THE CORPORATION OF THE DISTRICT OF BURNABY

4 July 1967.

SPECIAL REPORT.

His Worship, the Reeve,
and Members of the Council.

Gentlemen: Re: Private Hospitals.

At its meeting on 27th February 1967, Council directed that a Brief be prepared in support of the principle of purchasing private hospital facilities to accommodate extended and chronic care cases. On 12th April 1967, His Worship, the Reeve, reported to Council that the subject was one which required extensive study on a broader front than just a question of possible purchase of Private Hospitals and that since this work would have to be undertaken in addition to normal work it would not be possible to complete a Brief before 30th June 1967. Council agreed.

It is now 30th June 1967 and your Municipal Manager regrets that developments in the Regional Hospital Field and within various agencies of the Provincial Government prevent this Report from being anything other than an Interim Report on the subject.

Discussions carried on, during the period just prior to its directive for the preparation of the Brief, on the matter of extension to the Burnaby Hospital disclosed quite vividly that there is a lack of definition of the various categories of personal care. The difference of opinion as to the interpretation of "Extended Care" is a clear-cut example of the confusion which can be created unless there are agreed positive definitions with which to work. Obviously the physical or mental condition of the patient is the matter of greatest concern and it then becomes a question of classification, and determination of the best means of caring for the patient by provision of the optimum facility having regard to the patient care and public and private economics.

Your Officials, in the conduct of their function, have long been concerned with the matter of personal care. By its very nature, acute Hospital Care has been the easiest to cope with. It has been considered though that lack of other care facilities could well have an adverse impact on the availability of acute beds.

Once a move is made away from the single question of Acute Hospital Care the whole matter of personal care of people becomes important. Indeed, it even enters into the question of types of Personal Care which should be contained within an Acute Hospital as this would provide the facility care for attending to these segments of personal care.

There is also the matter of economics, both public and private. From the public standpoint this could largely be the matter of capital investment in which the objective would be the provision of adequate services of the proper kind at the cheapest cost commensurate with this objective. From the private point-of-view there are two aspects seen:

1. provision of services by private entrepreneurs.

2. the financial impact of required care upon the patient, or upon the public purse as the case may be.

It seems a strange anomaly that the greatest protection against financial disaster through ill-health is provided at the acute Hospital Care level. It is very questionable whether the incidence of health circumstances requiring acute hospital care is now the burden it undoubtedly was when incomes were low and hospital stays long which created large Hospital bills and loss of income. Times have changed radically for the better. The average length of stay in a Hospital has been drastically reduced by modern medicine, procedures and care. Most working people have some form of insurance against loss of income through sickness or accident.

On the other hand, medicine, and public health procedures, have at the same time greatly extended the anticipated life-span of Canadians. So much so that a new problem, which in actual essence is the purpose of this Report, has arisen, namely the care of those in various stages of incapacitation due to age or a deterioration of health not requiring acute Hospital care. It is this class of person on whom the financial impact of his condition has the most damaging effect.

(.....2)

A person admitted to an acute Hospital is charged $1.00 per day for public ward care. The average patient stay is likely under 10 days. Until recently there was absolutely no recognition of the long-term patient not requiring an Acute Hospital bed. Now there is provision for the $1.00 per day where the patient is accommodated in a designated "Extended Care" Hospital where such is not in a profit-making institution.

Two further questions then readily come to mind:

1. What facilities, and where, should be provided to permit maximum use of the $1.00 per day privilege?

2. Is there any other approach which should be considered parallel to (1) which would affect (1)?

Since the pawns in the whole game are people and it is the people who are of the greatest concern, your officials decided without equivocation that the right approach to the question posed to them by Council required an examination of all types of personal care both current and suggested. Only in this way can the picture be clarified and the necessary form of attack on the problem be predicated on a sound basis.

As time has permitted all available definitions of care have been reviewed and discussions conducted with the Inspector of Hospitals for B. C.; the Director, Hospital Consultation of the B.C.Hospital Inspectors Service; the Inspector of Welfare Institutions; the Director of Medical Services of the Welfare Department for B.C. and various administrative people associated and/or concerned with similar problems.

This list demonstrates the cross-section of authority concerned with the problem in total. The discussions have been on a general basis but one pleasing result has been agreement that there is a problem; and that it is necessary to look at the overall picture and not just a segment of it.

At this point it was learned that various departments of the Provincial Government are conducting a study of the whole problem, and during the meeting of all Provincial-Municipal Welfare Administrators held in Victoria June 14 - 16, Mr. Coughlin was informed by the Deputy Minister of Welfare that this Provincial Committee had very nearly completed its report and that it was hoped it would soon be released.

Because the report is expected shortly, and because the type of problem which is being reviewed is a broad one which is not likely to be capable of resolution below a Regional level, it is considered that it is not very timely to proceed to finalization of this particular report.

However, there is no harm seen in outlining some of the present thinking of your Officials and to provide some of the basic information being studied.

In reviewing the current types of personal care we find:

(a) Acute care - General Hospital

(b) Activation or Rehabilitation - usually within the General Hospital.

(c) Extended care - either within a General Hospital or a separate facility.

(d) Private Hospital - tantamount to Nursing Home Care. Usually in a separate facility and for cases requiring constant nursing supervision.

(e) Personal Care - usually referred to as Intermedicare care. For ambulatory patients requiring some aid in walking, dressing, feeding, et cetera, but not requiring nursing supervision.

(.....3)

(f) Boarding Home Care - providing room, board and services of a domiciliary nature to aged or infirm ambulatory patients who can manage their own affairs.

(g) Homemaker Service - use of a qualified Homemaker to care for person(s) in their own homes. No professional nursing care except for occasional nursing or doctor visit.

There is then a broad spectrum of care being provided by one means or another, with two major divisions of authority. Acute hospitals and Extended Care Hospitals under B.C.H.I.S. and the balance of methods under the Welfare Institutions Board.

It is considered that:

(a) there is a constant flow of people for whom care is necessary, moving in both directions between the person's home and the Acute Hospital.

(b) at no levelof care is there a satisfactory supply of facilities and the situation is deteriorating - not improving.

(c) it should be possible to re-categorize care to provide even better service.

(d) with such re-categorization, the B.C.H.I.S. coverage should be broadened or on sound grounds.

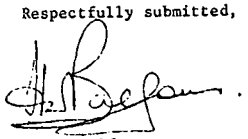
(e) a redistribution of responsibility based on more consideration of the "person" would be indicated.

At this point, the very first problem enunciated comes back into focus. With the concept of re-categorization <u>new</u> definitions would have to be prepared. These would be designed to fit the re-categorization rather than be faced with attempting to design something of an improvement to accommodate any current definition.

For the information of Council, a Chart has been prepared which outlines the above approach. The type of facility now known as a Private Hospital would disappear. The concept is not too radical at all but it is anticipated, though hopefully it can be successfully justified, that the major problem will be the one of extending B.C.H.I.S. coverage.

In conclusion, this is considered to be a progress report which should not anticipate the Government Committee Report.

Respectfully submitted,



H. W. Balfour,
MUNICIPAL MANAGER.

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