendance in various roles at intraprovincial advisory groups; patient classification survey, and educational seminars.

RESEARCH DIVISION

The Division performs a statistical resource function for Hospital Programs and serves as a focal point for data collection and analysis. Primarily responsible for examining the need for new hospital beds and services, the Division is also involved in a wide range of activities.

The preparation of recommendations for additional hospital capacity, in the face of an ever-increasing range of benefits and services covered by Hospital Programs, necessitates close liaison at the hospital, regional, and Provincial level. In spite of a greater emphasis being given to alternatives to acute in-patient beds in

recent years, the growth of the Province necessitates a continuing review of general hospital bed requirements. Reports and recommendations for additional hospital capacity are placed before the Planning Group of Hospital Programs for review through the Director, who is a member of the group. During the course of the year, 30 hospitals were assessed with respect to future needs.

In 1975 the Director was appointed Chairman of a subcommittee of the Planning Group dealing with the development of psychiatric in-patient beds and day hospital programs; he also acted as Chairman of the Riverview Hospital Planning Committee's Statistical Subcommittee, and was a member of the Community Care Facilities Licensing Board, the Health Department's *Ad Hoc* Committee on Long Term Care, and the UBC Department of Psychiatry/Health Department Liaison Committee.

The Division is also responsible for maintaining and compiling statistical data relating to all hospitalization 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 Eighth Revision of the International Classification of Diseases Adapted (ICDA). Through this classification system, the incidence of disease is analysed by age, sex, geographical location, as well as other variables. In connection with morbidity analysis, the Division publishes a number of annual reports. The *Statistics of Hospital Cases Discharged* includes the standard morbidity tables which all provinces publish, and which affords an opportunity to make interprovincial comparisons of hospital data. The *Statistics of Hospitalized Accident Cases,* which is also prepared annually, provides a broad analytical coverage of hospitalized accident cases by circumstance, type of accident, and nature of injury. A report of the *Day Care Surgery in British Columbia Hospitals* is also prepared by the Division for purposes 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.

The Division also maintains a reporting system for therapeutic abortions performed in hospitals in the Province. During 1975, 10,041 abortions were performed in British Columbia, which represents 28 abortions per 100 hospitalized live births.

On October 1, 1975, R. H. Goodacre was appointed Director of the Research Division, replacing D. S. Thomson, who left the Service to become Associate Director of the British Columbia Cancer Control Agency in Vancouver.

HOSPITAL FINANCE DIVISION

The Hospital Finance Division is responsible for the assembling of relevant information and the preparation of data for the use of the Hospital Rate Board in its review of the annual and preconstruction operating estimates of hospitals. 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 1975 amounted to $460 million.

The Division also reviews the annual budgets prepared by regional hospital districts, 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 1975 the regional hospital districts debenture sales to the

British Columbia Regional Hospital Districts Financing Authority amounted to $27 million.

Another function of the Finance Division is the processing of Admission-Separation Records (accounts), which hospitals submit for each patient, and approving for payment all acceptable claims. Also included are out-patient, day care, and out-of-Province accounts.

The Division is also responsible for the approval of grants to assist hospitals in the purchase of equipment. The equipment grant structure is such that Hospital Programs pays a 100-per-cent grant on approved equipment where the equipment purchase will result in a reduction in approved operating costs and the recovery of the capital cost in a reasonable time. Grants of 75 per cent are paid on diagnostic equipment used in pathology, radiology, nuclear medicine, and ultrasound, and 33⅓ per cent grant on all other movable depreciable equipment. In 1975, after review of approximately 6,800 applications received from hospitals, grants totalling $6 million were approved on purchases of movable and fixed technical equipment amounting to approximately $10 million.

The Division assists in administering the Federal/Provincial Agreement under the *Hospital Insurance and Diagnostic Services Act*. This involves the preparation of annual claims and the disbursement of Hospital Program funds in a manner that will maximize the Province's reimbursement under the agreement.

In order to ensure that plans for new hospitals or hospital additions are prepared with economical and efficient operation in mind, a system of preconstruction operating budgets is used. 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 preconstruction operating budget does 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 preconstruction operating budget has been agreed upon by the hospital officials and Hospital Programs, 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.

As a means of assisting hospital staff to maintain and develop health care skills, Hospital Programs provided over $360,000 in hospital operating budgets during the year to enable hospital employees to attend or participate in short-term educational training courses.

It is estimated that the increase in gross hospital expenditures for the calendar year ending December 31, 1975, will amount to approximately $92 million over 1974. Salaries increased 26 per cent, accounting for $75 million of the total increase.

The following is a summary of comparative expenditures of Hospital Programs for the fiscal years 1971–75, inclusive:

	1971	1972	1973	1974	1975
	$	$	$	$	$
Administration	1,261,940	1,400,095	1,538,905	1,800,229	2,438,265
Payments to hospitals	183,806,933	206,667,254	235,594,194	275,801,859	370,769,218
Totals	185,068,873	208,067,349	237,133,099	277,602,088	373,207,483[1]

[1] This does not include Special Warrant No. 91 for $116,683, or Special Warrant No. 99 for $41,904, a total of $158,587.

FINANCE CLAIMS SECTION

Patient accounts processed during the year were in excess of 2,000 per working-day, plus over 2,550 emergency-service and minor-surgery accounts.

The staff of Admission Control reviews each application for benefits under the *Hospital Insurance Act*. Details of residence are checked with the verifying documents, and as a result over 5,000 claims had to be returned to the hospitals during the year because they were incomplete or unacceptable, and over 1,800 letters were written on eligibility, verification, and related matters.

The in-patient claims checkers pre-audit the charges made to Hospital Programs, and ensure 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 Hospital Programs, Workers' Compensation Board, the Department of Veterans Affairs, or other provinces and territories.

Preliminary figures for 1975 show that more than 465,000 accounts (excluding out-of-Province) were processed.

The Day-care Surgical Services, Day-care/Night-care Psychiatric Services, Out-patient Psychiatric Services, and Day-care Diabetic Services accounts increased in volume to over 9,500 per month in 1975. During the year the Service continued to provide a quarterly statistical run of Day-care Surgical Services for the hospitals of the Province. Payment for out-patient phsysiotherapy patients was provided and preliminary figures indicate that accounts for over 330,000 treatments were processed.

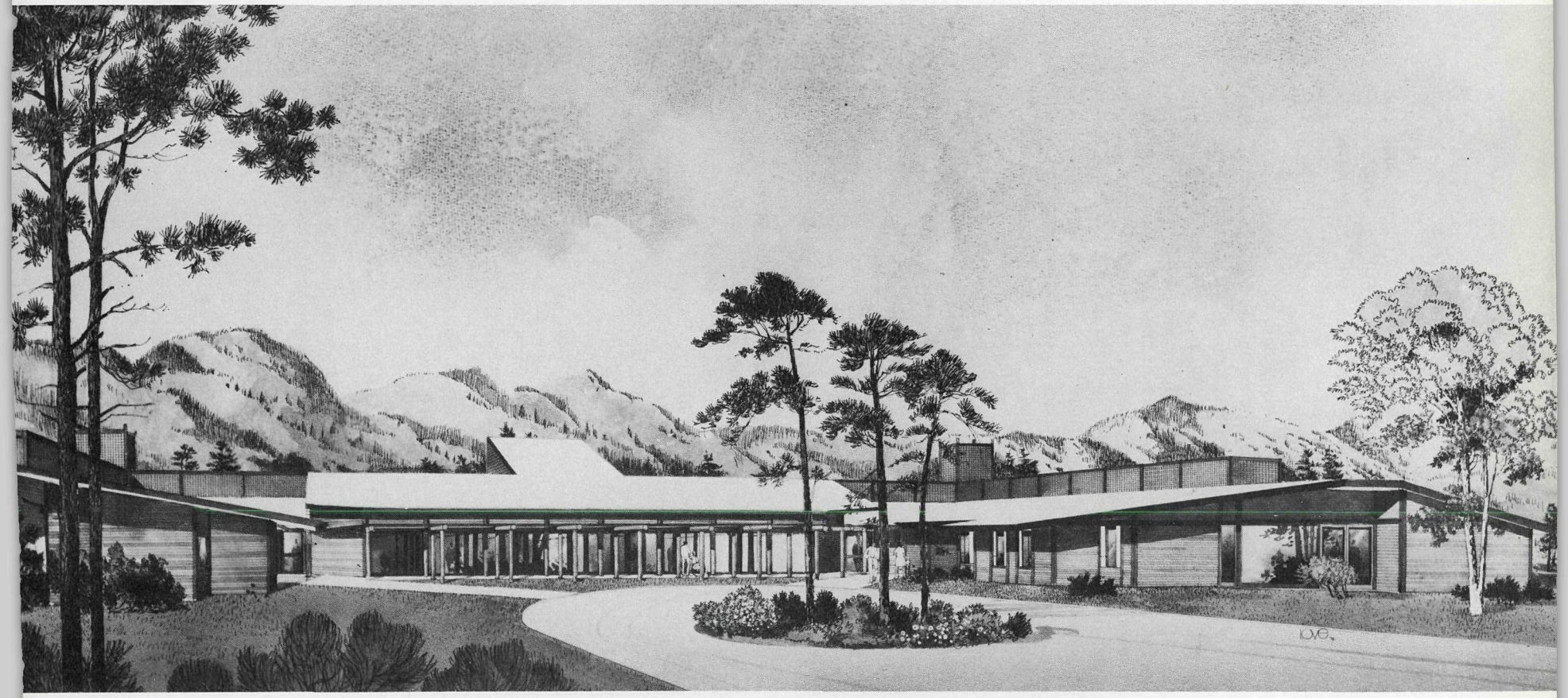
The out-of-Province personnel process all claims for hospital accounts incurred by British Columbia residents in hospitals outside the Province. This requires establishing eligibility and the payment of claims. During 1975, over 575 accounts were processed each month, resulting in an estimated total expenditure of over $4.6 million. The Claims Distribution Centre receives, sorts, and distributes all the forms and correspondence received in the Hospital Claims Section. Over 11,000 claims, documents, and letters are handled daily.

HOSPITAL CONSTRUCTION AND PLANNING DIVISION

The Hospital Construction and Planning Division provides a consultative service to hospital boards planning new acute or extended-care hospital facilities, diagnostic and treatment centres, and additions or alterations to these buildings. With continuing inflation, emphasis continued to be placed on using public funds to the best advantage and deleting any work not considered strictly necessary. Hospitals' construction programs and grant applications were reviewed with this objective in mind.

During 1975, 20 major projects were completed in the Province, costing nearly $20 million. Construction and renovation projects involved a total of 272 acute beds and the upgrading of many service departments. Two of the projects involved special units—the spinal cord injury unit at Shaughnessy Hospital and the nuclear medicine laboratory at the Vancouver General Hospital. Seven of the projects provided a total of 208 additional extended-care beds in new units or additions to existing units.

As a result of Hospital Program's desire to see construction projects carried out not only as economically as possible, and with the least amount of delay, approval was given for two multi-million dollar projects in the Lower Mainland



to be carried out under project management. Client Committees were formed at both Burnaby General Hospital and Royal Columbian Hospital, New Westminster, each consisting of representatives from the hospital, the Greater Vancouver Regional Hospital District, and this Division to administer the project. Project managers were appointed once schematic drawings had been developed and cost estimates approved. As the preparation of complete working drawings under the project management arrangement can overlap the start of actual construction on the site, much time can be saved and greater control can be effected over capital costs.

In connection with the above, a new field of involvement has been the co-operation of the Provincial Government with the Greater Vancouver Regional Hospital District in the provision of multi-storey parking facilities for three major hospitals in the Lower Mainland area—Burnaby General, Royal Columbian, and Lions Gate. Burnaby's project was completed in May and is being operated by the Greater Vancouver Regional Hospital District. Revenue from the operation of this and the other two facilities will be used to amortize capital costs.

Another way in which planning time has been shortened is by the use of the plans of the Overlander Extended Care Hospital, Kamloops, for two similar units at Delta and Kelowna.

In order to assist hospitals in the preparation of functional programs and expedite the approval mechanism for major construction projects, a standard format has been developed by staff of this Division, working with an outside firm. This guide has been field-tested on one expansion program and staff are in the process of evaluating the results so that the guideline may be finalized.

During the year a Committee, formed to study Surgical Suite Ventilation, produced its report. W. H. Cox, Consultant in Hospital Engineering, was a member of this committee, which recommended the division of all operating-rooms into two categories, depending on the type of anæsthesia used and the adoption of standards of air supply systems for each type, to ensure the safety of patients and staff. Several meetings were held with the Provincial Fire Marshal and his staff with the aim of standardizing the interpretation of fire safety regulations throughout the Province as set down in the National Building Code. This was necessary because of the high cost of providing fire alarm systems in both new construction and existing buildings, to meet the new Code requirements.

The Division worked closely with other Government departments, regional hospital districts, hospitals, consultants, and agencies. Co-operation was extended by the medical profession and consulting engineers in the preparation of the Surgical Suite Ventilation recommendations; Karl Schmidt and Mike Rayburn contributed their time assessing the advantages of construction management for hospital construction; and A. Shaw and E. Phillips of the British Columbia Construction Association provided information on construction matters.

A. HOSPITAL PROJECTS COMPLETED DURING 1975

Matsqui-Sumas-Abbotsford General Hospital, Abbotsford—A new 75-bed extended-care unit was officially opened on March 15, 1975.

Burnaby General Hospital—The new parking structure was officially opened on May 1, 1975. The facility is being operated by the Greater Vancouver Regional Hospital District.

Chilliwack General Hospital—Phase IV of the addition and renovations, which consisted of the provision of a six-bed intensive care unit, 18 additional extended-care beds, and pædiatric renovations was completed in early December.

Cowichan District Hospital, Duncan—A program involving the completion of 22 additional extended-care beds, for a total of 100, plus air-conditioning the entire hospital, was finalized in December 1975.

Boundary Hospital, Grand Forks—An addition of 14 extended-care beds was officially opened on May 12, 1975. An extra bed, for a total of 15, was approved on July 31, 1975.

Fraser Canyon Hospital, Hope—A new laboratory, which was completed on July 24, 1975, was officially opened by the Minister of Health on November 1, 1975.

Kelowna General Hospital—The completion of the "shell" area of the east wing of the fourth floor in the acute block, to accommodate 36 extended-care beds temporarily, was effected in August 1975.

Kitimat General Hospital—On June 21, 1975, a new 35-bed extended-care unit was opened at the hospital. The unit is situated partly in the formerly unused portion of the third floor, and its installation necessitated the relocation of the maternity department.

Langley Memorial Hospital—The Minister of Health officially opened the hospital's completed expansion project on June 14, 1975. The expansion includes an ambulatory care addition, the provision of a new parking-lot, and renovations to the existing hospital to provide 50 additional acute beds.

Arrow Lakes Hospital, Nakusp—The project was officially opened on March 8, 1975; the new building contains 16 acute beds and replaces the old 15-bed hospital.

Kootenay Lake District Hospital, Nelson—The Phase II expansion program was completed in November 1975 and provided for the expansion of day care, emergency, radiology, and laundry services, plus a new Provincial Laboratory.

Royal Columbian Hospital, New Westminster—A psychiatric day-care unit of 20 spaces was officially opened on January 24, 1975. The accommodation has been provided in prefabricated units.

100 Mile District Hospital—Additions and alterations to provide seven additional acute beds and supporting services were completed in December 1975.

Prince George Regional Hospital—Interim renovations to improve radiology and day-care surgery facilities, provide a doctors' lounge, library and "on-call" room, classrooms, offices, etc., were completed by the year-end. Twenty-six psychiatric beds on the third floor north were also completed.

Bulkley Valley District Hospital, Smithers—The completed project was officially opened on May 10, 1975; the addition provides 57 acute beds and replaces most of those contained in the now demolished original hospital building. The program resulted in nine additional acute beds, a seven-bed extended-care unit, and expansion of services.

Trail Regional Hospital—The new combined intensive care/coronary care and renal unit of 10 beds was officially opened on February 27, 1975.

Vancouver General Hospital—Renovations to provide a nuclear medicine laboratory were completed in January 1975.

St. Paul's Hospital, Vancouver—The School of Nursing conversion program was completed in December 1975. The program consists of the provision of staff lockers, an administration area, educational facilities, and 40 psychiatric beds (10 of these form the "Short Stay Unit," where patients may not remain longer than five days).

Shaughnessy Hospital, Vancouver—A spinal cord injury unit of 22 beds was opened by the Minister of Health on May 6, 1975.

Vernon Jubilee Hospital—Phase II, consisting of the conversion of the old extended-care unit to provide 38 acute beds, was completed in December 1975. The program also included a new out-patient and diagnostic services wing, education and administrative areas, renovations to provide new physiotherapy and medical records departments, enlargement of postoperative recovery room, and modernization of the children's ward and central sterilizing room.

B. HOSPITAL PROJECTS UNDER CONSTRUCTION AT YEAR-END

Burnaby General Hospital—A major expansion program was being carried out under project management, including the provision of 260 additional acute beds. A second block will house expanded diagnostic, treatment, and service facilities.

Cumberland General Hospital—Construction of a diagnostic and treatment centre with six holding beds and an intermediate care unit of 50 beds.

Dawson Creek and District Hospital—Stage I will provide for the relocation of a 24-bed nursing unit from the main floor to the second floor addition on the west wing of the existing hospital, so that the vacated space can accommodate ambulatory care and the diagnostic and treatment areas proposed in Stage II.

Delta Centennial Hospital—A new 100-bed extended-care hospital, based on the same design as the Overlander Hospital, Kamloops.

Fort Nelson General Hospital—An addition to provide seven additional acute beds and the expansion of diagnostic services.

Fort St. John General Hospital—An expansion program, including ambulatory care, central sterilizing room, radiology and nuclear medicine facilities.

Wrinch Memorial Hospital, Hazelton—A new hospital, providing 27 acute beds, plus eight in "shell" and four extended-care beds, was being built under construction management to replace the existing 50-bed hospital.

Overlander Extended-care Hospital, Kamloops—A new 100-bed extended-care facility was being constructed in North Kamloops.

Royal Inland Hospital, Kamloops—The second phase of the first stage of an expansion program—the enlargement of diagnostic services, including X-ray, emergency, laboratory, and dietary departments and provision of 14 acute beds in "shell."

Keremeos—Construction of a diagnostic and treatment centre and ambulance garage.

Queen's Park Hospital, New Westminster—New hospital facility providing 300 extended-care beds, 100 of which are to be teaching beds, was under construction adjacent to the Woodlands School.

Royal Columbian Hospital, New Westminster—A major expansion, consisting of an addition of 100 acute beds plus a further 45 beds for special services (intensive care, activation, renal dialysis, and metabolic investigation), and development of new service areas, was being carried out under project management.

Powell River General Hospital—An expansion and renovation program, including the provision of a four-bed intensive-care unit, and additions to provide expanded facilities for the radiology, laboratory, and central sterilizing departments, also a new hydrotherapy pool, were nearing completion.

Mills Memorial Hospital, Terrace—An expansion program consisting of an addition of 25 acute beds in "shell," 16 psychiatric beds, six day-care psychiatric spaces, and renovations to service areas.

Trail Regional Hospital—Stage I of an expansion program, including the upgrading of the dietary department, improvement of the second floor nursing station, and air cooling systems was expected to be completed early in 1976.

British Columbia Cancer Control Agency, Vancouver—Temporary structures were being provided for oncology residents and a cytology records computerization program.

Holy Family Hospital, Vancouver—During major expansion program to provide a total of 80 activation/rehabilitation beds and 154 extended-care beds, patients were moved into the new building to allow the original building to be renovated.

Mount St. Joseph Hospital, Vancouver—Construction of an addition and conversion of existing extended-care beds, to increase the hospital's capacity to 161 acute beds, including 20 psychiatric beds and day-care psychiatric facilities, a new 150-bed extended-care unit, and the upgrading and expansion of services.

St. Vincent's Hospital, Vancouver—Phase II of the hospital's expansion program involving alterations and renovations to the 1939 east wing, including the alteration of the old dietary department for ambulatory services, renovation of the radiology and physiotherapy departments, and upgrading the electrical and elevator services.

UBC Health Sciences Centre, Vancouver—A 300-bed extended-care unit, adjacent to the psychiatric unit.

Vancouver General Hospital—The renovation of Willow Pavilion to upgrade the intensive care nursery, electrical services, etc., to provide improved obstetrical and gynæcological facilities, is under way. Renovations were also being carried out to provide for a temporary acupuncture (pain referral) clinic.

Mount St. Mary Hospital, Victoria—Work was under way on an addition to provide a centralized dietary service and renovate areas in the existing building.

Royal Jubilee Hospital, Victoria—An interim program to upgrade the emergency department was being carried out by hospital staff.

C. TENDERING STAGE AT YEAR-END

Lions Gate Hospital, North Vancouver—Multi-storey parking facility, plus subgrade work for proposed services' expansion project.

Prince George Regional Hospital—Development of space for educational needs to support the proposed Diploma Nursing Program.

Queen Charlotte Islands General Hospital—Upgrading mechanical, plumbing, electrical services, water supply, etc.

Children's Hospital, Vancouver—Enlargement of surgical suite and new ambulatory care facilities.

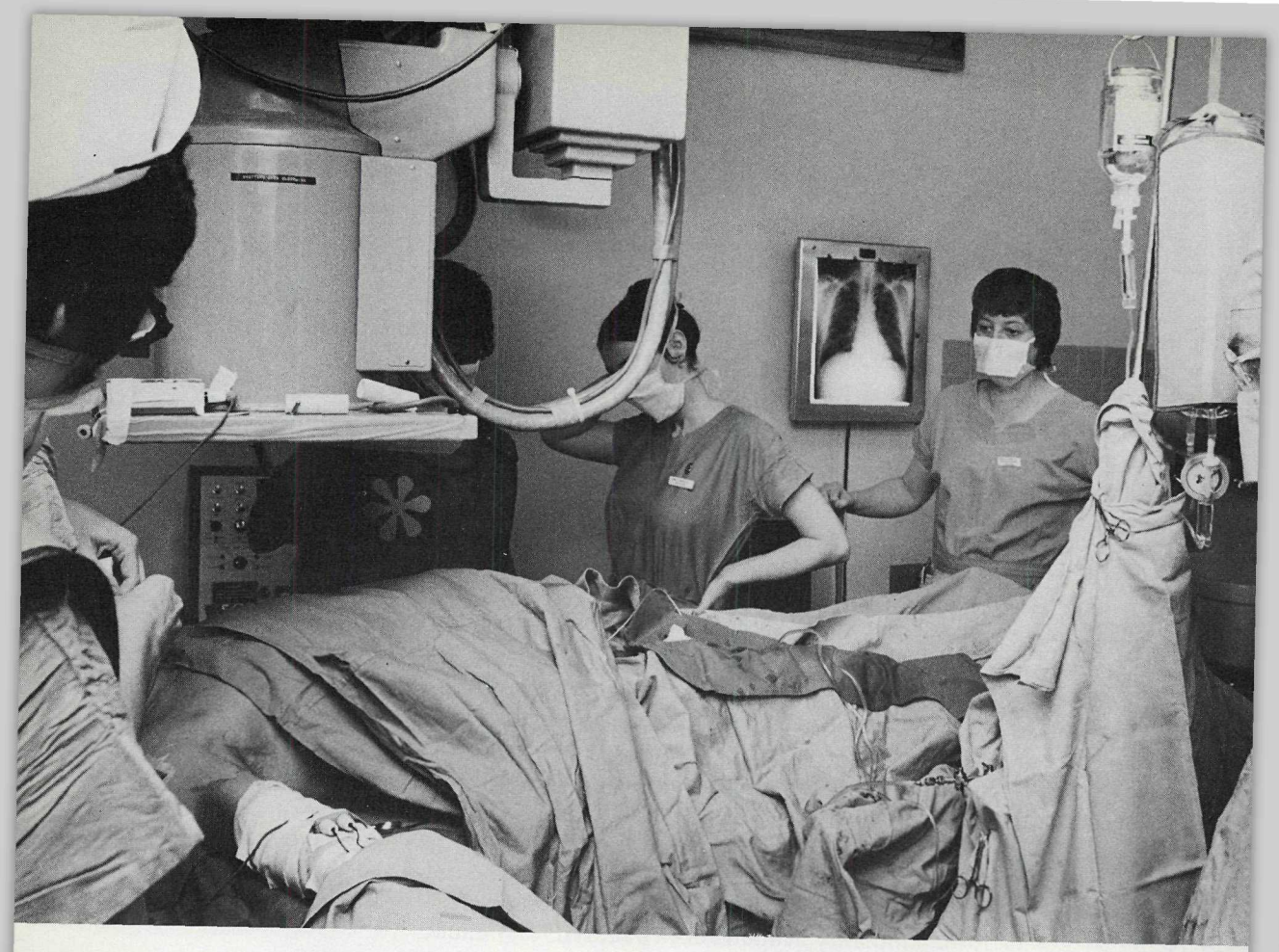
Vancouver General Hospital—Provision of a day-care surgical facility; installation of E.M.I. (brain) scanner.

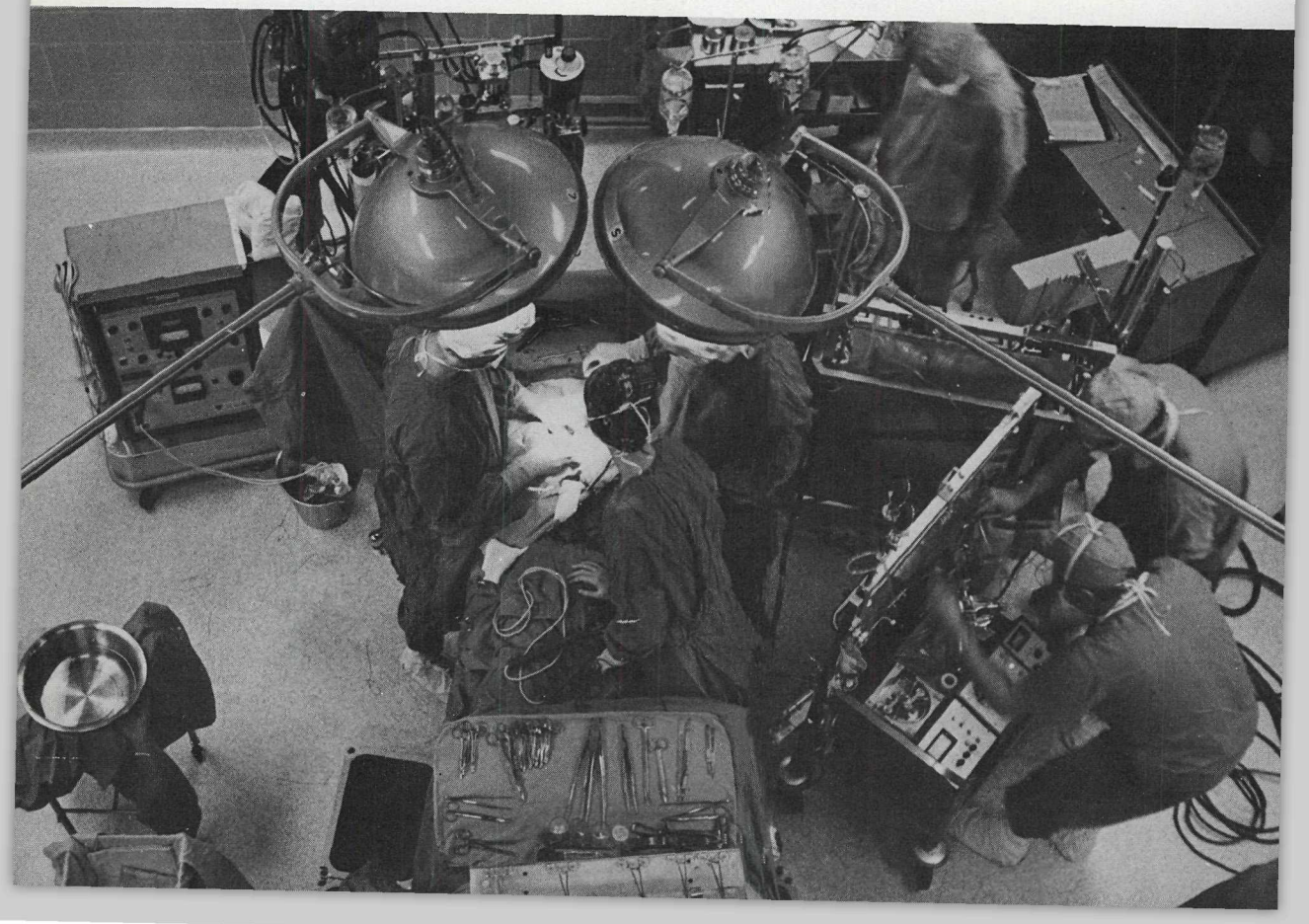
D. PROJECTS IN ADVANCED STAGES OF PLANNING

Kelowna General Hospital—Construction of an extended-care unit on a new site using the Overlander Extended-care Hospital plan. The unit will contain 100 beds, plus 50 which are to be in "shell" form.

South Okanagan General Hospital, Oliver—A 75-bed extended-care unit.

Tofino General Hospital—Expansion of services.





E. ADDITIONAL PROJECTS APPROVED AND IN VARIOUS STAGES OF PLANNING

New facilities—

Acute hospitals—Coquitlam (150), Sparwood (27).

Diagnostic and treatment centres—Delta, Elkford, and Pemberton.

Additional and (or) replacement acute beds—Abbotsford (24 plus 20 semi-finished and 54 in "shell"), Cranbrook (42), Duncan (12 psychiatric), Fort Nelson (7), Kamloops (Royal Inland, 47), Mackenzie (seven plus five in "shell"), Maple Ridge (58 including some psychiatric), Masset (4), Mission (47), Richmond (150), Saanichton (75), Vancouver (B.C. Cancer Control Agency, 28; Shaughnessy, 183 pædiatrics and 90 obstetrics).

New extended-care facilities—Creston (35), Merritt (10), Mission (50), Prince George (75), Princeton (10), Coquitlam (75).

Additional extended-care beds—Campbell River (15), Castlegar (15), Comox (15), Langley (25), Surrey (78), Vancouver (Louis Brier, 56; Metropolitan Council, 80 plus 75 intermediate and 10 personal care; Sunny Hill, 22), Victoria (Glengarry, 150).

Expansion and (or) updating of services—Chilliwack, Clearwater, Comox, Cranbrook, Creston, Dawson Creek, Fort Nelson, Fort St. John, Ganges, Kamloops (Royal Inland), Maple Ridge, Masset, Penticton, Prince George, Richmond, Sechelt, Tahsis, Trail, Vancouver (St. Paul's, Shaughnessy, Sunny Hill, Vancouver General), Victoria (Royal Jubilee).

MEDICAL CONSULTATION DIVISION

The function of this Division is to provide medical consultation to other departments of Government, to all hospitals, and to the regional hospital districts. Within Hospital Programs, in addition to general medical consultation, the Division assists in planning and implementation of new services by having representatives on the Planning Group, the Equipment Committee, and the Functional Programs Review Committee. Assisting development of out-patient and day-care programs to supplement and replace in-patient care is an important aspect of this role. The Division also worked with Community Health Programs to define the roles and equipment needs of community medical clinics and diagnostic and treatment centres, and on the development of a new prenatal form in conjunction with the Perinatal Program of B.C. During the year a Division representative participated in a three-day visit to Manitoba and Alberta, together with representatives from the Department of Human Resources and Community Health Programs, to study their systems for financing and delivering long-term care.

The Division maintained liaison with other health agencies such as the College of Physicians and Surgeons of B.C., the B.C. Medical Association, B.C. Health Association, and the Faculty of Medicine at UBC, and received valuable co-operation in the resolution of problems relating to medical staff activities. Participation on the Medical Advisory Committee of the B.C. Medical Association, with advisory subcommittees to the Government on many subjects, continues to be a useful function. In 1975, new continuing subcommittees on anæsthesia, intensive neonatal and maternal care, and pulmonary services were established, together with two new task committees, one to study the cost benefit of a metabolic screening program, and another to deal with a fifth open heart surgical review.

The Medical Consultation Division has responsibility for a general auditing of the quality of medical care for hospitals. This function is performed by a central review of discharge diagnoses and related information, patterns of care, hospital role, and by on-site visits. Efficiency in this area was increased during the year by the addition of another Medical Consultant. Continuing regular visits by the Medical Record Librarian Consultant also assist hospitals in maintaining a high standard of medical documentation. The audit process also involves assessment of eligibility, whether this be for acute care or some other type of care or insured benefit. Registered nurses within the Division audited and did the medical coding of 420,000 admission/separation records and day-care surgical service records. The coded information is utilized by the Research Division to produce the regional and hospital profiles necessary to planning and audit functions. At the year-end, staff were working with Finance Division toward development of an out-patient form, to permit gathering of similar information about all the other out-patient, emergency, and day-care services.

The Medical Consultation Division has the responsibility for both the program and eligibility status of extended-care patients. The Central Registry for long-term care applications is continuing to develop and will become better co-ordinated with Community Health Programs. During the year, new units for extended care were established at Abbotsford and Grand Forks; the Aberdeen and Fellburn Private Hospitals came under coverage; a unit at Kitimat and the Memorial Pavilion, Royal Jubilee Hospital, were designated for extended care; a number of small extended-care "holding units" were established within community hospitals throughout the Province. These institutions receive a regular quarterly review by a special multi-disciplinary team. This latter function emphasizes a consultative review of the hospitals to assist in establishing optimal patient programs. During the year, "teach in" at Comox, involving all the long-term care consultants, was highly successful and may be offered to other units in the coming year. The review also permits an individual audit to establish the need and eligibility for continuing care. The shortage of beds in intermediate care continues to hamper the placement of patients upgraded to this type of care in the extended-care system. Early in 1975 a policy of short-term admission of extended-care patients was established, supporting and encouraging relatives who wish to continue to take care of extended-care patients in their own homes, but who require occasional holiday or other relief.

During 1975 the Medical Consultation Division continued to have the responsibility of determining eligibility of the applicants for admission to the 663 beds in the five designated intermediate care homes in the Province. These homes are visited at least quarterly to contribute to the development of an intermediate care program in the unit and, secondly, to assess continued eligibility of the residents. A weighted scale of mental health and social factors, to amplify the present Province-wide and portable eligibility criteria, was being developed.

The development of an intermediate care program has proven an interesting challenge. Intermediate care patients who are mentally and emotionally handicapped people are no longer inevitably consigned to mental institutions but may be cared for in community facilities. Division Consultants held formal and informal teaching sessions and instruction in various aspects of intermediate care in an effort to improve the understanding of the philosophy and practice of a good intermediate care program. They enjoyed good co-operation from the units in a joint endeavour in this relatively new field of providing care, based on a home, rather than hospital, model.

ADMINISTRATIVE SERVICES DIVISION

The Division provides a variety of administrative services to the other divisions of Hospital Programs and to outside agencies. These services include the following:

Administration

The personnel function, including payroll, recruitment, promotion, and labour relations matters.

The review of requisitions and vouchers for all divisions, including travel expenses and requisitions for supplies and equipment.

The receipt and deposit of all incoming cheques.

The handling and distribution of all hospital forms and the sorting and distribution of mail.

The co-ordination of the preparation of the annual estimates for Hospital Programs.

The publication of the Hospital Programs *Bulletin.*

The preparation and distribution of information pamphlets for Hospital Programs.

Legislation

The drafting of legislation, regulations, and Orders in Council related to the various statutes administered by Hospital Programs. In the performance of these duties the Division works closely with the Attorney-General's Department. Statutes which relate to the division's activities include

- *Hospital Act;*
- *Hospital Insurance Act;*
- *Regional Hospital Districts Act;*
- *British Columbia Regional Hospital Districts Financing Authority Act;*
- *Medical Centre of British Columbia Act.*

Hospital Societies

The provision of assistance to hospital societies in connection with the drafting of hospital constitutions and by-laws and their interpretation and application.

The review of hospital by-laws or amendments to hospital by-laws prior to their submission for Government approval as required under the *Hospital Act.*

The processing, in collaboration with the Hospital Consultation and Inspection Division, of transfers of private hospital property and transfers of shares in the capital stock of private hospital corporations.

The co-ordinating of the acquisition and disposal of hospital sites and private hospitals and associated problems connected therewith.

In conjunction with the Land Registry Office, control over the property of hospitals and private hospitals to ensure that the property records are suitably endorsed so that land transfers may not be made until they are approved under the *Hospital Act.*

Federal-Provincial Hospital Arrangements

The drafting and processing of the necessary amendments to the Federal-Provincial Agreement and associated matters.

Regional Hospital Districts

In conjunction with officials of other divisions, other Government departments, and the various regional hospital districts, the Division assists in processing capital

expense proposals and in arranging for the necessary by-laws and Orders in Council for temporary borrowings and related matters.

ELIGIBILITY

The review of all applications for benefits made by or on behalf of persons admitted to hospitals.

The maintenance of uniform standards of eligibility in all hospitals and the provision of assistance to hospitals in training admitting staff.

The handling of applications to the Health Insurance Supplementary Fund.

THIRD-PARTY LIABILITY

The review of all hospitalization reports for patients admitted to hospitals with accidental injuries.

The processing and verification of the reimbursement from public liability companies for hospital expenses paid on behalf of accident victims.

The Division was involved with the purchase of two private hospitals during 1975, namely, Aberdeen Private Hospital, in Victoria, and Fellburn Private Hospital, in Vancouver. Following the purchase of these hospitals, arrangements were concluded to lease the buildings and turn over the operations of the hospitals to nonprofit hospital societies. At the year-end the purchase of the Priory property in Colwood was under way.

As the year drew to a close, the Division, in conjunction with the Finance Division and members of the Federal Department of Health, were reviewing the Federal-Provincial cost-sharing agreement in an effort to streamline it.

APPROVED HOSPITALS

Hospitals as Defined Under the Hospital Insurance Act Designated by Order in Council 1391/1958, Effective July 1, 1958 (Revised to June 12, 1975)

PART I

Hospitals defined as such under section 2 of the *Hospital Act:*

(A) PUBLIC HOSPITALS

Armstrong and Spallumcheen Hospital, Armstrong.
Arrow Lakes Hospital, Nakusp.
Ashcroft and District General Hospital, Ashcroft.
Bella Coola General Hospital, Bella Coola.
Boundary Hospital, Grand Forks.
British Columbia Cancer Institute of the Cancer Control Agency of British Columbia, 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.
Dawson Creek and District Hospital, Dawson Creek.
Dr. Helmcken Memorial Hospital, Clearwater.
Enderby and District Memorial Hospital, Enderby.
Fernie Memorial Hospital, Fernie.
Fort Nelson General Hospital, Fort Nelson.
Fort St. John General Hospital, Fort St. John.
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.

(A) PUBLIC HOSPITALS—*Continued*

Kitimat General Hospital, Kitimat.
Kootenay Lake District Hospital, Nelson.
Lady Minto Gulf Islands Hospital, Ganges.
Ladysmith and District General Hospital, Ladysmith.
Langley Memorial Hospital, Langley.
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, The, Rossland.
Matsqui-Sumas-Abbotsford General Hospital, Abbotsford.
Michel-Natal District Hospital, Sparwood.
Mills Memorial Hospital, Terrace.
Mission Memorial Hospital, Mission City.
Mount Saint 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 Regional Hospital, Penticton.
Port Alice Hospital, Port Alice.
Port Hardy Hospital, Port Hardy.
Pouce Coupe Community Hospital, Pouce Coupe.
Powell River General Hospital, Powell River.
Prince George Regional Hospital, Prince George.
Prince Rupert Regional Hospital, Prince Rupert.
Princeton General Hospital, Princeton.
Queen Alexandra Hospital for 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's General Hospital, Comox.
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.
Shaughnessy Hospital, Vancouver.
Shuswap Lake General Hospital, The, Salmon Arm.
Slocan Community Hospital, New Denver.
South Okanagan General Hospital, Oliver.
Squamish General Hospital, Squamish.
Stewart General Hospital, Stewart.
Stuart Lake Hospital, Fort St. James.
Summerland General Hospital, Summerland.
Surrey Memorial Hospital, North Surrey.
Tahsis Hospital, Tahsis.
Tofino General Hospital, Tofino.
Trail Regional Hospital, Trail.
University Health Service Hospital, University of British Columbia, Vancouver.
University of British Columbia Health Sciences Centre Hospital, Vancouver.
Vancouver General Hospital, Vancouver.
Vernon Jubilee Hospital, Vernon.
Victoria General Hospital, Victoria.
Victorian Hospital, Kaslo.
West Coast General Hospital, Port Alberni.
Windermere District Hospital, Invermere.
Wrinch Memorial Hospital, Hazelton.

(B) 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, Tatla Lake.

(C) FEDERAL HOSPITALS

Canadian Forces Station Hospital Holberg, San Josef.
Canadian Forces Station Hospital Masset, Masset.

PART II

Private hospitals which are defined as such under section 7 of the *Hospital Act,* and with which the Province has entered into an agreement requiring the hospital to furnish the general hospital services provided under the *Hospital Insurance Act:*

Cassiar Asbestos Corporation Private Hospital, Cassiar.
*Hollywood Hospital Ltd., New Westminster.
Mica Creek Private Hospital, Mica Creek.

* Closed July 18, 1975.

PART III

REHABILITATION HOSPITALS

(Hospital Act, Sec. 25)

G. F. Strong Rehabilitation Centre, Vancouver.
Gorge Road Hospital, The, Victoria.
Holy Family Hospital, Vancouver.
Pearson Hospital (Poliomyelitis Pavilion), Vancouver.
Queen Alexandra Hospital for Children, Victoria.
Shaughnessy Hospital, Vancouver.
Sunny Hill Hospital for Children, Vancouver.

PART IV

EXTENDED-CARE HOSPITALS

(Hospital Act, Sec. 25)

Aberdeen Hospital, Victoria (excluding the lower floor area).
Fellburn Hospital, Burnaby.
Glengarry Hospital, Victoria.
Louis Brier Hospital, The, Vancouver.
Menno Hospital, Abbotsford.
Mount St. Francis Hospital, Nelson.
Mount St. Joseph Hospital, Vancouver (top floor).
Mount St. Mary Hospital, Victoria (excluding top floor).
Mount Tolmie Hospital, Victoria.
Pearson Hospital, Vancouver (excluding facilities for tuberculosis patients).
Priory Hospital, Colwood (24-bed unit and 71-bed unit).
Saanich Peninsula Hospital, Saanichton.

PART V

DIAGNOSTIC AND TREATMENT CENTRES

Arthritis Centre of British Columbia, The, Vancouver.
Cumberland General Hospital, Cumberland.
Gold River Health Clinic, Gold River.
Houston Hospital, Houston.

STATISTICAL DATA

The tables as shown on the following pages represent statistical data compiled by the Hospital Finance Division. The data show the extent of hospital coverage provided to the people of British Columbia through the British Columbia Hospital Programs service.

In 1975 there were 104 public general hospitals, as well as three diagnostic and treatment centres, approved to accept British Columbia Hospital Programs patients. Additional care was also provided by six Red Cross outpost hospitals, two Federal hospitals, three contract hospitals, five public rehabilitation hospitals, plus one rehabilitation hospital operated by the Provincial Government.

Two specialized out-patient facilities, the Canadian Arthritic Society at their Vancouver Centre, and the Narcotic Addiction Foundation, provided services in several facilities throughout the Province. Hospital coverage for patients in the nonprofit extended-care hospitals and units commenced December 1, 1965, and by the end of 1975 had increased to 52 extended-care hospitals, which includes one hospital operated by the Provincial Government.

Data for the year 1975 have been estimated, based on reports submitted by hospitals to September 30, 1975, and are subject to minor revision when the actual figures for the year are submitted.

Table 18 shows that 405,598 adult and child patients were discharged (separated) from British Columbia public hospitals in 1975, an increase of 11,091 or 2.8 per cent over 1974. This table also shows that 95.7 per cent of the total adult and children patients discharged (separated) from British Columbia public

hospitals were covered by Hospital Programs compared to 95.6 per cent in 1974. Table 19 indicates that in 1975 Hospital Programs service paid public hospitals in British Columbia for 3,472,971 days of care for adults and children, an increase of 72,098 days or 2.1 per cent more than in 1974. As shown in Table 20, the average length of stay for adult and child patients in British Columbia public hospitals during 1975 was 8.56 days and the days of care per thousand population were 1,421. These figures, which show a continuation of the trend of decreased length of stay, are a result of a more effective utilization of hospital beds and ambulatory services. For comparison purposes, the data for extended-care hospitals are not included in the above observations, although an additional 581 days of care per thousand population were provided for these patients.

Table 21 is supplemented by Table 22 because the number and volume of ambulatory services covered by Hospital Programs have been expanded considerably. It should be noted that psychiatric and diabetic day-care services are provided only in a limited number of hospitals. Services listed under "Other" are related to special out-patient services provided by the Cancer Control Agency of B.C., G. F. Strong Rehabilitation Centre, and the Narcotic Addiction Foundation. The growth of ambulatory services reflects a trend toward the broader provision of hospital-based services, providing greater patient convenience and reducing the pressure for construction and maintenance of in-patient beds, which is partially reflected by the reduction in incidence of patient-days noted above.

Table 18—Patients Separated and Proportion Covered by Hospital Programs, British Columbia Public General Hospitals[1] Only (Excluding Federal, Private, Extended-care, and Out-of-Province Hospitalization)

	Total Hospitalized in Public Hospitals			Covered by Hospital Programs		
	Adults and Children	New-born	Total	Adults and Children	New-born	Total
Patients separated—						
1970	371,266	36,931	408,197	355,499	35,047	390,496
1971	380,651	35,101	415,752	364,452	33,732	398,184
1972	391,732	34,774	426,506	375,373	33,595	408,968
1973	395,120	34,544	429,664	377,719	33,599	411,318
1974[2]	412,500	35,566	448,066	394,507	34,665	429,172
1975[3]	424,004	37,293	461,297	405,598	36,423	442,021
Percentage of total, patients separated—						
1970	.....	.....	.....	95.7	94.9	95.7
1971	.....	.....	.....	95.7	96.1	95.8
1972	.....	.....	.....	95.8	96.6	95.9
1973	.....	.....	.....	95.6	97.3	95.7
1974[2]	.....	.....	.....	95.6	97.5	95.8
1975[3]	.....	.....	.....	95.7	97.7	95.8

[1] Includes rehabilitation hospitals.
[2] Amended as per final report received from hospitals.
[3] Estimated, based on hospital reports to September 30, 1975.

Table 19—Total Patient-days and Proportion Covered by Hospital Programs, British Columbia Public General Hospitals[1] Only (Excluding Federal, Private, Extended-care, and Out-of-Province Hospitalization)

	Total Hospitalized in Public Hospitals			Covered by Hospital Programs		
	Adults and Children	New-born	Total	Adults and Children	New-born	Total
Patients separated—						
1970	3,384,586	253,081	3,637,667	3,233,553	238,049	3,471,602
1971	3,400,366	227,372	3,627,738	3,259,097	216,305	3,475,402
1972	3,462,509	219,158	3,681,667	3,323,252	210,764	3,534,106
1973	3,400,453	214,003	3,614,456	3,257,106	206,178	3,463,284
1974[2]	3,582,774	213,439	3,796,213	3,400,873	206,376	3,607,249
1975[3]	3,624,750	220,182	3,844,923	3,472,971	213,698	3,686,698
Percentage of total, patient-days—						
1970	.....	.....	.....	94.5	94.1	94.5
1971	.....	.....	.....	95.8	95.1	95.8
1972	.....	.....	.....	96.0	96.2	96.0
1973	.....	.....	.....	95.8	96.3	95.8
1974[2]	.....	.....	.....	94.9	96.7	95.0
1975[3]	.....	.....	.....	95.8	97.1	95.9

[1] Includes rehabilitation hospitals.
[2] Amended as per final report received from hospitals.
[3] Estimated, based on hospital reports to September 30, 1975.

Table 20—Patients Separated, Total Patient-days, and Average Length of Stay According to Type and Location of Hospital for Hospital Programs Patients Only, and Days of Care per Thousand Covered Population

	Total (Excluding Extended Care)		B.C. Public Hospitals		Other B.C. Hospitals, Including Federal and Private		Institutions Outside British Columbia		Extended-care Hospitals
	Adults and Children	New-born	Adults and Children	New-born	Adults and Children	New-born	Adults and Children	New-born	
Patients separated—									
1970	369,210	35,431	355,449	35,047	8,307	87	5,454	297	1,022
1971	379,144	34,192	364,452	33,732	8,654	109	6,038	351	1,495
1972	388,747	33,878	375,373	33,595	8,140	39	5,234	244	1,822
1973	392,550	33,962	377,719	33,599	8,092	34	6,739	329	2,293
1974[1]	404,271	34,979	394,507	34,665	3,572	78	6,190	237	2,449
1975[2]	413,254	36,757	405,598	36,423	1,456	59	6,200	275	3,059
Patient-days—									
1970	3,465,504	240,657	3,233,553	238,049	176,086	450	55,865	2,158	531,808
1971	3,486,671	218,971	3,259,097	216,305	167,339	442	60,235	3,224	672,099
1972	3,543,587	212,549	3,323,252	210,764	168,950	264	51,385	1,521	817,321
1973	3,474,733	208,154	3,257,106	206,178	155,150	172	62,477	2,164	1,044,529
1974[1]	3,565,198	208,224	3,400,873	206,376	103,064	464	61,261	1,384	1,227,949
1975[2]	3,549,882	215,648	3,472,971	213,698	15,911	300	61,000	1,650	1,428,080
Average days of stay—									
1970	9.39	6.79	9.10	6.79	21.20	5.34	10.24	7.27	520.36
1971	9.20	6.40	8.94	6.41	19.34	4.06	9.98	6.34	449.56
1972	9.12	6.27	8.85	6.27	20.76	6.77	9.82	6.23	448.58
1973	8.85	6.14	8.62	6.14	19.17	5.06	9.27	6.58	455.53
1974[1]	8.81	5.95	8.62	5.95	28.85	5.95	9.90	5.84	501.41
1975[2]	8.59	5.87	8.56	5.87	10.93	5.08	9.84	6.00	466.85

[1] Amended as per final reports from hospitals.
[2] Estimated, based on hospital reports to September 30, 1975. Estimated patient-days (including newborn days) per thousand of population covered by Hospital Programs: 1970, 1,734; 1971, 1,696; 1972, 1,669; 1973, 1,600; 1974, 1,531; 1975, 1,421. (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 of extended care amounted to 308 in 1971, 372 in 1972, 454 in 1973, 502 in 1974, and 584 in 1975. Population figures are revised according to latest census figures.

Table 21—Summary of the Number of Hospital Programs 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
1970	405,663	235,000	640,663
1971	414,831	292,850	707,681
1972	424,447	453,589	878,036
1973	428,805	792,367	1,221,172
1974[1]	441,699	1,045,460	1,487,159
1975[2]	453,070	1,256,325	1,709,395

[1] Amended as per final reports received from hospitals.
[2] Estimated, based on hospitals reports to September 30, 1975.

Table 22—Summary of Hospital Programs Out-patient Treatments by Category, 1971–75, Inclusive

	1971	1972	1973	1974	1975
Psychiatry—					
Out-patient	5,012	7,955	8,943	12,771	16,800
Day care	7,536	8,131	9,277	19,737	33,000
Minor and emergency	191,113	267,203	408,925	503,492	638,000
Day-care surgery	40,289	44,633	50,089	55,920	61,000
Diabetic day-care[1]	.....	167	885	1,493	2,200
Physiotherapy[2]	.....	.....	162,997	296,863	338,000
Dietetic counselling[3]	.....	.....	.....	.....	1,900
Other[4]	48,900	125,500	151,251	155,184	165,425
	292,850	453,589	792,367	1,045,460	1,256,325

[1] Commenced October 1972. [2] Commenced April 1973. [3] Commenced January 1975.
[4] Other includes (*a*) cancer out-patients, (*b*) rehabilitation day-care, (*c*) narcotic addiction out-patients (1972–75 only).

Table 23—Patients Separated, Total Days Stay, and Average Length of Stay in British Columbia Public Hospitals for Hospital Programs Patients Only, Grouped According to Bed Capacity, 1975[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	405,598	225,690	107,518	33,797	28,469	10,124
Newborn	36,423	17,296	10,981	5,049	2,140	957
Patient-days—						
Adults and children	3,472,971	2,035,632	833,662	349,715	198,282	55,680
Newborn	213,698	108,083	60,737	29,422	11,179	4,277
Average days stay—						
Adults and children	8.56	9.02	8.22	10.35	6.96	5.50
Newborn	5.87	6.25	5.53	5.83	5.22	4.47

[1] Estimated, based on hospitals' reports to September 30, 1975.

Table 24—Percentage Distribution of Patients Separated and Patient-days for Hospital Programs Patients Only, in British Columbia Public Hospitals, Grouped According to Bed Capacity, 1975[1] *(Excluding Extended-care Hospitals)*

	Bed Capacity					
	Total	250 and Over	100 to 249	50 to 99	25 to 49	Under 25
Patients separated—	Per Cent	Per Cent	Per Cent	Per Cent	Per Cent	Per Cent
Adults and children	100.0	55.64	26.51	8.33	7.02	2.50
Newborn	100.0	47.49	30.15	13.86	5.88	2.62
Patient-days—						
Adults and children	100.0	58.61	24.01	10.07	5.71	1.60
Newborn	100.0	50.58	28.42	13.77	5.23	2.00

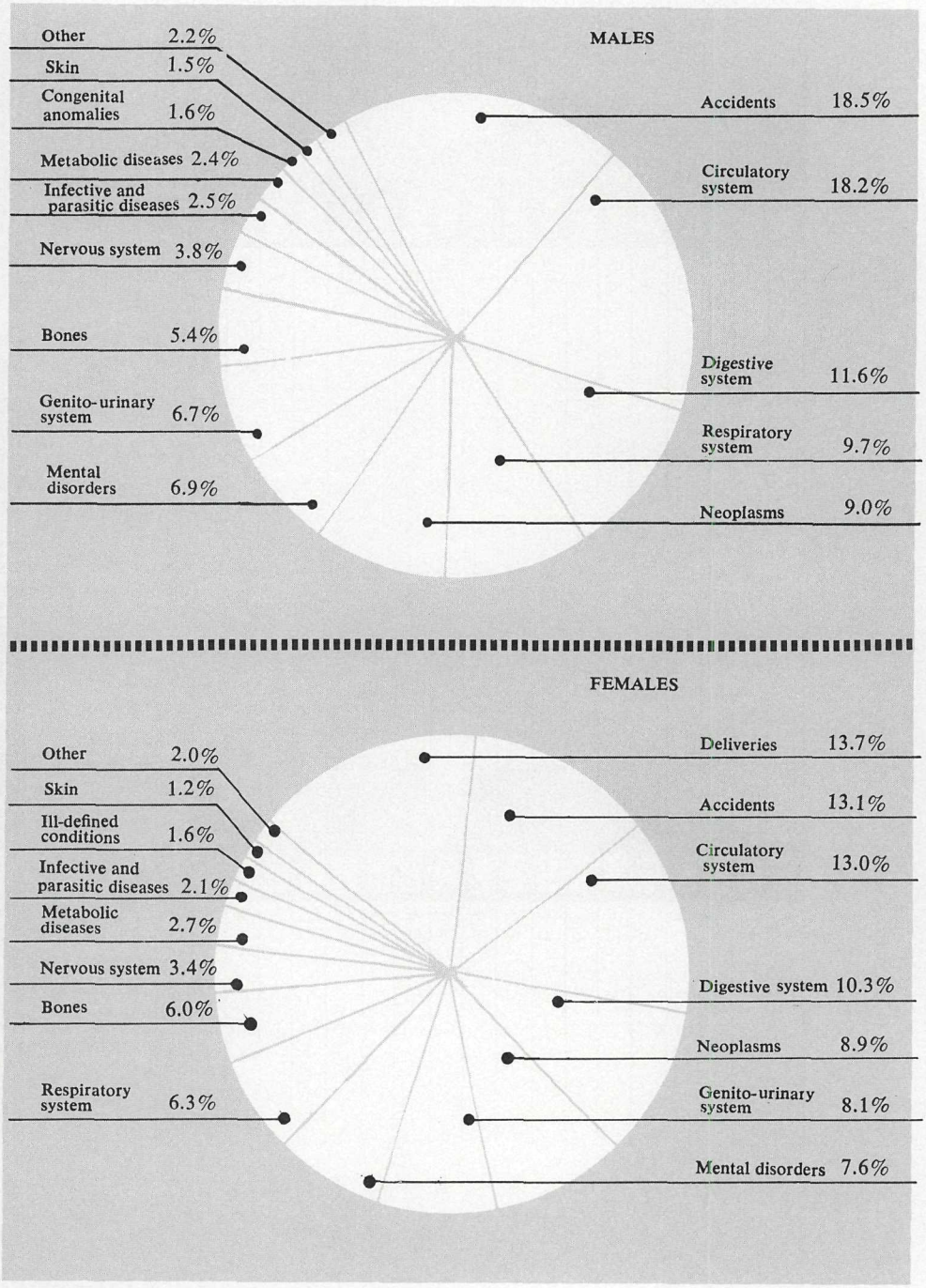
[1] Estimated, based on hospitals' reports to September 30, 1975.

CHARTS

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

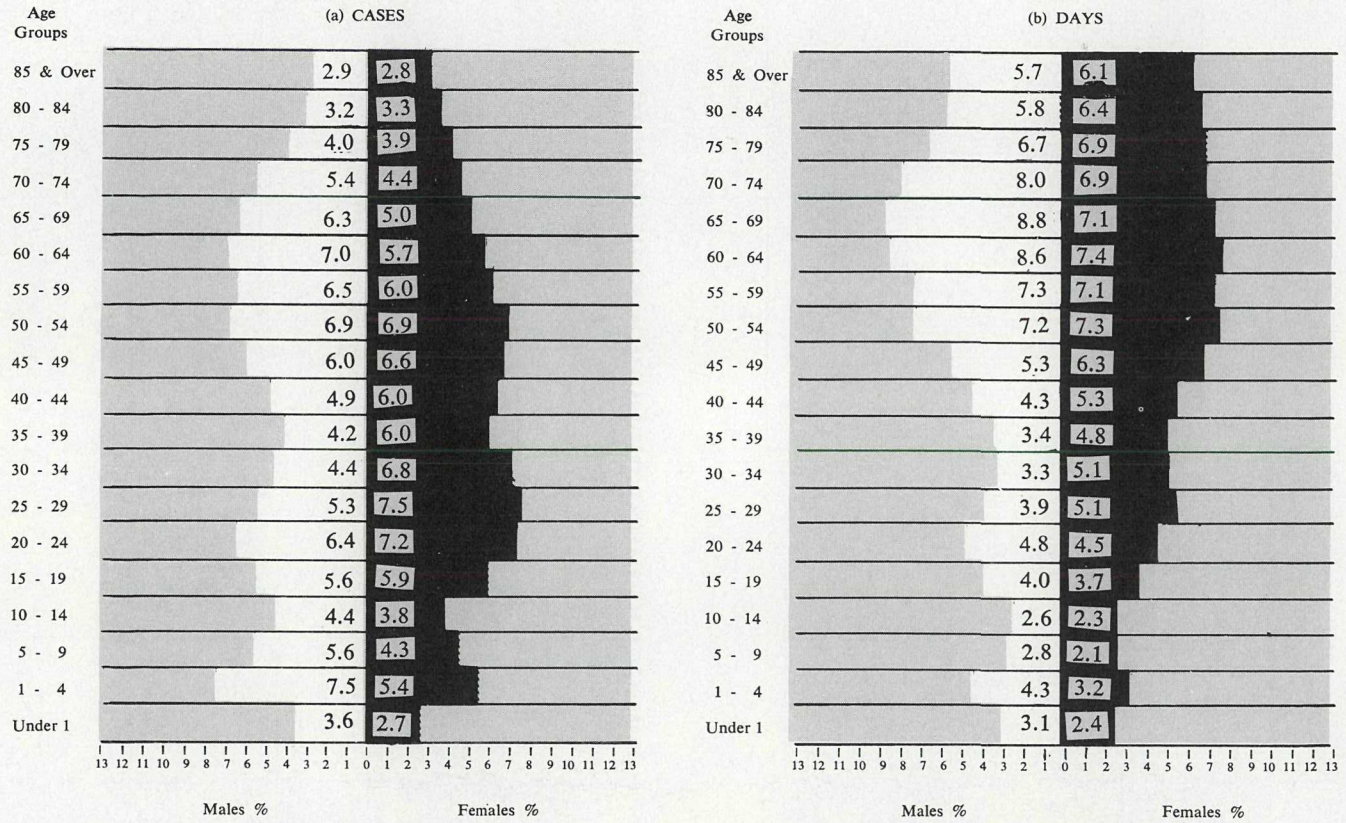
Readers interested in more detailed statistics of hospitalization in this Province may wish to refer to "Statistics of Hospital Cases Discharges During 1974" and "Statistics of Hospitalized Accident Cases, 1974," available from the Research Division.

CHART I—PERCENTAGE DISTRIBUTION OF DAYS OF CARE* BY MAJOR DIAGNOSTIC GROUPS, HOSPITAL PROGRAMS, 1974 (IN DESCENDING ORDER)



* Including rehabilitative care.

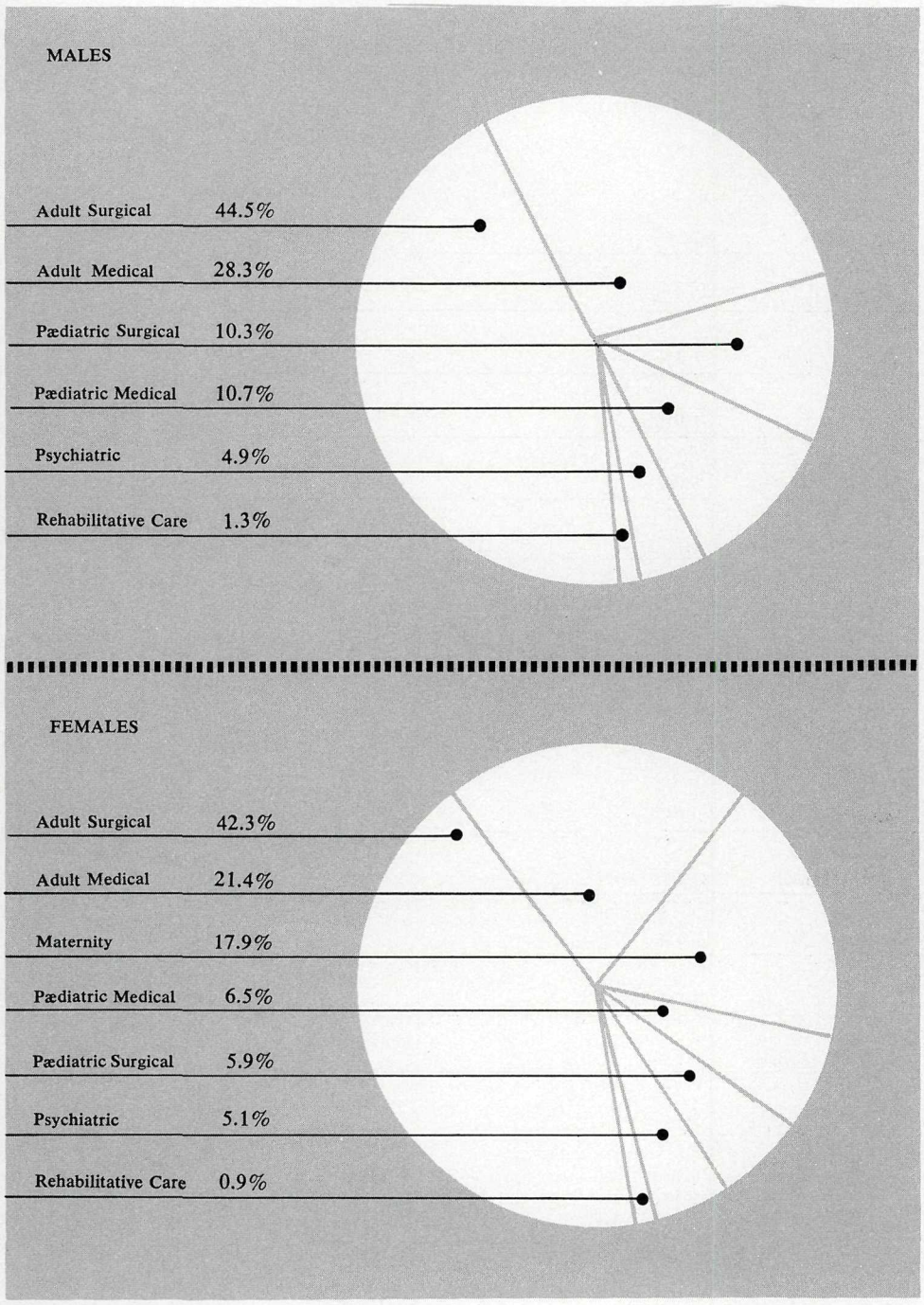
CHART II—PERCENTAGE AGE DISTRIBUTION OF MALE AND FEMALE* HOSPITAL CASES AND DAYS OF CARE,† HOSPITAL PROGRAMS, 1974



* Group XI (Deliveries and Complications of Pregnancy, Childbirth, and 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.

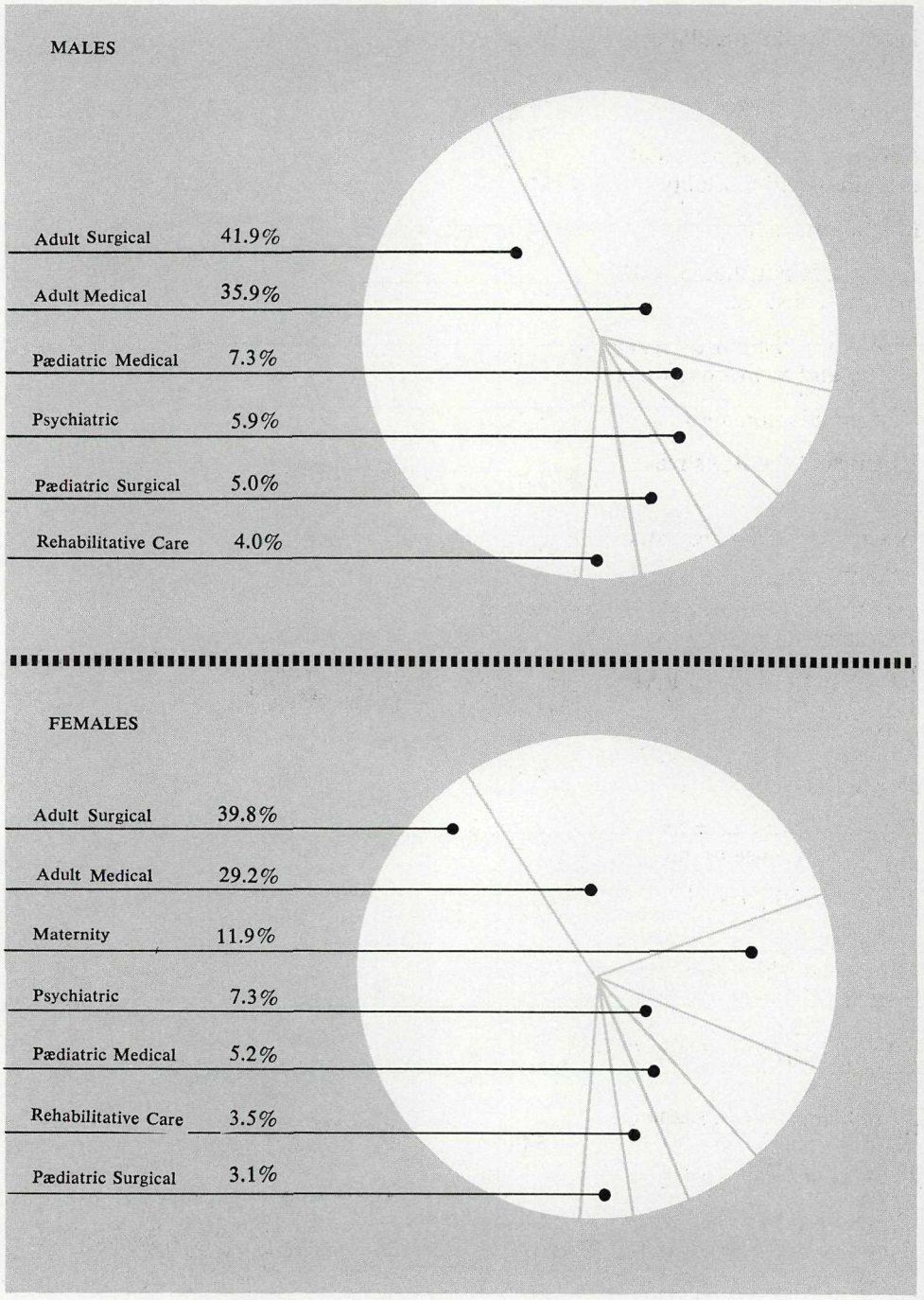
† Including rehabilitative care.

CHART III—PERCENTAGE DISTRIBUTION OF HOSPITAL CASES* BY TYPE OF CLINICAL SERVICE, HOSPITAL PROGRAMS, 1974



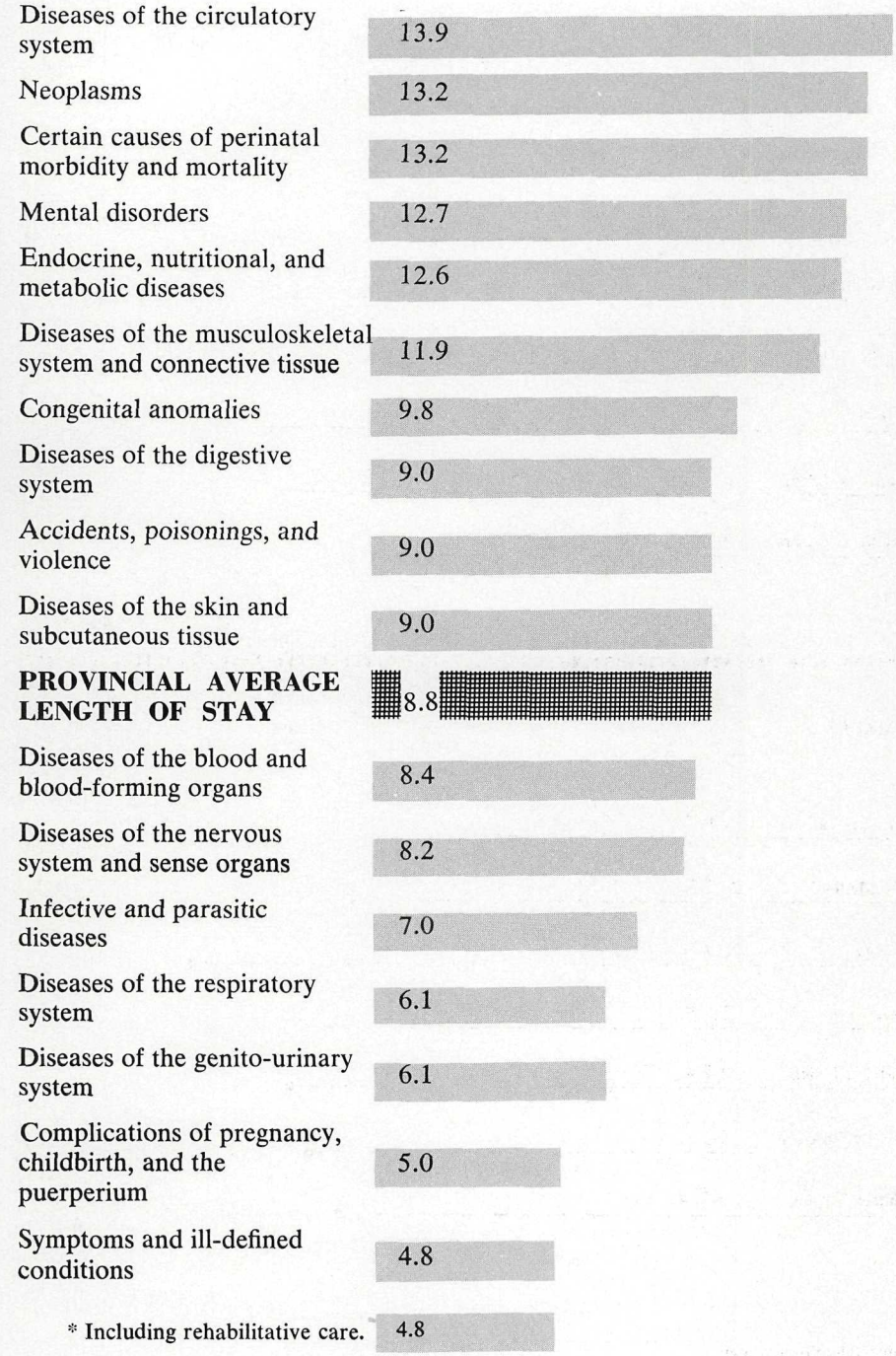
* Including rehabilitative care.

CHART IV—PERCENTAGE DISTRIBUTION OF HOSPITAL DAYS* BY TYPE OF CLINICAL SERVICE, HOSPITAL PROGRAMS, 1974



* Including rehabilitative care.

CHART V—AVERAGE LENGTH OF STAY OF CASES* IN HOSPITALS IN BRITISH COLUMBIA, BY MAJOR DIAGNOSTIC GROUPS IN DESCENDING ORDER, HOSPITAL PROGRAMS, 1974 (EXCLUDING NEWBORNS)



* Including rehabilitative care.

MEDICAL SERVICES COMMISSION

Medical Services Commission

On July 1, 1968, the Government established an over-all Medical Services Plan, which is administered and operated on a nonprofit basis in accordance with the *Medical Services Act* and regulations, under the supervision of the Medical Services Commission. The Commission is empowered to function as the public authority appointed by the Government of the Province to be responsible to the Minister in respect of the administration and operation of the Plan established under the regulations.

The Medical Services Plan of British Columbia provides a prepaid medical services plan upon uniform terms and conditions for all residents of the Province and their dependants. Insured services under the Plan are paid for insured persons regardless of age, state of health, or financial circumstances, provided the premiums fixed by the Commission are paid. Payment of these services is made, on a fee for services basis, according to a tariff of fees approved or prescribed by the Commission, or by salaried, sessional, or contract basis at levels approved by the Commission.

BENEFITS UNDER THE PLAN

BASIC MEDICAL SERVICES

The Medical Services Plan provides insurance coverage for all medically required services rendered by medical practitioners, including osteopathic physicians in British Columbia and certain surgical procedures of dental surgeons where necessarily performed in a hospital as provided under the *Medical Care Act* of Canada. A contribution from the Federal Government is payable to the Province toward the cost of these insured services on the basis of 50 per cent of the national *per capita* cost of these services multiplied by the average number of insured persons in the Province during the 12-month period ending on the 31st day of March.

ADDITIONAL BENEFITS

In addition to payment for the above services, additional benefits, when rendered in the Province, are provided without extra premium by the Government of British Columbia. The Federal Government does not share in these costs. All payments are paid only at a tariff of fees approved by the Commission. "Year" means calendar year. A brief description of these additional benefits follows, for exact details *see* the Medical Services Act Regulations.

1. *Chiropractic*—Payment for the services of a registered chiropractor is limited in any one year to a total of $75 per patient under the age of 65 years and $100 per patient 65 years of age or over. No payment for X-rays taken by a chiropractor; no payment for a chiropractic service performed outside the Province.

2. *Naturopathic*—Payment for services of a naturopathic physician is limited in any one year to a total of $75 per patient under the age of 65 years and $100 per patient 65 years of age or over. No payment for X-rays taken by a naturopathic physician; no payment for any naturopathic services performed outside the Province.

3. *Orthoptic treatment*—Up to a limit of $50 per patient in any one year and a maximum of $100 per family in any one year, services for orthoptic treatments when rendered in the Province of British Columbia to an insured person on the instructions of, or referral by a medical practitioner, shall be paid under the Plan at a tariff of fees approved by the Commission, but there shall be no payment for such services performed outside the Province of British Columbia.

4. *Physiotherapy*—Payment for the services of a registered physiotherapist on the instructions of, or referral by, a medical practitioner where performed other than in general or rehabilitative hospitals, is limited in any one year to a total of $75 per patient under the age of 65 years and $100 per patient 65 years of age or over. No payment for any physiotherapy services performed outside the Province.

IMPORTANT—Out-patient physiotherapy services in general hospitals or in rehabilitative hospitals on referral by a medical practitioner are benefits provided by the British Columbia Hospital Programs.

5. *Podiatry*—Payment for services of a registered podiatrist is limited to $50 per patient in any one year and a maximum of $100 per family in any one year when rendered other than on the instructions of, or referral by, a medical practitioner within the year. No payment for X-rays taken by a podiatrist; no payment for any services performed outside the Province.

6. *Optometry*—Services of registered optometrists are approved for required diagnostic optometric services to determine the presence of any observed abnormality in the visual system. There is no payment for any service performed outside the Province of British Columbia by an optometrist. The Plan does not pay for the fitting or cost of lenses.

7. *Orthodontic*—Service provided by a dental surgeon for an insured person 20 years of age or younger and which is consequentially necessary in the care of a cleft lip and (or) cleft palate is paid only where that service arises as part of or following plastic surgery repair performed by a medical practitioner. There is no payment for orthodontic services provided outside the Province. There is no payment for dentures, appliances, prostheses, or for general dental services.

8. *Special nursing*—Special nursing services of a registered nurse shall be paid, including the cost of board, to a maximum of $40 per patient in any one year, but only where such services are deemed advisable by a medical practitioner. There shall be no payment for such services performed outside the Province of British Columbia.

9. *Victorian Order of Nurses*—The services of a member of the Victorian Order of Nurses, acting under or with an attending medical practitioner, shall be paid under the Plan at a rate of $2 net per visit to a maximum of $40 per patient per year, but this limit will not apply to the administering of injections on the instructions of a physician. There shall be no payment for any service performed outside the Province of British Columbia by a member of the Victorian Order of Nurses.

SERVICES EXCLUDED UNDER THE PLAN

1. Services which are provided under other Federal or Provincial Acts such as the *National Defence Act* of Canada, the *Hospital Insurance Act,* and the *Workers' Compensation Act* of the Province.

2. Pathology, radiology, and (or) electrodiagnostic services performed within the Province at a laboratory that, at the time the service is rendered, is not an approved laboratory for the performance of the service.

3. Services which are not considered to be medically required by the patient, e.g., cosmetic services, examinations at the request of a third party, medico-legal services, advice by telephone, travel charges of a practitioner.

4. While unexpected medical services arising when an insured person is temporarily absent from British Columbia are covered at British Columbia rates, prior authorization in writing from a Medical Director of the Plan is required where the insured person elects to seek medical attention outside the Province, otherwise payment may not be made under the Plan.

PREMIUM RATES AND ASSISTANCE

For those persons having maintained a permanent residence in British Columbia for the 12 consecutive months immediately prior to making application, and who otherwise qualify as eligible under the Medical Services Act Regulations, premium assistance under the *Medical Services Act* is available as follows:

- Applicants who were not liable to pay income tax in the 12 months ending December 31 of the previous year qualify for a subsidy of 90 per cent of the full premium rate.

- Applicants whose taxable income in the 12 months ending December 31 of the previous year did not exceed $1,000 qualify for a subsidy of 50 per cent of the full premium rates.

  Monthly premiums payable by subscribers are as follows:

	Full Premium	If Qualified for— 50 per cent Subsidy	90 per cent Subsidy
	$	$	$
One person	5.00	2.50	0.50
Family of two	10.00	5.00	1.00
Family of three or more	12.50	6.25	1.25

- Temporary premium assistance is available for a three-month period under unusual circumstances which by reason of illness, disability, unemployment, or financial hardship render an eligible person unable to pay his currently required premiums for coverage under the Plan. Temporary premium assistance is at 90 per cent of the full premium rate.

LABORATORY APPROVAL

A six-member Advisory Board on Laboratories, appointed by the Commission, continues to provide advice and recommendations to the Commission pertinent to its determination of approval of laboratories for the performance of insured services under the regulations set down by the Lieutenant-Governor in Council in September 1971. The Commission is responsible for ensuring the reasonable availability of quality laboratory services for insured persons throughout the Province, of controlling the expansion of facilities or provision of new facilities until there is reasonable utilization of existing facilities, and of requiring that, where approved public facilities provide service of equal quality and availability, priority consideration be given to the services provided by such approved public facilities.

PROFESSIONAL REVIEW COMMITTEES

As in the past, the Commission has continued to work closely with the peer review committees of physicians and other practitioners providing services under the Plan.

The Commission provides data to the professional licensing authorities or other relevant practitioner bodies with respect to the volume and type of services rendered under the Plan, and various other statistical information on an annual basis, whenever feasible. The Commission also provides various statistical information to them on a request basis.

SALARIED AND SESSIONAL

While most medical services in British Columbia are paid for on a fee-for-service basis, there is, nevertheless, a substantial volume of services paid on a salary or sessional fee basis.

Apart from the Provincial Government, which employs physicians in this way, there are many other organizations within the Province which make arrangements

with physicians to provide insured services on this basis and arrange with the Medical Services Commission for reimbursements of their costs.

When the Medical Services Commission reimburses an organization which employs a doctor performing insured services on a salaried basis, a payment is made to the organization for the shareable portion of the doctor's salary, that is, the proportion of the salary which represents the time he spent on providing insured services to individuals. An additional amount is paid to cover the relevant overhead costs of the organization employing the doctor. A sessional fee is a payment of a set amount of money for the services of a physician for half a day (three and one-half hours) and the sessional fee includes, where pertinent, a payment for overhead, which goes to the physician because of his continuing overhead costs in this additional private practice.

In the year 1974/75 the total expenditure on medical services by the Medical Services Commission was $211,966,988, which was made up of $201,757,831 in the form of fee-for-service payments and $10,209,157 for salary and sessional payments.

SUBSCRIBER STATISTICS

For detailed statistical tables *see* Annual Report of the Medical Services Commission for the Year Ended March 31, 1975.

Table 25—Registration and Persons Covered[1] by Premium Subsidy Level, Medical Services Plan, at March 31, 1975

Subsidy (Per Cent)	Subscribers[2]	Persons[2]
90	224,476	367,672
50	28,138	52,768
Nil	793,405	2,022,560
Totals	1,046,019	2,443,000

[1] Coverage data do not include members of the Canadian Armed Forces, RCMP, and inmates of Federal penitentiaries.

[2] Subscriber data have been adjusted to agree with the population statistics of the Dominion Bureau of Statistics and are not comparable to those published in the previous Annual Report.

Table 26—Persons covered[1] by Age-group, Medical Services Plan, at March 31, 1975

Age-groups	Persons[2]
Under 1	29,560
1–4	149,267
5–14	440,473
15–24	473,453
25–44	637,623
45–64	468,079
65–69	78,420
70–79	98,209
80–89	44,951
90 and over	7,573
Unknown	15,392
Total	2,443,000

[1] Coverage data do not include members of the Canadian Armed Forces, RCMP, and inmates of Federal penitentiaries.

[2] Subscriber data have been adjusted to agree with the population statistics of the Dominion Bureau of Statistics and are not comparable to those published in the previous Annual Report.

Table 27—Distribution of Fee for Service Payments for Medical Services (Shareable)[1], Medical Services Plan, 1973/74 and 1974/75

Specialty	Amount Paid		Per Cent of Total		Cost per Person[2]	
	1973/74	1974/75	1973/74	1974/75	1973/74[3]	1974/75
	$	$			$	$
General practice	67,487,760	82,177,788	43.59	43.44	28.9647	34.1270
Dermatology	1,575,525	1,967,399	1.02	1.04	0.6762	0.8170
Neurology	1,202,646	1,330,210	0.78	0.70	0.5162	0.5524
Psychiatry	4,662,309	5,707,746	3.01	3.02	2.0010	2.3703
Neurology and psychiatry	167,264	196,666	0.11	0.10	0.0718	0.0817
Obstetrics and gynæcology	6,052,637	7,040,645	3.91	3.72	2.5977	2.9239
Opthalmology	6,612,574	7,318,932	3.98	3.87	2.6449	3.0394
Eye, ear, nose, and throat	40,750	79,167	0.03	0.04	0.0173	0.0328
Otolaryncology	2,875,681	3,369,209	1.86	1.78	1.2342	1.3992
General surgery	11,734,262	13,327,682	7.58	7.05	5.0362	5.5348
Neurosurgery	1,046,138	1,113,838	0.68	0.59	0.4490	0.4626
Orthopædic surgery	3,641,230	4,386,095	2.35	2.32	1.5628	1.8215
Plastic surgery	1,130,061	1,329,294	0.73	0.70	0.4850	0.5520
Thoracic surgery	996,843	1,200,697	0.64	0.64	0.4278	0.4986
Urology	2,621,390	3,216,603	1.69	1.70	1.1251	1.3358
Pædiatrics	3,481,484	4,055,096	2.25	2.14	1.4942	1.6840
Internal medicine	9,074,018	11,272,817	5.86	5.96	3.8944	4.6814
Radiology	11,888,791	14,428,831	7.68	7.63	5.1025	5.9920
Pathology	9,229,333	12,957,618	5.96	6.85	3.9611	5.3811
Anæsthesiology	6,412,213	7,371,601	4.14	3.90	2.7520	3.0613
Physical medicine	241,070	308,232	0.16	0.16	0.1035	0.1280
Public Health	85,518	72,989	0.06	0.04	0.0367	0.0303
Dental surgery in hospital	455,552	403,906	0.29	0.21	0.1955	0.1677
Osteopathy	174,539	206,284	0.11	0.11	0.0749	0.0857
Unclassified	2,378,209	4,323,452	1.54	2.29	1.0956	1.7955
Totals	154,817,797	189,162,797	100.00	100.00	66.5203	78.5560

[1] Medical practitioners' and dental surgery services in hospital, shareable under Medical Care Act, Canada, and Hospital Insurance Diagnostic Services Act.

[2] Based on population as at October 1, as provided by the Dominion Bureau of Statistics (October 1, 1973 = 2,330,000; October 1, 1974 = 2,408,000).

[3] Cost per person data for 1973/74 in this Report differ slightly from that given in the 1973/74 Report due to the change in the population base used. The 1973/74 Report of the Medical Services Commission used plan population data; the 1974/75 Report uses Federal population data.

Table 28—Distribution of Fee for Service Payments for Insured Services, Nonshareable[1] Additional Benefits, Medical Services Plan, 1973/74 and 1974/75

Type of Service	Amount Paid[2]		Per Cent of Total		Cost Per Person[3]	
	1973/74	1974/75	1973/74	1974/75	1973/74[4]	1974/75
	$	$			$	$
Special nursing	5,553	4,721	0.07	0.04	0.0024	0.0020
Victorian Order of Nurses	160,451	75,565	1.88	0.69	0.0689	0.0314
Red Cross	14,474	12,798	0.17	0.12	0.0062	0.0053
Chiropractic	3,786,597	5,747,051	44.45	52.17	1.6251	2.3866
Naturopathic	203,400	191,174	2.39	1.74	0.0873	0.0794
Physiotherapy (office)	1,162,967	1,290,244	13.65	11.71	0.4991	0.5358
Physiotherapy (hospital)	157,703	829	1.85	0.01	0.0677	0.0004
Orthoptic	2,720	3,928	0.03	0.04	0.0012	0.0016
Podiatry	899,311	1,014,628	10.56	9.21	0.3860	0.4214
Optometric	2,125,743	2,671,380	24.95	24.25	0.9123	1.1094
Unclassified	107	2,512	0.00	0.02	0.0000	0.0010
	8,519,026	11,014,830	100.00	100.00	3.6562	4.5743

[1] Nonshareable by Federal Government.

[2] These amounts are fee for service payments paid under the Plan only, and in no way reflect the total for the services of these practitioners.

[3] Based on population as at October 1, as provided by the Dominion Bureau of Statistics (October 1973= 2,330,000; October 1974=2,408,000).

[4] Cost per person data for 1973/74 in this Report differ slightly from that given in the 1973/74 Report of the Medical Services Commission due to the change in the population base used. The 1973/74 Report used plan population data; the 1974/75 Report uses Federal population data.

GOVERNMENT HEALTH INSTITUTIONS

GOVERNMENT HEALTH INSTITUTIONS

There will continue to be a need for specialized facilities to accommodate those whose treatment cannot be adequately taken care of through the community-based services. Therefore, the Department of Health also provides assistance in the development of facilities and services for those of the mentally ill, the emotionally disturbed, the senile aged, the tubercular, and the profoundly physically disabled, whose condition requires admission to a specialized treatment facility.

Effective December 1, 1975, a Director of Government Health Institutions was appointed. These institutions comprise Riverview Hospital and Valleyview Hospital (Essondale), Dellview Hospital (Vernon), Pearson Hospital, and the Willow Chest Clinic (Vancouver). A brief report of these facilities follows:

RIVERVIEW HOSPITAL

Riverview Hospital continued as a major component of the Provincial Mental Health Program, and endeavoured to cope with the changing demands made upon it as community services evolved. This was a difficult role for any hospital to fulfil, especially one without adequate facilities and with administrative limitations.

To an increasing degree the hospital served the seriously mentally ill, disabled, and infirm long-term patients, and the acute short-term patients who could not be cared for in general hospital psychiatric wards and other community resources. Therefore, while there was a significant drop in admissions and in the number of patients in residence, there was a marked increase in the level of care required by the individual patient.

Clinical services were well maintained, although there was a shortage of psychiatrists on the staff. This problem could only be countered by placing the responsibility for the admission and medical care of patients on community psychiatrists, wherever this was feasible. In this way the hospital would become one of several options open to the physician in handling his patient. This arrangement was working well in the Fraser Valley region, and would be introduced to the Greater Vancouver area in 1976 and involve the Greater Vancouver Mental Health Service, the psychiatric units in general hospitals, and Riverview Hospital in a co-ordinated delivery system.

In September the Riverside Forensic Unit was placed under the administrative control of the Executive Director of the Forensic Psychiatric Service, and in December operational responsibility was formally assigned to the Commission. The unit would continue as a mental health facility in accordance with the *Mental Health Act,* and the staff would remain as Public Service employees.

In keeping with the general policy to develop and strengthen community-based programs, the Riverview Hospital out-patient service in Vancouver and the Venture and Vista halfway house programs were seconded to the Greater Vancouver Mental Health Service in August in order to augment the community mental health teams and to provide a short-stay hostel for acute cases.

The rehabilitation of patients and preparation for community re-entry continued to be a major emphasis in the mental hospital programs. The Hillside Program, the Brookside Program, and the Home 10 Program were developed specifically for this purpose. The patients who remained in hospital, while fewer in number, had a greater degree of residual disability and required a more prolonged and intensive preparation for community re-entry. Close liaison with the

mental health centres and the community care teams was established to assist these patients in a gradual transition to community living and provide them with the necessary follow-ups in psychiatric care.

The Intensive Care Unit was developed as a specialized program, providing intensive psychiatric care for patients, not only from various parts of Riverview Hospital but also from the psychiatric units of other hospitals such as the Burnaby Mental Health Centre and the Health Sciences Centre Hospital.

The hospital was granted provisional accreditation in the fall of 1974, and during the past year attempted to implement the recommendations of the Canadian Council on Hospital Accreditation. The medical staff by-laws were updated and a number of changes were introduced in accordance with the Council's recommendations. By the year-end all medical staff had been fully registered by the College of Physicians and Surgeons of British Columbia.

The Planning Committee, with broad departmental representation, met regularly to review the current and future function of the hospital. A study to categorize patients according to their need was under way in conjunction with newly developed standards, which would enable a rational plan to be developed for the upgrading, refurbishing, or replacement of the existing buildings.

VALLEYVIEW HOSPITAL

This 726-bed hospital continued to provide service to patients over the age of 70 suffering from mental disorders requiring special management. The majority suffer from organic brain syndromes associated with aging. In addition, a small number of patients were admitted suffering from psychotic or neurotic reactions common to any age-group.

During the year there was a decrease in admissions due in part to temporary staff shortages in the summer and in part to a decrease in applications for admission. There was also a drop in the average death rate in the hospital, and increased difficulty in finding suitable community placements for patients capable of discharge. Contrary to experience in previous years, there was a preponderance of male applications for admission.

Clinical services remained at a high level with an excellent standard of care being provided by the nursing services. A number of newly negotiated contract benefits, which were not compensated for by the provision of supplementary staff, at times placed a serious strain on the nursing resources. An experienced psychiatrist joined the staff during the year and this has resulted in an expansion of services on the psychiatric ward, with a more meaningful involvement of ward staff in the psychotherapeutic management of patients.

The anticipated appointment of a nonmedical executive director did not take place, but it was anticipated that this situation will be remedied early in the new year.

DELLVIEW HOSPITAL

On April 1, 1975, Dellview Hospital was decertified as a mental health facility under the *Mental Health Act,* 1964, and designated as a special care facility to meet the special needs of the psychogeriatric patient who cannot be cared for in the average intermediate or extended-care unit. The necessary changes in admission procedure were instituted in accordance with the change of status of the hospital.

There was a decrease in the number of admissions, presumably resulting from the availability of alternative intermediate and extended-care programs. This virtually eliminated the waiting-list and permitted the administration to waive the age-limit in certain suitable cases.

Despite a good level of maintenance, Dellview Hospital remained an old and inconvenient facility. Nevertheless, a high level of service was maintained and the addition of a social worker and activity therapist added significantly to the program. The ability to carry out pre-admission consultation and to return a limited number of patients to the community was particularly helpful.

PEARSON HOSPITAL

Pearson Hospital provides in-hospital care for tuberculosis patients, persons with severe respiratory disabilities from poliomyelitis, and extended-care patients. All these types of patients have been admitted to Pearson Hospital, while the Willow Chest Centre in-service program has only admitted persons with tuberculosis.

With the declining numbers of people needing to be hospitalized for tuberculosis, both institutions have had fewer of this type of admission, and in July it was decided to consolidate all of them at Pearson Hospital to provide a more efficient and economical use of resources. It is expected when renovations at Willow Chest Centre are complete all in-patient care for tuberculosis will be at the centre. Two tuberculosis wards at Pearson Hospital will then be utilized for additional extended-care patients, thus helping to alleviate the need for more such beds in the Province.

A Patient-Management Liaison Committee established at Pearson Hospital was successful. The committee encouraged the discussion of mutual concerns and improvement of communications.

A Director of Social Service and a new Senior Occupational Therapist were appointed to fill vacancies. The transfer of patients from Willow Chest Centre resulted in the moving of Nursing, Housekeeping, Dietary, and Activity Services staff.

In June a new extended-care program admitting young adults was started. The goal of this project was to provide a suitable milieu for eligible extended-care persons, providing them with a staff oriented to the special needs of such patients. The selection, care, and encouragement of these patients required considerable time and effort.

The operation of the various departments proceeded well throughout the year, despite increasing costs due to economic conditions generally. In summary,

- the Dietary Service has, by continued testing of products, inventory control, menu planning, and judicious utilization of staff, kept costs from rising as much as had been forecast; however, indications are that food costs, despite price controls, will continue to show a significant increase;
- the Department of Nursing extended the activities of the Interservice Committee, and the multidisciplinary approach to patient care; the Activity Services Department was also involved in this program;
- the In-Service Education program involved all departments and also had staff from the Vancouver Dogwood Lodge participate in certain activities;
- the Pharmacy Department extended its drug control program, and a Pharmacy and Therapeutics Committee was established; the work on patient drug profiles continued;
- the establishment of a laboratory supervisory service, as recommended by the Provincial Diagnostic Services Committee, was completed and will result in improved quality control (the Shaughnessy Hospital Laboratory is providing this service);
- the work of the X-ray Department was relatively unchanged until the transfer of Willow Chest Centre patients occurred, but was increasing at the year-end; the need for new and safer equipment was becoming more urgent;

- the Social Service Department increased its emphasis toward the extended-care wards, particularly the Young Adult Program;
- the Housekeeping Department consolidated its services and all laundry for patients and staff was being done at Shaughnessy Hospital;
- Community Services involving students receiving training at Pearson Hospital, and participation by members from various departments continued, and increased in some areas;
- the Women's Auxiliary and other groups maintained their interest and financial support to the patients.

EMERGENCY HEALTH SERVICES COMMISSION

EMERGENCY HEALTH SERVICES COMMISSION

The Commission was established pursuant to an Act of the Legislature, effective July 1, 1974, with the powers and authorities

- to provide emergency health services in the Province;
- to establish, equip, and operate emergency health centres and stations in such areas of the Province that the Commission considers advisable;
- to assist hospitals, other health institutions and agencies, municipalities, and other organizations and persons, to provide emergency health services and to train personnel to provide such services, and to enter into agreements or arrangements for that purpose;
- to establish or improve communication systems for emergency health services in the Province;
- to make available the services of medically trained persons on a continuous, continual, or temporary basis to those residents of the Province who are not, in the opinion of the Commission, adequately served with existing health services;
- to recruit, examine, train, register, and license emergency medical assistants;
- to provide ambulance services in the Province; and
- to perform any other function related to emergency health services as the Lieutenant-Governor in Council may order.

To these functions has been added the responsibility for the medical aspects of the Provincial Emergency Program, such as medical involvement in disaster planning, responsibility for Federal stores stockpiled around the Province, and involvement when actual disasters occur.

Development of a Provincial ambulance service was considered the first priority and, effective July 1, 1974, the Commission assumed financial responsibility for all ambulance services operating within British Columbia, with the exception of those ambulances operated by industry under the requirements of the Workers' Compensation Board. All residents of the Province are entitled to the use of an ambulance, where it is a medical necessity, for a charge to the individual of $5. Charges based on cost are made in the case of certain Federal Government employees, individuals who have not been residents for a period of three months, and those for whom other agencies assume responsibility.

The acquisition of operators' assets has begun, and may eventually cost approximately $1 million.

Training programs have been developed and, to this date, 80 hours of basic training have been given to 507 crew, six weeks of more advanced training to 237 crew, and 9 crew members have been trained to the highest level (paramedic), which is a one-year course. Industrial First Aid tickets were either obtained or renewed by 1,600 ambulance crew. Instruction has also been provided to pilots of Provincial Government aircraft regarding the loading and unloading of stretchers, and the care of patients during transit.

Courses in emergency medicine have been sponsored by the Commission in Vancouver in the spring of 1975, where more than 300 registrants attended, and in Prince George and Quesnel, where emergency department personnel, including physicians and nurses, have been sent to provide advance training in the care of multiple trauma and in cardiopulmonary resuscitation.

The Commission is producing its own ambulances, based on a van-type chassis, at a saving of several thousand dollars over a similar vehicle available commercially. Forty-one new vehicles have been provided to communities around the Province. In addition, back-up support vehicles have been provided to two communities, and a further seven communities have been provided with reconditioned vehicles in good condition.

In 1975, as in 1974, two physicians were employed by the Commission to provide medical attention for the fishing fleet for one month at Rivers Inlet, and a subsequent month at Port Renfrew.

A Province-wide network of radio communication has been designed with the assistance of the Department of Transport and Communications and it is hoped to commence installation very shortly.

The initial steps have been taken in a program of categorization of hospital emergency departments. This action will enable the members of the public and ambulance crew to know exactly the capability of a hospital to provide certain standards of care in an emergency. An example of this is the decision to categorize the Emergency Department at the Vancouver General Hospital as a tertiary referral centre for trauma and burns.

The Commission has just under 500 full-time employees involved in ambulance work, with a further 3,000 personnel available for crew on a call-out basis.

By the end of 1975 the ambulance service was experiencing calls at the rate of approximately 130,000 per year.

FORENSIC PSYCHIATRIC SERVICES COMMISSION

FORENSIC PSYCHIATRIC SERVICES COMMISSION

Although progress during the year was not as rapid in certain areas as the Commission had anticipated, significant advances were made in the provision of Forensic Psychiatric Services.

In April, the Human Services Committee of Cabinet approved, in principle, plans and estimates for a basic Forensic Psychiatric Service. These proposals stressed the need for adequate assessment and treatment of the mentally ill offender, while ensuring that his or her civil rights were protected. While certain special forensic services would be necessary, wherever feasible the individual should be treated in existing community resources. Specifically, the Commission called for the transfer of the Riverside Unit at Essondale to the operational control of the Commission; the establishment of in-patient, out-patient, and consultation services in Vancouver and Victoria; and the involvement of community mental health centres in other areas of the Province in the provision of Forensic Services.

In June, Dr. John Duffy, an experienced forensic psychiatrist, was appointed Executive Director. By the year-end, his work with the Department of the Attorney-General, the judiciary, and other agencies, had already resulted in the more effective use of existing services. The administration of the Riverside Unit was formally passed to the Commission in December. Twenty positions to provide administrative services, out-patient services, and augment the Riverside operation, had been approved, effective January 1, 1976. Negotiations with Shaughnessy Hospital, the British Columbia Medical Centre, and the Eric Martin Institute of the Royal Jubilee Hospital were proceeding satisfactorily for the establishment of the Vancouver and Victoria centres.

During the year the Commission met approximately twice a month and, in addition to planning for direct service, also concerned itself in the wide and complex field of the law and the mentally ill offender.

DEPARTMENT OF HEALTH EXPENDITURES, 1974/75

FINANCIAL TABLES AND CHART

Table 29—Expenditure by Principal Categories in the Department of Health for the Fiscal Year 1974/75[1]

	Total Expenditure in Fiscal Year Ended March 31, 1975 $
Public Health Services	28,364,123
Mental Health Services	56,821,726
Hospital Insurance Services	373,366,070
The Overall Medical Services Plan of British Columbia	224,468,003
Emergency Health Services	6,097,477
Total Health Services	689,117,399

[1] Data are shown according to the administrative organization of the Department at the commencement of the 1974/75 fiscal year.

CHART VI—EXPENDITURE BY PRINCIPAL CATEGORIES IN THE DEPARTMENT OF HEALTH FOR THE FISCAL YEAR 1974/75

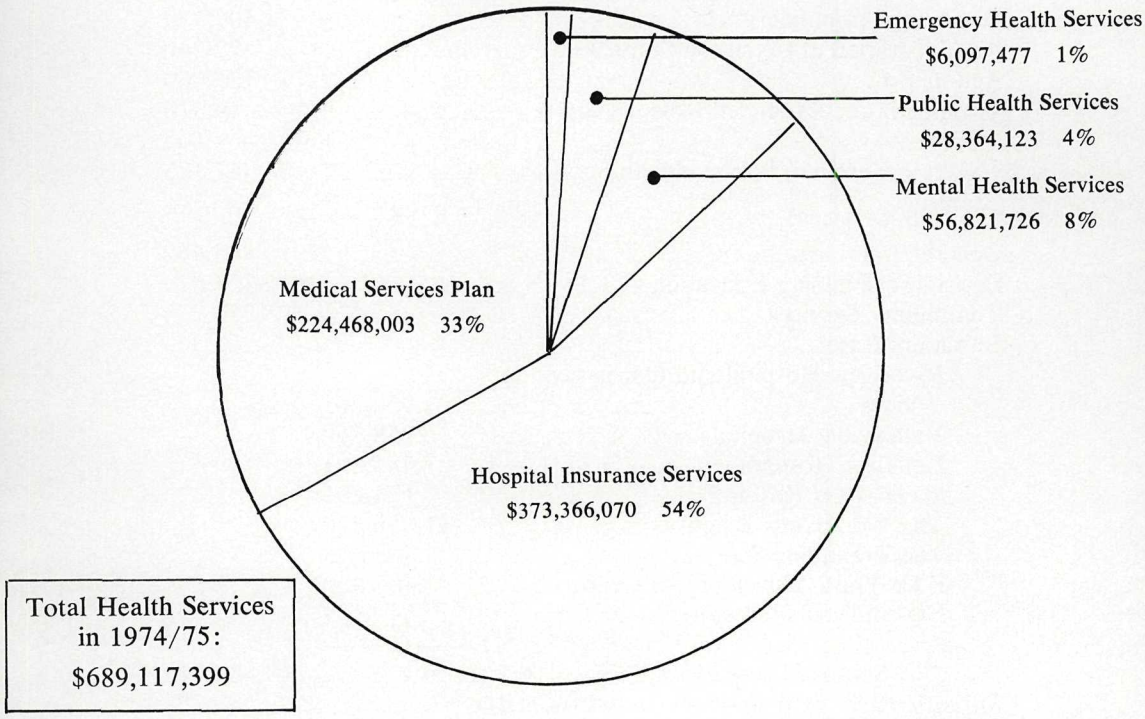


Table 30—Detailed Expenditure by Principal Categories in the Department of Health for the Fiscal Year 1974/75[1]

		Total Expenditure in Fiscal Year Ended March 31, 1975
Public Health Services:		$
Minister's Office		80,099
Accounting Division		501,036
General Services		2,474,903
Division for Aid to Handicapped		894,448
Development of Alternative Care Facilities		323,612
Hearing-aid Regulation Act		12,287
Grants for Health Agencies		1,639,695
Community Health Services Development		210,517
Local Health Services		15,142,996
Division of Laboratories		1,234,927
Division of Vital Statistics		871,142
Division of Venereal Disease Control		349,268
Division of Tuberculosis Control		1,025,033
Division of In-patient Care		3,407,110
Administration of Cemetery Companies Program		22,240
Action B.C.		125,000
Training in the Expanded Role of Nurses		49,810
Subtotal, Public Health Services		28,364,123
Mental Health Services:	$	
General Administration		845,462
Division of Nursing Education		319,879
Community Services		5,751,374
In-patient Care:		
Riverview Hospital and Out-patient Services	21,934,201	
Valleyview Hospital	6,258,168	
Dellview Hospital	1,485,291	
Skeenaview Hospital	124,231	
The Woodlands School	11,856,520	
The Tranquille School	5,402,303	
B.C. Youth Development Centre	2,486,830	
Net undistributed stores	340,169	
Subtotal, In-patient Care		49,887,713
Forensic Psychiatric Services Commission Act		17,298
Subtotal, Mental Health Services		56,821,726

[1] Data are shown according to the administrative organization of the Department at the commencement of the 1974/75 fiscal year.

Hospital Insurance Services:		
Aministration		2,438,265
Payments to hospitals—		
Claims		357,857,187
Grants in aid of equipment		4,422,898
Capital and debt services		8,647,720
Subtotal, Hospital Insurance Services		373,366,070
The Overall Medical Services Plan of British Columbia:		
Benefits—		
Medical care	199,371,953	
Additional benefits	11,014,830	
	210,386,783	
Adjustment of provision for unpresented and processed benefit costs	1,580,205	
		211,966,988
Administration, licensed carriers (MSA and CU & C)—		
Salaries and employee benefits	2,768,825	
General office expenses	1,486,414	
		4,255,239
Commission Central Administration, Medical Services Plan—		
Salaries and employee benefits	4,099,185	
General office expenses	2,038,120	
		6,137,305
Amalgamation administration expenses—		
Salaries and employee benefits	1,409,346	
General office expenses	699,125	
		2,108,471
Subtotal, The Overall Medical Services Plan of British Columbia		224,468,003
Emergency Health Services		6,097,477
Total Health Services		689,117,399

Printed by K. M. MacDonald, Printer to the Queen's Most Excellent Majesty
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1976

2030-775-9355