

THE UNIVERSITY OF MANITOBA

AN ANALYSIS OF THE INCOME OF PUBLIC WARD  
PATIENTS DISCHARGED FROM THE WINNIPEG  
GENERAL HOSPITAL IN THE MONTH OF  
NOVEMBER, 1956, IN RELATION TO  
SAVINGS, SIZE OF FAMILY, DEBTS  
AND COST OF PRESENT ILLNESS

BEING THE REPORT OF A RESEARCH PROJECT  
SUBMITTED IN PARTIAL FULFILMENT OF  
THE REQUIREMENTS FOR THE DEGREE  
OF MASTER OF SOCIAL WORK

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# CHAPTER I

## INTRODUCTION

It has long been assumed that the teaching wards of university hospitals have been used primarily by patients who are medically indigent. With recent trends in the growth of government support for public ward beds, and in the growth of insurance plans and of government sponsored agencies who care for persons with special illnesses or disabilities, this assumption was questioned by a group of doctors on the staff of the Winnipeg General Hospital, the teaching hospital of the University of Manitoba School of Medicine. Expected changes in the public ward accommodations--the replacement of the twenty bed dormitories by smaller four bed rooms, similar to the two or four bed semi-private rooms--supported the belief that there might be further changes in the type of person using the public wards. The lack of information available on this subject led the doctors and eventually the administrative staff of the hospital to request a study of the social and economic status of the patients who use these wards. The request, made to the Director of the School of Social Work at the University of Manitoba, was accepted as a pilot group research project.

### STATEMENT OF THE PROBLEM:

The purpose of this study is to analyze the income of the selfsupporting patients discharged from the Winnipeg General Hospital in the month of November, 1956, in relation to such factors as savings, size of family, debts and cost of present illness, and out of this study to select special cases who

appear to have greater assets than the majority and to study the circumstances of this group in greater detail.

FOCUS:

In choosing to analyse the income of the public ward patient it has been the writer's contention that the income in itself is not an adequate criterion in discussing financial status of the public ward patient. The amount of income, considered alone, has little significance unless it is compared to the obligations and liabilities which it is expected to cover. In our study, we have chosen to discuss income in relation to three factors--size of family, debts and cost of present illness. These factors constitute three broad categories into which claims upon income can be classified. A study of liquid savings in relation to income will be included to broaden the picture of the public ward patient's assets. After presenting a broad picture of some of the most significant assets and liabilities of those who use the public ward, a special study of those patients with the greatest assets will be made to determine in greater detail the circumstances of this group.

IMPORTANCE OF THE PROBLEM:

The overall social and economic study of the public ward patients was a pilot project designed to indicate trends in the public ward usage and to point out areas in which further research is needed. The study was initiated by the Economics Committee of the Medical Staff of the Winnipeg General Hospital who believed that a study was needed because of recent trends in government support of public ward beds, the development of a new

type of public ward accommodation, the growth of insurance schemes, and the growing number of government sponsored bodies in the health field which they felt might be affecting the type of person using the public wards. Since medical bills are not submitted to the public ward patient, it is assumed that those admitted to these wards use them because they are medically indigent. If this is not always so, then a loss of income occurs to the medical profession. But if this assumption be largely correct, then the public wards of the hospital are performing a needed service to the community.

In studying some of the major assets and liabilities of these patients, we hope to indicate what groups are using the public wards from an economic point of view.

QUESTIONS WHICH THE STUDY SEEKS TO ANSWER:

What is the income distribution of the public ward patients? Where and to what extent do the factors of savings, size of family, debts and cost of present illness occur in relation to it? What are the economic circumstances of those patients with the greatest assets?

LIMITATIONS OF THE STUDY:

It has not been possible in this study to assess the ability of the public ward patient to pay for his present illness costs. The chief difficulty has been the lack of any standards by which to measure this ability. The choice of the group with the greatest assets has been made on the assumption that if there are patients who could possibly pay for illness costs, they might be found in this group. No assessment of their ability

to pay, however, can be made, since there is no available standard by which to make this judgment. The study of this group has, therefore, been limited to a more detailed picture of their economic circumstances.

INCOME: Two types of income will be used in this study--yearly earnings and monthly incomes from sources other than earnings. Earnings have been recorded on a yearly basis. Monthly income refers to income received in the month prior to the patient's illness or, if another person were responsible, income in the month previous to the study. One limitation in the use of yearly earnings is that it does not include resources from other sources such as income from rental of capital, property, pensions, etc. A limitation in the use of monthly income is that it does not necessarily represent a picture of monthly income for the total year.

A study of savings and other assets which have been accumulated from former sources of income, has been undertaken in an effort to compensate for these limitations.

Another limitation present in discussing income is the lack of available knowledge on the question of income as measured in terms of purchasing power and its relation to the cost of living. Without such knowledge, income cannot be measured in terms of its worth and adequacy.

Inaccuracies in reporting income or unwillingness to give such information constitute further limitations.

DEPENDENTS: The ages of dependents and the varying needs of different age groups within this category have not been taken

into consideration in this study.

DEBTS: For the purpose of this study the assumption that debts have been incurred for necessities of living has been made. Such an assumption is necessary, since it is beyond the scope of this paper to go into the question of the wisdom of the spending habits of those who use the public wards.

Another assumption is made by the study--that debts for necessities have prior claim on the individual's income before medical debts (although the statistics on debts include medical debts for former illnesses.) The validity of this is a question of social values.

Further limitations are provided by the inaccuracies or unwillingness of patients in reporting information. It may be noted, too, that prior to the past couple of years, the hospital sometimes did not send bills to patients considered both economically and medically indigent, so that in some cases, knowledge of the financial burden of former illnesses has been unavailable.

SAVINGS, BONDS AND OTHER ASSETS: The chief limitation in gathering data on this subject has been the unwillingness of some patients to divulge this information due possibly to fear of jeopardizing their status as a public ward patient, or to fear of loss of these savings through collection of hospital debt, if such information were known. To what degree this factor is present is unknown.

SOURCES OF DATA AND METHOD OF COLLECTION: The data for this study was obtained from those patients who were discharged

from the public wards of the Winnipeg General Hospital in the month of November, 1956.

A schedule was devised to assemble the pertinent information. Interviewing of the patients was done by nine second year students at the School of Social Work, three graduate social workers, one of whom was a part-time worker for the Social Service Department. Patients who could not speak English were interviewed by the interpreter on the staff of the Social Service Department of the hospital. The section of the schedule which asked for medical information, length and cost of hospitalization, and cost of medical care, was filled in by the medical records office, the accounts office and by medical staff of the hospital. (In recording cost of medical care, the scale of Manitoba Medical Services was used.)

PROPOSED METHOD OF ANALYSIS AND PRESENTATION OF DATA:

The writer proposes to analyze the income in relation to savings, size of family, size of debts and cost of present illness of that group of patients (or persons responsible) who are not in receipt of any form of public assistance or of that group of patients whose income is unknown. The exclusion of the former group is made on the basis that these patients have been found economically indigent and can, therefore, be considered medically indigent as well. The latter group is excluded because of insufficient information about their economic status. If there is a group who could be both economically and medically self-sufficient, it is reasonable to assume that they might be found in the remaining group.

The remaining group constitutes those patients who are

economically selfsupporting. They will be divided into two groups throughout the study--those with yearly earnings and those with fixed income only. The range of income and its distribution in relation to the pertinent factors will be presented for both groups. The distribution of health insurance and home ownership in relation to income will also be presented, but not evaluated.

For the special study of those with the greatest assets, patients with income of \$3000. a year and over and with savings of \$1,000. and over will be studied in greater detail.

DEFINITIONS:

INCOME: the amount, expressed in money, that is derived from labor, business, property or capital. It also included monies received from children or relatives. In this study income has been divided into earnings and fixed income. Earnings refers to the total income of the patient and/or person responsible of the year previous to November, 1956, that have been received in cash or in kind for services rendered and is the amount recorded in the schedule. Earnings of two or more members of the same family are included in the figure. Fixed income has been calculated on a monthly basis, the month chosen being the one prior to the patient's admission to hospital if he himself is the person responsible and if he is not, then the income of the month previous to the time of the study.

SAVINGS: liquid assets such as cash, bank deposits or stocks or bonds which are easily convertible into cash. Assets such as life insurance, property, goods and chattels have not

been included.

DEPENDENT: one who for any reason is completely or partially supported on a regular basis by the patient or person responsible.

DEBTS: monies owing by the patient or person responsible for unpaid bills for any reason. It includes such liabilities as hospital, medical, furnishings, grocery debts, etc. Mortgages are not included as a debt since the property against which the mortgage is held represents a capital asset and is security for payment of the debts.

PRESENT ILLNESS: refers to the illness for which the patient had been hospitalized and was subsequently being discharged in the month of November, 1956.

PERSON RESPONSIBLE: refers to the person who is responsible for the financial support of the patient, including the payment of his sickness costs. This may be the patient himself or some other person on whom the patient is dependent.



## CHAPTER II

### BACKGROUND

Good health is a matter of both individual and national concern. To the individual it means personal happiness; to the nation, strength and prosperity. Collectively and individually, the people of Canada have become increasingly aware of the desirability of this goal. The attention of the nation, as never before, has been focused on the need of providing adequate health services for all citizens and for finding satisfactory methods of financing these.

While the question of providing adequate facilities and personnel is a very important one, we shall, nevertheless, not be concerned with it in this paper, but shall turn our attention to the closely related, but equally important problem of financing health care. One of the most striking trends in the development of modern health services has been the rising cost of health care both to those who provide the services and to those who consume them. This has been the result of many complex and interrelated factors. We shall discuss the most important of these next and from there we shall turn to a discussion of the major trends of Canadian communities and governments in meeting the financial problems of illness. After this broad view of the Canadian scene, we shall focus our attention on some of the particular problems that concern the staff of the Winnipeg General Hospital about their public ward population and from there, to a review of the studies having a bearing on this project.

The advance of medical science within the last hundred years

has been a fundamental cause contributing to the high cost of illness in the present day. Medical advances have revolutionized the practice of medicine and have made available to the public treatments and cures for illnesses which formerly were inaccessible to treatment. Medical care in the last century was inexpensive because it involved only simple and routine procedures. Today the skills involved in diagnosis and treatment are extremely complex, requiring practitioners with long training, aided by specialized equipment and technical personnel. The use of hospitals has become an essential part of the treatment process of many kinds of illness.<sup>1</sup> While medical care has become more effective, at the same time it has become more expensive and these costs have been passed on to the patient.

As the quality of medical care improved, the demand for all types of service increased. Originally, general hospitals were established "to serve the sick poor, and offer a roof and bed for the homeless or for those whose homes were inadequate."<sup>2</sup> Their purpose was purely custodial and they were considered as a last resort for the sick. Patients received free care or else paid only a small part of the cost. Medical care took place in the home and people called doctors only when it was absolutely necessary. With the introduction of new and better techniques of treatment, the role of the hospital in the community changed. It no longer served only the poor, but began to be used by all

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<sup>1</sup>Hayes, John H. Editor, Financing Hospital Care in the United States, Vol. I, pp. 9-12.

<sup>2</sup>Ibid., p. 9.

classes of people who came with every hope of being cured. Many medical services now could only be efficiently provided in hospitals and the hospitals became essential in the practice of medicine as well as surgery. Separate facilities for private patients were set up and "patients began to pay an increasing proportion of the increasing costs of hospital care."<sup>3</sup> Richer, private patients often became overpay patients in order to help pay the costs of the care to the poorer. As the causes and cures of illness became better known and understood, the functions of the general hospital expanded and broadened in scope until today we have "the concept of the general hospital as a centre for community health services,"<sup>4</sup> with greater and greater emphasis being placed on the early detection and the prevention of disease. This increased use of health services has, of course, steadily raised the cost of these services.

Inflationary forces, too, have exerted their influence on the rising cost of illness. The costs of all goods and services the hospitals and medical professions have to purchase to render their services have steadily increased in the past twenty years. These costs have been passed on to the patient. To the wage-earner, rising prices represents diminishing purchasing power and value of money. Wages tend to be raised, but not in proportion to the cost of living and the real value of the raise is elusive when compared to the higher prices of things. Thus, while incomes tend to be higher in inflationary periods, at the

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<sup>3</sup>Ibid, p. 13.

<sup>4</sup>Ibid, p. 14.

same time they are less effectual. This present trend, then, would appear to make it more difficult, particularly for those in lower income brackets, to pay for the increased costs of sickness.

The problem of rising health costs is one which vitally affects the consumer who wants the best care when he needs it. The magnitude of the problem may be illustrated by the following figures. "The direct cost of sickness in this country--doctors, dentists, nurses, drugs and treatment, is estimated to be \$840,000,000. a year. In 1945 it was only approximately \$250,000,000."<sup>5</sup> Medical care for the average person is a difficult thing to budget for. Medical needs are unpredictable as to the time they occur and the amount to be expended, and often the expense occurs at the very time when income is reduced as a result of sickness. Payment at the time of illness is burdensome, if not impossible, for the majority of the population. Hospitals and physicians have traditionally charged on a fee-for-service basis and the patient's ability to pay may be an important factor in determining how much care he feels he can afford. Today, with higher costs of illness, he may not be able to afford adequate care. In the past, richer patients have tended to be charged for a part of the cost of poorer ones, but this practice has broken down with higher costs.

Out of the need to find more adequate ways of financing medical care, a tremendous growth of various types of private

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<sup>5</sup>Reprinted from the pamphlet, Health Services for All: How and When?, prepared by the Canadian Association for Adult Education, 113 St. George St., Toronto, December, 1955. p. 1.

hospital and medical insurance plans has occurred. Voluntary prepayment has provided a way of pooling risks and budgetting for illness costs before they occur. By 1955, estimates of the coverage of Canadians in private plans for hospital, surgical and medical expense were 6.5 million, 5.6 million and 4.2 million respectively. Comparable figures for 1945 were 1.8 million, 0.7 million and 0.3 million.<sup>6</sup> Health insurance has made it possible for increasing numbers of people to be able to pay part and sometimes all of the cost of illness at the time it occurs.

Although health insurance has done much to meet the need of the Canadian people to find more adequate ways of financing health care, there are nevertheless, many limitations inherent in the set-up and operation of the present systems. Because of the voluntary nature of insurance plans, a complete, co-ordinated system of coverage to the Canadian people is difficult to attain. Coverage is more extensive in industrial, urban areas where premiums can be collected economically and efficiently through pay-roll deductions. Benefits vary widely and may cover only part of the costs of illness. Insurance does not guarantee that adequate facilities will be available and lack of any sort of formal, coordinating control over the development of these has meant an unevenness of growth of facilities and many gaps in service, particularly in rural areas.

Despite the wide use that has been made of insurance, there are still large groups of people who are unable to afford the

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<sup>6</sup>Ibid., p. 2.

cost of premiums. The Canadian Sickness Survey, 1950-51, reported that only 28.6% of all families with income of \$1,500. or less carried any type of life insurance.<sup>7</sup> The ability or willingness of a man to buy health insurance depends on many factors. He will be influenced in his choice by "his income and other resources; the demands on that income, affected by the size of his family, the cost of living, etc.; the importance he places upon prepayment, influenced by his attitude to illness and his fear of the costs; and the degree to which the terms of the contract will meet his possible need and therefore relieve him of the fear."<sup>8</sup> The 1951 census figures for income earned by males in the labor force over fourteen years of age showed that 58.2% earned less than \$3,000. a year, 47.3% less than \$2,500. and 31.4% less than \$1,000. These incomes would have to provide coverage for dependents as well and the average size of family in Canada is 3.7 persons.<sup>9</sup>

The cost of comprehensive insurance coverage to these groups is high. As an example, in Manitoba, hospital insurance is available through purchase of group or individual policies from the autonomous Blue Cross organization and medical care insurance can be purchased from Manitoba Medical Services, a program set up by the medical profession. In 1956, a family with an income of \$2,586. to be covered by both plans would be required to pay a premium that amounted to 4.5% of their income

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<sup>7</sup>Canadian Sickness Survey, 1950-51, Special Compilation: #2, Family Expenditures for Health Service by Income Groups, Ottawa, Canada, July, 1953, p. 9.

<sup>8</sup>Health Insurance, What are the Issues? Canadian Welfare Council, Ottawa, 1956, p. 22.

<sup>9</sup>Ibid., p. 22.

or \$116.37 a year.<sup>10</sup>

In recognition of the difficulties that are present to the average man in obtaining adequate medical care at the time he needs it, both provincial and federal governments have taken a more active interest in the matter of personal health services. Personal health care has traditionally been thought of as the exclusive responsibility of the private individual. The government's role was concerned with community health needs and was expressed in the provision of environmental measures designed to protect the health of the group. Health education, sanitation, laws concerning the selling and serving of food, immunization, vaccination, control of infectious or contagious diseases are examples of such measures. However, the trend of many governments' thinking and activity in the past twenty-five years has been toward a beginning of recognition of the principle that illness is a social rather than a personal responsibility.

On the federal level, interest in the health of the individual was first expressed in 1919, when the Liberal party adopted health insurance as one of the planks in its program. Health, however, is a provincial jurisdiction under the British North America Act and the wide variety of thinking in the different provinces has mitigated against any general agreement on the subject. In July, 1944, a Draft Health Insurance Bill was presented to the House of Commons by a Special Committee on Social Security under Dr. J. J. Heagerty. Federal grants

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<sup>10</sup>Ibid., p. 21.

were proposed as part of the plan at the Dominion-Provincial Conference in 1945. However, disagreements over the question of tax agreements prevented any discussion of the Bill, and it was dropped. In 1948 the federal government announced a program of National Health Grants to be given to the provinces to assist them to fill gaps in medical facilities and personnel. The program was considered by the government to be a preparatory step in the direction of national health insurance. In January, 1956, the government offered to participate financially with the provinces in a limited plan for hospital care and diagnostic services. The plan would go into effect when a majority of the provinces representing a majority of the population indicated their willingness for such help. At the present time, only five provinces have indicated their desire to participate.<sup>11</sup> The federal government also provides health services for special groups who presented special problems. Thus, it assumes responsibility for the care of servicemen, veterans with war-incurred disabilities, and Indians and Eskimos.

Provincial governments vary as to the amount of help given to their citizens to ease the burden of health costs. Workmen's Compensation Laws in all provinces provide for employers to finance the medical costs of industrial accidents and diseases. Provincial and municipal governments provide some public support for hospital operating costs by underwriting the cost of hospital care for patients who are unable to finance themselves. Special care may be provided for sufferers of certain diseases such as tuberculosis, mental illness, cancer, poliomyelitis,

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<sup>11</sup>March, 1957.



and venereal diseases. Four provinces--British Columbia, Alberta, Saskatchewan and Newfoundland--have recently established compulsory hospital care plans for all or a portion of their residents. Greater social concern over the personal health of children has been seen in the expansion of many public health services to include such programs as well-baby clinics, school health services, etc.

The province of Manitoba provides medical care for those groups of indigents for whom it is responsible--persons living in unorganized territory and those who have no municipal residence. It assists municipalities with grants of money in proportion to their welfare expenditures on relief and medical care, and it finances the entire cost of maintenance and treatment of mentally defective, mentally diseased persons and tuberculosis patients.

Provision of hospital care for indigents is mandatory upon municipalities. The municipality must assume responsibility for public ward maintenance of such patients admitted on the authority of the local medical health officer. Indigency of the patient is determined on the basis of his inability to pay. The municipality pays for the cost of care and may then try to collect from the patient. Under the new Hospital Aid Act, 1956, the provincial government assists the municipality by paying 40% of the total bill. Recently, the provincial government has agreed to finance the total cost of hospitalization after 180 days. This is aimed at relieving municipalities of the burden of persons suffering from long-term illnesses who are not cared for under other programs.

The Winnipeg General Hospital was organized in 1872 and incorporated in 1875. The hospital was a charity institution. In 1879 only 8% of the total patients treated were paying patients and services of practitioners for public patients were given free. A provincial subsidy was given as early as 1883. The medical college of the University of Manitoba became affiliated to the hospital in 1883 when students were given permission to attend the hospital.

Because of its affiliation with the medical school, the Winnipeg General Hospital is also a teaching hospital. Patients who are admitted to the public ward are available to the staff and students of the University of Manitoba for teaching purposes. Because of this, it has not been the practice to charge these patients a medical fee from any of the doctors in attendance. As this has been discussed previously, governmental support is given to the hospital for the cost of public ward patients unable to pay their hospital bill. None of the above considerations applies to private ward patients in the hospital.

The recent hospital building program about to be completed will provide a new type of public ward accommodation. The large twenty-bed dormitories will be replaced by smaller four-bed rooms, similar to the two or four-bed semi-private wards. With this change in the public ward accommodation, the Economic Committee of the Medical Staff of the Winnipeg General Hospital became interested in the kind of patient who may be expected to use these wards. Recent trends in the growth of government support of public ward beds, of insurance plans and of government sponsored agencies who look after people with specific

illnesses or disabilities were supporting factors in the belief that there might be further changes in the character of the public ward population. The lack of definite knowledge about the patients who use these wards led the Committee to request a social and economic study of public ward patients. This request was made to the Director of the School of Social Work and was accepted as a pilot group research project. The project was given support by the administrative as well as the medical staff of the hospital.

While there is much literature available on hospitals and hospital studies, the writer was unable to find any studies that were strictly relevant to our present study. In most cases the studies were focused on total hospital population groups in certain areas or on groups defined as indigents. Our study is concerned with a specifically defined group--the public ward patient--and the assumption of indigency is not made. The Commission on Financing Hospital Care in the United States, as part of their inquiry, studied the characteristics of a group of 3,407 patients who were unable to pay their bills. Their sample was selected at random from thirty-two general hospitals and their findings were reported in a volume entitled "Financing Hospital Care for the Nonwage and Low Income Groups."<sup>12</sup> They divided their findings into five groups according to the cause of inability to pay. These groups were--Old Age, Temporarily Unemployed, Disabled, Low Income and Public Aid. A study

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<sup>12</sup>Becker, H. Editor, Financing Hospital Care in the United States, Vol. 3.

of their assets and liabilities was made. Their findings revealed that the average income for the total group was \$2,320. a year. Over one-third were receiving public aid, and 40% had low income, as defined by the study--under \$2,000.<sup>13</sup> These findings will be roughly comparable to those of our report. The remainder of their study is not, however, because of their different definition of groups.

The Canadian Sickness Survey, 1950-51, was the first comprehensive statistical report on sickness in this country. It was carried out by the Department of National Health and Welfare and the Dominion Bureau of Statistics in co-operation with the provinces. Its object "was to obtain estimates of the incidence and prevalence of illness and accidents of all kinds, the amount of medical nursing and other health care received, and the volume of family expenditures for the various types of health services."<sup>14</sup> A sample group representing the population of Canada was studied for one year. The survey was undertaken to obtain scientific data for the purpose of assisting governments in planning and providing health services.

Some interesting studies on hospital care have been carried out by the Saskatchewan Department of Public Health since the inauguration of their universal hospitalization scheme, the Saskatchewan Hospital Services Plan, in 1947. One in particular, "Some Factors Influencing Hospital Utilization in

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<sup>13</sup>Ibid., p. 12.

<sup>14</sup>Canadian Sickness Survey, op. cit., p. 1.

Saskatchewan"<sup>15</sup> was undertaken to analyze what social, medical and other factors contribute to hospital utilization. The study compared characteristics of fifty localities showing high hospitalization rates and fifty with low rates. The study is of interest because it points out social and medical factors influencing hospitalization when the economic barrier of ability to pay is removed. It is not comparable to our study because the group studied represents a broader section of the population than our study is concerned with and because of the presence of universal hospital insurance.

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<sup>15</sup>Roth, F. B., M.D., Acker, M. S., M.D., Roemer, M. I., M.D., and Myers, G. W., Canadian Journal of Public Health, Vol. 46, No. 8., Toronto, August, 1955.

### CHAPTER III

#### THE EXPERIMENTAL POPULATION

Data concerning the social and economic status of the public ward patients of the Winnipeg General Hospital was obtained from a sample group of patients. The sample chosen to be studied included all those patients discharged from the public wards in the month of November, 1956. The time unit, a month, was selected because it would limit the size of the sample, but at the same time, would be long enough to provide a sufficiently large sample from which to draw conclusions. The month of November was considered typical of most other months of the year.

The interview method was used in obtaining data. An open-end schedule was devised to guide interviewers in seeking the relevant information. Interviews were conducted on the wards or in private rooms, if these were available. Answers to the questions were recorded on the schedule at the time of the interview in order to facilitate accuracy in reporting data. The schedule has been reproduced in Appendix A to this paper.

The schedule contained seventy-eight questions. The questions on financial status and earnings and income were designed to ascertain information about the person responsible for the support of the patient. This might have been the patient himself, or a husband if his wife were the patient, the responsible parent if the child were the patient and so on. Where the patient himself was unable to give the information, it was obtained in an interview with the responsible person or another reliable source. The words "patients", "individuals

and families," "persons," "persons responsible" are used interchangeably throughout the report and refer to the patient or to the person responsible for the support of the patient.

The interviewers used in the study were in most cases trained social workers. Nine second year students of the School of Social Work and three members of the staff of the hospital's Social Service department did the interviewing. Patients who did not speak English were interviewed by the interpreter on the staff of the same department. The medical records office, the accounts office and the medical staff of the hospital recorded the data concerning medical information, length and cost of hospitalization and cost of medical care. Instructions were given interviewers to assist in uniform interpretation of the questions to patients.

A system of coding answers for statistical purposes was devised and the second year students undertook the actual coding which was then reproduced on a set of cards, one card for each patient.

Every effort was made to interview all patients at the point of their discharge. However, there were some cases in which this was not possible. In such cases, a schedule containing as much information as was available was made out and included in the sample. Readmissions and discharges of the same patient within the month were included as separate discharges.

The interviewers used in the study were persons, who, by training and experience or both, had skill in interviewing people. While this was a positive factor in eliciting data, it might be added that the majority had had no previous experience

in research interviewing which perhaps calls for greater accuracy in understanding the questions to be asked and in clarifying the answers given at the time of the interview. A factor that provided some compensation for the above criticism was that most of the questions in the schedule dealt with factual matters rather than ideas or attitudes and were subject, therefore, to more accurate interpretation.

A test sample of the schedule was undertaken prior to the study. It consisted of each of the social work students undertaking one interview. Helpful changes were made as a result, but the time for testing was too short to bring to light all the significant weaknesses inherent in the schedule. A question ascertaining the length of time during which the head of the household was in receipt of public assistance would have rendered more thorough the picture of the group dependent on public funds. It was not possible within the scope of this study to evaluate resources of the patient such as the value of his home, farm or business. Nor was it possible to assess the cost of living. These latter two limitations render the picture of the assets and liabilities of the public ward patient less complete.

#### METHOD:

The sample for which data was collected contained a total of 371 schedules, equivalent to 371 patients discharged. Two groups have been excluded from the analysis. The first group consists of those individuals and families for whom the information regarding income was unobtainable. Since such information was essential to this study, the writer felt it impossible to



include this group. It amounted to seven individuals and sixteen families, a total of twenty-three schedules in all. This was 6% of the sample. The second group may be referred to as the public assistance group. Public assistance has been defined as "help given in cash or kind from public funds, on a means test basis." Any person who had income from this source was eliminated from the study. A hundred and one schedules or 28% were excluded on this basis. This step was taken on the assumption that persons in receipt of such assistance are economically indigent and are therefore, medically indigent as well. In addition to a rather well-defined public assistance group, this group included those persons whose income in the month previous to hospitalization was from public funds, but who were not, at the time of discharge in receipt of such funds and those persons whose income in the previous month was from other sources, but who were in receipt of such assistance at the time of discharge.

Two hundred and forty-seven schedules remained to be studied. Eleven of these represented readmissions and discharges of four patients. In addition, there were two schedules for two patients belonging to one family. Five families in all were involved. In handling these thirteen schedules the costs of illness were added up and considered as costs chargeable to the five families.

Two hundred and thirty-nine individuals and families then made up the study group. These have been divided into two groups, first, those who reported earnings in the last year and second, those who reported no yearly earnings, but had a fixed income other than public assistance. This included old age security

pensions. The first group constituted 168 individuals and families, the second, 71 individuals and families.

Originally it had been felt desirable to work with a single income unit, such as yearly earnings or monthly income, but a choice of either one would have rendered the study incomplete. To have studied those with yearly earnings only would have excluded those with fixed resources and to have studied a monthly income figure only would have given an incomplete picture of the earning group, as they would have appeared over a longer period of time. A decision to study both groups was then made.

An overall picture of the economic and financial status of the earning and fixed income groups will be presented. The income of the earning group has been divided into income categories or ranges of \$500. intervals up to \$2,500. After \$2,500. the interval is \$1,000. up to \$4,000. \$4,000. and over is an open interval. This method of grouping income data is the one used by the Dominion Bureau of Statistics in their Canadian Census figures. The fixed income group has been divided into intervals of \$50. up to \$350. These intervals provide consistent units throughout the study and the analysis of pertinent factors in relation to income is made with each grouping. The earning and fixed income groups will be studied separately.

The range and distribution of the earnings of the public ward patients will be presented first, together with a statistical analysis of the results. The average and median incomes will be calculated. A comparison of these figures with other

significant income figures will follow. The decision of the Commission on Financing Hospital Care in the United States<sup>1</sup> to choose \$2,000. as the "money-income" line below which it was assumed that families could not pay hospital bills will be commented on. The median income calculated by the 1951 census figures is the other income figure.

A similar report on the findings in regard to the fixed income group will be presented. Range and distribution of income will be reported on and average and median incomes will be calculated.

An analysis of the income of both groups in relation to size of family, the amount of debts and the cost of present illness will be made. Averages will be calculated for the total groups and then for each income category. Comments will be made on significant features observed.

The figures on debts include only those debts which have been reported in cash terms. Unknown amounts have been excluded. Mortgage debts have also been excluded since the house or farm against which the mortgage is held represents a capital asset and is security for payment of the debts.

A picture of those persons with savings will be given in relation to size of income. Other resources such as home food production, life insurance policies, cattle and grain have been excluded from this because of the difficulty in estimating their value. In the case of cattle and grain there are additional

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<sup>1</sup>Becker, H., Editor, Financing Hospital Care in the United States, Vol. 3, p. 46.

difficulties involved in the economic uncertainty associated with their liquidation. Savings, then, includes only those amounts reported in cash terms, that can be considered liquid assets. Bonds were included in this category.

Regarding income figures, only cash amounts were used in the study, but since efforts were made by interviewers to translate income in kind into approximate cash values, a more accurate or correct amount may have been achieved.

A table of the ownership of homes, farms and businesses will be presented, and the extent of mortgage indebtedness will be commented on. No attempt has been made to assess the value of these assets. Monthly mortgage payments have been considered roughly equivalent to economic rents for shelter purposes and as such, part of the basic cost of living which this study has not attempted to assess.

Health insurance was considered as an asset and will be looked at separately. The number having such insurance and its distribution in relation to the income groups will be ascertained. It is recognized that this insurance may only cover a portion of the cost of illness and an estimation of its value has been beyond the scope of this paper.

A picture of the groups' expectations to pay for their hospital bills will also be presented.

Out of the general picture of the assets and liabilities of the public ward patient, the writer will select for special study that group of patients with the greatest assets. Those with income of \$3,000. a year and over and savings of \$1,000. and over will be studied. The decision to study these groups

has been based on the assumption that if there are patients to be found who could possibly pay for their illness costs, they might be found in the group showing the greatest economic assets. Since no attempt can be made to assess their ability to pay, the study will be confined to a more detailed description of their assets and liabilities.

## CHAPTER IV

### ANALYSIS OF RESULTS

The earning and fixed income groups constitute sixty-six per cent of our sample group. It is these two groups that we shall look at to determine their resources and liabilities.

The findings about the group who reported earnings in the past year will be presented first. There were 168 individuals and families in this group and they made up almost half of the total sample. Their earnings ranged from \$12. to \$6,000. per annum.<sup>1</sup> The distribution is as follows:

<u>Earnings</u>	<u>Number of Persons Responsible</u>
\$ 1- 499	25
500- 999	34
1,000-1,499	28
1,500-1,999	20
2,000-2,499	30
2,500-2,999	15
3,000-3,999	13
4,000+	3

The average earnings for the group is \$1,563.82. The Commission on Financing Hospital Care in the United States studied the characteristics of a random selection of 3,407 patients who were unable to pay their hospital bills and found that the average income for their group was \$2,320.<sup>2</sup> From the

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<sup>1</sup>This information was obtained from question 66 of the schedule.

<sup>2</sup>Becker, H., Editor, Financing Hospital Care in the United States, Vol. 3, p. 12.

viewpoint of our study, it is significant that, although the average income of the Commission's sample was \$756.18 higher than the comparable figure for our sample, none of the group studied by the Commission had been able to pay their hospital bills.

It is not possible to determine precisely what low income is. What is low income for one family may not be so for another. There are more factors than income itself which have to be considered. The Commission on Financing Hospital Care arbitrarily chose a money income line of \$2,000. and considered those families who were below this line as low income families.<sup>3</sup> Their findings revealed that forty per cent of the above study were in this group.<sup>4</sup> Applying this standard to our sample, we found that 63.7 per cent of the patients fell below this figure.

Median earnings for our sample was \$1,400. Half of the earning group fell below this amount. The median earnings of the people of Canada according to the 1951 census for males and females over fourteen years of age in the working force were \$2,132. and \$1,191. respectively. The median earnings of our sample which includes earnings of both males and females is about \$130. lower than halfway between the two medians quoted in the census.

While money income from earnings is the chief asset of the earning group, other assets do occur, although less frequently. Of the three we have chosen to look at--savings, health insurance

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<sup>3</sup>Ibid., p. 46.

<sup>4</sup>Ibid., p. 12.

and home ownership--no attempt has been made to evaluate the latter two. The question of doing so with health insurance is beyond the scope of this paper and sufficient information on the value of homes was not available.

The following table shows the distribution of these factors among the earning categories:

TABLE I

NUMBER WITH SAVINGS, HEALTH INSURANCE AND  
HOMES OWNED BY SIZE OF EARNINGS

Earnings	Savings	Insurance	Homes Owned
\$ 1- 499	5	1	7
500- 999	4	4	7
1,000-1,499	4	3	6
1,500-1,999	4	3	4
2,000-2,499	4	7	4
2,500-2,999	5	5	4
3,000-3,999	4	4	4
4,000 +	1	0	0
TOTAL	31	27	36

We find that less than a quarter of our group, in each case, had these kinds of assets. Those with savings constituted 18.5 per cent of the group, those with insurance, 16.1 per cent, and 21.4 per cent owned their own homes. The picture of home ownership may be broadened by considering the amount of mortgage indebtedness. Only seventeen of the homes were owned outright. There were nineteen homes with mortgages still to be paid for and the indebtedness amounted to \$73,984.

A picture of savings in relation to income follows:



TABLE II

DISTRIBUTION OF SAVINGS BY AMOUNT OF SAVINGS  
IN RELATION TO INCOME

Earnings	Savings							TOTAL
	\$ 1- 99	100- 199	200- 299	300- 399	400- 499	500- 749	750- 999	1,000+
\$ 1- 499	2		1					2 5
500- 999	2		1			1		4
1,000-1,499	1		1	1		1		4
1,500-1,999	1	1	1			1		4
2,000-2,499	1	1			1	1		4
2,500-2,999	3		1					4
3,000-3,999	1	1	1			1		4
4,000+			1					1
TOTAL	11	3	7	1	1	5	2	30

This group represented 18.5 per cent of the earning group. Savings amounted to \$8,683. and the average for the total group was \$51.65. Only eight people had savings over \$400.

In the picture of assets, we see that earnings fell most frequently in the categories below \$2,500. and the number began to lessen noticeably in the categories above that amount. Only small percentages of the group, less than one-quarter in each case had other assets of savings, health insurance and home ownership.

The liabilities of the public ward patient which we have chosen to study are size of family, size of debts and cost of patients' present illness.

Of our total group of 168, the earning group, we found that fifty-two or thirty-one per cent of the group were single persons. The number of families with one or more dependents

was 116 or sixty-nine per cent. The distribution of families and the number of dependents is given in the following table:

TABLE III

NUMBER OF FAMILIES, NUMBER OF DEPENDENTS  
AND AVERAGE NUMBER OF DEPENDENTS  
PER FAMILY BY EARNING RANGE

Earnings	Number of Families	Number of Dependents	Average Number of Dependents Per Family
\$ 1- 499	12	33	2.75
500- 999	17	41	2.41
1,000-1,499	21	58	2.76
1,500-1,999	16	58	3.62
2,000-2,499	25	99	3.96
2,500-2,999	11	44	4.
3,000-3,999	11	42	3.81
4,000+	3	11	3.66
TOTAL	116	386	

The average number of dependents per family for all families was 3.3. For the total earning group, including single individuals, it was 2.3 dependents per person responsible. From the table, it can be observed that the income groups above \$1,500. had the highest average number of dependents per family. This would suggest that those with higher incomes have a greater liability in that they have more dependents to support on the earnings.

The number of persons with debts was 108. This constituted sixty-four per cent of the earning group. The indebtedness amounted to \$47,447.50, not including mortgages. Average debt was \$282.42. This may be compared with the average

savings of \$51.65 per person. The debt picture is considerably greater.

The distribution of size of debts in relation to income size is given next:

TABLE IV

DISTRIBUTION OF SIZE OF DEBT  
BY SIZE OF EARNINGS

Earnings	\$1-99	100-199	200-299	300-399	400-499	500-749	750-999	1000-1,999	2,000+	TOTAL
\$ 1- 499	8	2	1	1	1	2				15
500- 999	7	6	4		2	2			1	22
1,000-1,499	5	3	2	1	2	2		1		16
1,500-1,999	3	3	1	3	1	1	1	3		16
2,000-2,499	5	2	1	2	1	3	1	3	1	19
2,500-2,999	1	1	1	1	1	1	2			8
3,000-3,999			2	1		3	1	1	2	10
4,000+				1				1		2
TOTAL	29	17	12	10	8	14	5	9	4	108

The different sizes of debts seemed to be scattered fairly consistently throughout the body of the table, with perhaps a greater concentration in the lowest debt size. A little over a quarter of the number of debts fell into this range.

A table showing the total amount of debt and the average debt for each income range follows:

TABLE V

TOTAL AMOUNT OF DEBT AND THE AVERAGE DEBT  
FOR EACH EARNING RANGE

Earnings	Total Amount of Debt	Average Size of Debt
\$ 1- 499	\$ 2,524.50	\$ 100.98
500- 999	5,857.00	172.26
1,000-1,499	4,833.00	172.61
1,500-1,999	7,829.00	391.85
2,000-2,499	11,256.55	375.21
2,500-2,999	3,651.22	243.81
3,000-3,999	9,376.23	670.51
4,000 +	2,104.	701.33

The average amount of debt was highest in the income ranges above \$1,500.

The cost of the patients' present illness is the third liability to be looked at in relation to income. This does not include previous hospital or medical debts incurred for former illnesses. Present illness costs have been divided into (1) costs of hospital care and (2) costs of hospital and medical care combined. The distribution of hospital costs and of hospital and medical costs for the earning group by the size of the debt will be presented next:

TABLE VI

DISTRIBUTION OF PATIENTS BY COST OF PRESENT  
ILLNESS ACCORDING TO THE SIZE OF  
HOSPITAL BILL AND HOSPITAL  
AND MEDICAL BILL

Cost of Present Illness	Number of Hospital Bills	Number of Hospital and Medical Bills
\$ 1- 99	82	33
100-199	34	46
200-299	22	43
300-399	10	15
400-499	10	10
500-749	7	14
750-999	2	4
1,000+	1	3

From the above table, it can be seen that almost one-half of the group had hospital bills of less than \$100. But when doctors' medical bills were added, this number was reduced to less than one-quarter of the group.

The following table shows the distribution of present hospital costs by size of earnings:

TABLE VII

DISTRIBUTION OF PRESENT HOSPITAL COSTS  
BY SIZE OF EARNINGS

Earnings	Cost of Present Hospital Care								TOTAL
	\$1-99	100-199	200-299	300-399	400-499	500-749	750-999	1,000+	
\$ 1- 499	11	4	5		2	2	1		25
500- 999	11	4	5	7	4	2		1	34
1,000-1,499	12	9	3	2	1	1			28
1,500-1,999	11	2	3		2	2			20
2,000-2,499	18	9	3						30
2,500-2,999	8	4	1	1	1				15
3,000-3,999	9	1	2				1		13
4,000 +	1	2							3
TOTAL	82	34	22	10	10	7	2	1	168

Hospital debts under \$100. occurred most frequently in all earning categories, but particularly so in the earning range \$2,000. to \$2,499. The total amount of present hospital debt and the average hospital debt for each earning range is given next:

TABLE VIII

TOTAL AMOUNT OF PRESENT HOSPITAL DEBT  
AND THE AVERAGE HOSPITAL DEBT  
FOR EACH EARNING GROUP

Earnings	Total Amount of Present Hospital Debt	Average Hospital Debt
\$ 1- 499	\$ 5,597.20	\$ 223.88
500- 999	8,652.86	254.49
1,000-1,499	4,417.20	157.75
1,500-1,999	3,835.54	191.77
2,000-2,499	2,906.40	96.88
2,500-2,999	2,068.80	137.92
3,000-3,999	1,930.90	148.53
4,000 +	335.45	111.81

For those patients with earnings above \$2,000. average hospital costs were lower than for other categories, the group with earnings between \$2,000. and \$2,499. having the lowest average costs. The highest average hospital costs occurred for the two lowest earning groups.

Similar tables are presented for the distribution of present hospital and medical bills combined:

TABLE IX

DISTRIBUTION OF PRESENT HOSPITAL AND  
MEDICAL COSTS BY EARNING SIZE

Earnings	Cost of Present Hospital and Medical Care								TOTAL
	\$1-99	100-199	200-299	300-399	400-499	500-749	750-999	1,000+	
\$ 1- 499	4	8	4	2	3	2	1	1	25
500- 999	6	5	5	5	5	7		1	34
1,000-1,499	5	4	11	4	1	3			28
1,500-1,999	2	6	8			1	3		20
2,000-2,499	12	7	9	2					30
2,500-2,999	1	7	4	1	1	1			15
3,000-3,999	2	7	2	1				1	13
4,000 +	1	2							3
TOTAL	33	46	43	15	10	14	4	3	168

When the medical debt is added to the cost of the hospital debt for the patient's present admission to hospital, it can be seen that the distribution of sickness costs is altered. The concentration of illness debts of under \$100. that occurred when only hospital costs were considered, no longer shows when medical costs are included.

The total amount of present hospital and medical costs for each earning range and the average hospital and medical debt for the same groups is given next:



TABLE X

TOTAL AMOUNT OF PRESENT HOSPITAL AND MEDICAL  
DEBTS AND THE AVERAGE DEBT FOR  
EACH EARNING RANGE

Earnings	Total Amount of Hospital and Medical Bill	Average Hospital and Medical Debt
\$ 1- 499	\$ 7,832.25	\$ 313.29
500- 999	11,701.40	344.15
1,000-1,499	7,089.10	253.18
1,500-1,999	5,889.99	294.49
2,000-2,499	4,586.98	152.89
2,500-2,999	3,342.50	222.83
3,000-3,999	2,962.90	227.91
4,000 +	435.40	145.13

When medical bills are added to hospital costs, the public ward patient's indebtedness is increased considerably. The total amount of present hospital indebtedness for the earning group was \$29,408.90, but when hospital and medical bills are added together, the indebtedness rises to \$43,906.02. Medical bills, therefore, totalled \$14,597.12. The average cost of present hospital indebtedness for the earning group was \$175.05 per patient and of hospital and medical care, \$261.34. Average doctors' bills would be \$86.88.

The two lowest earnings categories, those under \$1,000. show a higher proportion of single persons and higher hospital and medical costs than other groups. Their debts are lower, however. This may be an older group whose families have grown up, whose income has dwindled with increasing age and who may be more susceptible to diseases of the aged. Or it may be that

low income has an effect on health. These are questions that would need further study to confirm. The group with the greatest number of dependents, high debt costs, but the lowest sickness costs is the \$2,000. to \$2,500. earning group. Further study might be indicated for this group to discover what other factors may be present.

The expectations of the 168 in the earning group to pay for the costs of their hospitalization is as follows:

TABLE XI

NUMBER EXPECTING TO PAY HOSPITAL BILL  
IN RELATION TO SIZE OF EARNINGS

Number Expecting to Pay:				
Earnings	In Full	In Part	None	Unstated
\$ 1- 499	4	4	17	
500- 999	8	4	22	
1,000-1,499	12	5	11	
1,500-1,999	10	3	6	1
2,000-2,499	11	10	9	
2,500-2,999	10	2	3	
3,000-3,999	10	2	1	
4,000 +	2		1	
TOTAL	67	30	70	1

Those who expected to be able to pay for their hospital bill constituted forty per cent of the earning group. This may well be an overestimate reflecting some patients' desire rather than ability to pay. Those in the two lowest income categories accounted for the largest number of those who felt they could not pay. This was forty-two per cent of the group.

To complete our study of those with independent income we shall look next at those who reported no yearly earnings, but who had some form of fixed income. The income unit used was monthly income. Twenty per cent of our total sample, or seventy-one persons responsible made up this group. Their income ranged from \$0.00 to \$205.25 per month. For those who reported no income, it may be remembered that income for the month of November only was reported. They may have had income in other months or be living on savings. The distribution is as follows:

<u>Income</u>	<u>Number of Persons Responsible</u>
\$ 0	3
1- 49	32
50- 99	30
100-149	4
150-199	1
200-249	1
<hr/>	
TOTAL	71

The average income for this group was \$60.27 a month. The median income was almost the same, \$60. a month. It might be noted that these figures are not very high when one considers that the assistance given in the federal government's categorical relief programs for a single person will be \$46. a month. Persons receiving Old Age Security pensions account for a large number of the people falling in the fixed income category, (53).

The picture of other assets--savings, health insurance and home ownership is given as follows:

TABLE XII.

NUMBER WITH SAVINGS, HEALTH INSURANCE AND  
HOMES OWNED IN RELATION TO INCOME SIZE

Income	Savings	Insurance	Homes Owned
\$ 0	1	0	2
1-49	4	1	3
50-99	8	2	6
100-149	0	0	2
150-199	1	0	1
200-249	0	0	0
TOTAL	14	3	14

The percentages of the fixed income group with these assets are small: twenty per cent with savings, four per cent with insurance and twenty per cent owned their own homes. Thirteen homes were owned completely and one had a mortgage outstanding of \$8,000.

Twenty per cent reported savings, totalling \$11,392.50. Five persons responsible had savings over \$400., nine had savings below this amount. The savings of one person of \$7,000. raised the total and average considerably for the total group. The average was \$146.37.

A picture of savings in relation to income is given next:

TABLE XIII

DISTRIBUTION OF SAVINGS BY AMOUNT OF SAVINGS  
IN RELATION TO INCOME

Income	\$1-99	100- 199	200- 299	300- 399	400- 499	500- 749	750- 999	1,000+	TOTAL
\$ 0								1	1
1- 49	2	1		1					4
50- 99	1	2	2		2	1			8
100-149									0
150-199								1	1
200-249									0
TOTAL	3	3	2	1	2	1		2	14

The findings of our study of the liabilities of this group in relation to income are presented next. There were forty-four individuals with no dependents in the fixed income group. These constituted sixty-two per cent of the group. The rest were family groups and these made up thirty-eight per cent of the group. The number of families, dependents and average number of dependents follows:

TABLE XIV

NUMBER OF FAMILIES, NUMBER OF DEPENDENTS AND  
AVERAGE NUMBER OF DEPENDENTS  
PER FAMILY BY SIZE OF INCOME

Income	Number of Families	Number of Dependents	Average Number of Dependents Per Family
\$ 0	2	2	1
1- 49	3	4	1.33
50- 99	18	20	1.11
100-149	3	3	1
150-199	0	0	0
200-249	1	5	5
TOTAL	27	34	

The average number of dependents per family for all families is 1.25. This is a much smaller figure than the comparable one for the earning group which is 3.3. This would indicate that the fixed income group's liability as far as dependents are concerned is much less. For the total fixed income group, the average number of dependents per person responsible was 0.43.

An analysis of income in relation to debts yielded the following results:

TABLE XV

DISTRIBUTION OF SIZE OF DEBT BY INCOME SIZE								
Income	Debts							TOTAL
	\$1-99	100-199	200-299	300-399	400-499	500-749	750-999	1,000+
\$ 0			1					1
1- 49	1	1			1	1		4
50- 99	4		1					5
100-149		1						1
150-199				1				1
200-249				1				1
TOTAL	5	2	2	2	1	1		14

The debt picture for this group is not as large as it is for the earning group. Fourteen or twenty per cent of this group had debts, totalling \$3,996.34. The average debt per person was \$56.28. The savings picture is comparably better, average savings per person being \$146.37. The percentage of those with savings was the same as for those with debts.

In looking at the third liability, cost of the patients' present illness, it will be remembered that hospital and medical debts incurred for former illnesses have not been included. Costs of present illness have been divided into hospital costs and hospital and medical costs. The distribution of hospital costs and hospital and medical costs for the fixed income group by the size of the bill is presented next:

TABLE XVI

DISTRIBUTION OF PATIENTS BY COST OF PRESENT  
ILLNESS ACCORDING TO THE SIZE OF HOSPITAL  
BILL AND HOSPITAL AND MEDICAL BILL

Cost of Present Illness	Number of Hospital Bills	Number of Hospital and Medical Bills
\$ 1- 99	11	4
100-199	18	12
200-299	23	17
300-399	7	20
400-499	2	6
500-749	7	8
750-999	3	1
1,000+	0	3

The heaviest concentration of hospital bills occurred in the groups having cost of illness below \$300. 73.2 per cent of the group had bills below this amount. Only 46.4 per cent had both hospital and medical costs below \$300. With medical costs added to hospital costs, the distribution of debts alters showing that the majority fall into the debt categories between \$100. and \$400. 74.6 per cent of the group come into these categories.

An analysis of present hospital and present hospital and medical debts in relation to income follows:



TABLE XVII

DISTRIBUTION OF PRESENT HOSPITAL COSTS  
BY INCOME SIZE

Income	Cost of Hospital Care for Present Illness								TOTAL
	\$1-99	100-199	200-299	300-399	400-499	500-749	750-999	1,000+	
\$ 0		1	2						3
1- 49	3	9	11	3	2	1	3		32
50- 99	7	6	9	3		5			30
100-149	1	1	1	1					4
150-199		1							1
200-249						1			1
TOTAL	11	18	23	7	2	7	3	0	71

The distribution of hospital costs for present illness in relation to income shows that of the fifty-two people who had hospital costs under \$300. forty-eight of them had income under \$100. a month. The person with the highest income had a hospital debt between \$500. and \$749.

TABLE XVIII

TOTAL AMOUNT OF HOSPITAL DEBT FOR PRESENT  
ILLNESS AND THE AVERAGE HOSPITAL  
DEBT FOR EACH INCOME RANGE

Income	Total Amount of Hospital Debt	Average Hospital Debt
\$ 0	\$ 627.70	\$ 209.23
1- 49	9,532.80	298.21
50- 99	7,467.95	248.93
100-149	791.25	197.81
150-199	121.75	121.75
200-249	514.76	514.76

Since the majority of the patients in the fixed income group had income under \$100., the figures giving the average

cost of their hospital debt are the ones which probably represent the situation for that group most accurately. Their average hospital debt is between \$200. and \$300. A comparison with the earning group shows that the earning groups who had average hospital debts in the same range were those groups who had earnings below \$1,000. a year. Their average hospital costs were also higher than other earning categories.

The distribution of the combined hospital and medical bills in relation to income size follows:

TABLE XIX

DISTRIBUTION OF HOSPITAL AND MEDICAL COSTS FOR PRESENT ILLNESS BY INCOME SIZE									
Income	\$1-99	100- 199	200- 299	300- 399	400- 499	500- 749	750- 999	1,000+	TOTAL
\$ 0			1	2					3
1- 49		7	8	10	2	2		3	32
50- 99	3	4	8	7	2	5	1		30
100-149	1			1	2				4
150-199		1							1
200-249						1			1
TOTAL	4	12	17	20	6	8	1	3	71

From the above table, it can be seen that when medical bills are added to hospital costs, the patients' indebtedness for illness costs is greater. The heaviest concentration of debts for hospital and medical care falls between \$100. and \$400., whereas debts under \$300. predominated when the hospital debt only was considered.

The total amounts of hospital and medical indebtedness and the average debt for each income range is given next:

TABLE XX

TOTAL AMOUNT OF HOSPITAL AND MEDICAL DEBTS FOR PRESENT  
ILLNESS AND THE AVERAGE HOSPITAL AND  
MEDICAL DEBT FOR EACH INCOME RANGE

Income	Total Amount of Hospital and Medi- cal Debt	Average Hospital and Medical Debt
\$ 0	\$ 972.70	\$ 324.23
1- 49	11,992.45	374.76
50- 99	9,939.05	331.30
100-149	1,122.35	280.58
150-199	171.75	171.75
200-249	669.75	669.75

Hospital indebtedness for the fixed income group amounted to \$19,056.21 and hospital and medical indebtedness totalled \$25,133.05. Doctors' bills, therefore, if submitted would have been \$5,806.85. The average cost of hospital care is \$268.39 per patient, of hospital and medical care, \$353.98. Average doctors' bills would be \$81.78, \$5.10 lower than the same figure for the earning group. The average cost of hospital care is \$93.34 per person higher than it is for the earning group. This would indicate that the fixed income group, on the average, have higher illness costs than the earning group. Factors of age, and the nature of the illness would have to be considered in discussing the reasons for this.

The expectations of this group to pay for the costs of their hospitalization follow:

TABLE XXI

NUMBER EXPECTING TO PAY HOSPITAL BILL IN  
RELATION TO INCOME SIZE

Income	Number Expecting to Pay:		
	In Full	In Part	None
\$ 0	1	1	1
1- 49	2	1	29
50- 99	7	4	19
100-149	2	0	2
150-199	1		
200-249			1
TOTAL	13	6	52

The majority of the lowest income groups did not expect to pay and only eighteen per cent of the total did. For those who expected to pay in full or in part, their desire to do so may well have influenced their answers. The average hospital debt, \$268.39, is high when income of the group is considered.

Since it is not possible to judge the public ward patient's ability to pay for costs of his present illness, we have instead looked at some of their significant economic characteristics. Out of this broad study we have chosen the patients with income of \$3,000. and over and savings of \$1,000. and over for special study. These are the patients who have the greatest assets. They appear to be some exception to the general pattern, since they constitute but a small part of the total sample. There are 16 patients with income of \$3,000. and over and four with savings of \$1,000. and over. Together they make up 8.4 per cent of the earning and fixed income groups. Since

these patients have the greatest assets, it might be reasonable to assume that if there are patients who could possibly pay for the cost of their present illness, they might be found in this group. However, our inability to determine this question has led us to focus our attention on a more detailed study of their economic circumstances. We shall comment on the factors which would appear to have had some influence in their choice of the public ward for hospital accommodation.

There was no one in the fixed income group who had income of \$3,000. and over. Our study deals only with those with earnings over \$3,000. Among those with earnings between \$3,000. and \$3,999., there were two families with seven dependents each, one with five and three with four dependents. It might appear, in addition to other factors, which may or may not have been present, that the family obligations alone of the breadwinners of these families would be sufficient to influence their choice of the public ward for hospital accommodations.

A case by case study of the remainder will be presented next since it has not been possible to generalize further. For the sake of brevity, it will be understood that the person responsible for hospital costs is employed full-time, unless otherwise stated. Also, the patient is the person responsible unless that, too, is mentioned otherwise. An interruption in earnings results when the patient is the breadwinner. Only the debts and savings of any significance have been included in the comments. Those patients who are admitted through casualty or by the police are automatically placed in the public ward. They may be transferred to other wards later after the

usual admissions procedures have been carried out, or they may remain in the public ward.

Case A: In this case, a man of sixty-three with an income of \$3,000. was a patient. He had three dependents, debts of \$1,300. including one of \$1,000. for a car, and a hospital bill of \$105.65. His medical treatment would have cost \$50.

It might appear that the factors of age, dependents, and debts may have influenced his choice of hospital accommodation.

Case B: A single man of fifty-five, although he had income of \$3,115. last year, was unemployed at the time of hospitalization and had a hospital bill of \$811.25 and medical treatment worth \$300. for his present illness. Age, employment status and hospital debt would appear to be significant factors in his economic circumstances.

Case C: A man of twenty-four with two dependents and income of \$3,380. was hospitalized at a cost of \$54.75. His medical bill would have been \$50. His other debts totalled \$687.73, and he had no savings. Possibly the large debt may have been a factor in his using the public ward.

Case D: A man with earnings of \$3,840. had two dependents and debts of \$500. for furniture and \$1,500. for a car. His wife was hospitalized at a cost of \$21.75. Her medical bill would have been \$35. He had \$100. saved. The earnings represented the combined earnings of husband and wife.

Case E: A man of forty-six was admitted to the public ward through casualty. He had had four previous illnesses all connected with chronic drinking. He had two dependents, \$212. worth of debts and a hospital bill of \$79.95 and medical

bill worth \$30. The earnings of \$3,700. were those of both husband and wife. He has had periods of unemployment in the past year.

Case F: A woman whose husband was responsible for her support had a hospital debt of \$52.50 and medical bill of \$10. Although the husband's job was seasonal, his earnings were \$3,800.

Case G: The breadwinner of a family of three was hospitalized at a cost of \$37.75. His doctor's bill would have been \$75. Earnings were \$3,600. a year and savings totalled \$600. There were no other debts.

Case H: One man who had earnings of \$4,020. in the last year was an inmate of a provincial reformatory, and was brought by the reformatory into the public ward. He had four dependents.

Case I: A man with earnings of \$4,500. a year was brought into the public ward through casualty. He had broken his back in a car accident and would probably be handicapped. He had four dependents, and a hospital bill of \$146.85 and a medical bill of \$50.

Case J: One man of forty had an income of \$6,000. from earnings. He had no savings, two dependents and a debt of \$1,800. for a car. His wife whose hospital bill was \$43.35 and medical bill would have been \$35. was referred to the public ward through casualty.

There were four patients with savings of \$1,000. and over.

Case K: A single man, seventy-three years old, had savings of \$1,000. and earnings of \$12. last year. He was admitted by the police. He had a hospital bill of \$275.65 and would have had a medical bill of \$60. His age, the size of the hospital bill

and method of admission are probably factors in his use of the public ward. He stated that his savings are for his funeral and for his children.

Case L: A single woman of seventy-two with earnings of \$416. a year and savings of \$1,200. was employed part-time. Her hospital bill was \$406.30 and medical bill \$90. Age and size of hospital bill would seem to account for her use of the public ward.

Case M: In this case, a woman of sixty-six years of age, retired, with no dependents had \$1,000. liquid savings and \$6,000. worth of Canada Savings Bonds. She was brought to the hospital by the police when she had an accident. She had a fixed income of \$180. a month from the interest on her savings. Her debts were \$300. and her bill for her present hospital care was \$121.75. Medical treatment was worth \$50.

Case N: A man of sixty-two years with one dependent, had had no earnings in the past year and no income in the past month. He had \$2,000. savings. He was classified as unemployed. His hospital debt for his present illness was \$250.20. Medical bills would have been \$125. His age, employment status and size of hospital debt may have been determining factors in his use of the public ward.



## CHAPTER V

### CONCLUSIONS

Out of our analysis of the income of the public ward patients in relation to savings, size of family, debts and cost of present illness, we have been able to make some observations about the economic circumstances of the groups who use the public wards.

Twenty-eight per cent of our sample were both economically and medically indigent. The remainder, excluding those whose incomes were unknown (6%) were economically independent at the time of the study.

One hundred and sixty-eight individuals and families reporting earnings in the past year made up forty-six per cent of the total sample. Their earnings ranged from \$12. to \$6,000. Average earnings were \$1,563.82, median earnings, \$1,400. The average earning figure was considerably lower than the average income of the medically indigent sample studied by the Commission on Financing Hospital Care in the United States.<sup>1</sup> The average income for that group was \$2,320.

The distribution of earnings fell most frequently in the earning categories below \$2,500. and gradually became less in the higher brackets. Other assets, savings, health insurance and homes owned, occurred less frequently and less than one-quarter of the group, in each case, had these kinds of assets. Mortgage debts against nineteen of the homes owned amounted to \$73,984. Savings amounted to \$8,683. and the average savings for the total earning group was \$51.65. Only two persons had

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<sup>1</sup>Becker, H., Editor, Financing Hospital Care in the United States, Vol. 3, p. 12.

savings over \$1,000.

The liabilities of the earning group which were considered were size of family, debts and cost of the patients' present illness. The average number of dependents per family was 3.3. The earning groups above \$1,500. had the highest average number of dependents per family compared to lower earning categories. Their liability in this matter appeared greater. One hundred and eight persons reported debts, totalling \$47,447.50, excluding mortgages. The average debt was \$282.42. Nine persons had debts over \$1,000. The average amount of debt was highest in the income ranges above \$1,500. The earnings groups' indebtedness was considerably greater than its savings. In considering the cost of hospital care for the patients' present illness, almost one-half of the group had hospital bills of less than \$100. When medical bills were considered, however, the indebtedness for illness costs would have increased considerably. Hospital bills totalled \$29,408.90, while hospital and medical bills together amounted to \$43,906.02. Medical bills, therefore, would have been \$14,597.12. The average cost of present hospital indebtedness was \$175.05 per patient and of hospital and medical care, \$261.34. It was observed that the three lowest earning categories, those under \$1,500., showed a higher proportion of single persons and their average debt was lower than other groups. The highest average hospital and medical costs occurred in the earning categories below \$1,000. The group with earnings between \$2,000. and \$2,499. had the greatest number of dependents, highest average debt, but the lowest sickness costs.

The patients' expectations of being able to pay their hospital bills seemed rather unrealistic, reflecting possibly a desire rather than an ability to pay. Sixty per cent expected to be able to pay in full or in part. Only forty-two per cent did not expect to pay at all.

The group which reported no yearly earning was called the fixed income group. The income figures were based on their monthly income. There were seventy-one persons in this group and they constituted twenty per cent of the total sample.

Their assets were considered first. There were three persons who reported no income in the month previous to hospitalization or to the study. The highest monthly income was \$205.25. The heaviest concentration of patients fell in the income categories between \$1. and \$99. Sixty-two or eighty-seven per cent of the group had income within this range. A large number of the patients in the fixed income group were single persons or couples receiving Old Age Security pensions. There were fifty-three of these. The average and median incomes for the group were \$60.27 and \$60. respectively. Regarding other assets, fourteen patients reported savings, four reported having some form of health insurance and fourteen owned their own homes. Only one home had a mortgage against it--\$8,000. Savings totalled \$11,392.50. Two persons had savings over \$1,000. The savings of one person, \$7,000., raised the total and average considerably for the group. The average was \$146.37.

Regarding their liabilities, there were forty-four single persons and twenty-seven individuals with dependents. The

average number of dependents per family was 1.25. There were more single persons than families in this group, while the opposite situation prevailed with the earning group. The earning group had more dependents per family, 3.3 dependents per family, than the fixed income group. Fourteen persons had debts, totalling \$3,966.34. The average debt per person was \$56.28. This was considerably lower than the average debt of \$282.42 for the earning group. The heaviest concentration of hospital debt for patients' present illness occurred for hospital debts under \$300. For hospital and medical costs, the greatest number of bills occurred under \$400. Hospital indebtedness amounted to \$19,056.21 and hospital and medical debts totalled \$25,133.05. Medical treatment would have been \$5,806.85. The average cost of hospital care was \$268.39 per patient and of hospital and medical care, \$353.98. Average doctors' bills would have been \$81.78. The average cost of hospital care for the groups with income under \$100. a month was between \$200. and \$300. A similar result was found for the two lowest earning categories, those below \$1,000. Hospital and medical costs for the same income categories of both groups were between \$300. and \$400. The average cost of hospital care for the total fixed income group was \$93.34 per person higher than the average cost of hospital care for the earning group.

This group's expectations of paying for hospital costs were a little more realistic than the earning group's. Thirty-seven per cent expected to be able to pay in full or in part as compared to sixty-three per cent who did not expect to pay

anything. However, for those who expected to pay, perhaps their expectations, too, reflect more of a desire to pay rather than the ability.

A special study of those patients with the greatest assets, income of \$3,000. and over and savings of \$1,000. and over, was made. There were twenty persons in all in these categories, sixteen with income of \$3,000. and over and four with savings of \$1,000. and over. Together they represented 8.4 per cent of the earning and fixed income groups and 5.5 per cent of the total sample. Their assets and liabilities were looked at more closely largely on a case by case basis and economic factors which might have been significant in their choice of the public ward for hospital accommodation were commented on. Conclusions regarding their ability to pay could not be made.

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APPENDIX A

Questionnaire Schedule  
Addressed to Public Ward Patients



STUDY OF PATIENTS IN THE PUBLIC WARDS  
OF THE WINNIPEG GENERAL HOSPITAL

November, 1956

Interviewer:

Surname \_\_\_\_\_

Sex \_\_\_\_\_

Lenth of Interview \_\_\_\_\_

Date \_\_\_\_\_

I. Identifying Information

1. Code Number \_\_\_\_\_ 2. Sex \_\_\_\_\_ 3. S.M.W.D. Sep. \_\_\_\_\_  
 (of patient)
4. Address \_\_\_\_\_ 5. \_\_\_\_\_  
 (street or P.O. address) (municipality)
6. Age at last birthday \_\_\_\_\_
7. Relationship to patient of person interviewed \_\_\_\_\_
8. Relationship to patient of person responsible \_\_\_\_\_
9. Address \_\_\_\_\_ 10. \_\_\_\_\_  
 (Street or P.O. address) (Municipality)

Note Sections II, IV, V, VI apply either to the patient or to the person responsible for his expenses, if this is someone other than the patient.

II. FAMILY

11. Number of dependent children \_\_\_\_\_
12. Number of other dependants \_\_\_\_\_
- \_\_\_\_\_
- (give relationship)

For single person: 13. Living with relatives \_\_\_\_\_

14. Rooming \_\_\_\_\_ Boarding \_\_\_\_\_ in Institution \_\_\_\_\_
- Other \_\_\_\_\_ Describe \_\_\_\_\_

15. Has hospitalization necessitated any special arrangements at home?

Describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

16. Patient referred by \_\_\_\_\_  
( include name of physician or agency)

17. Why is patient using the Public Ward?

18. Has patient a family physician

19. Has he ever had

20. Does patient or his family usually receive medical care from O. P. D. here?

21. No. of times patient has been in hospital in last 5 years

22. <u>Year</u>	23. <u>Type of Illness</u>	24. <u>Approximate Stay in days</u>	25. <u>Type of Accom.</u>	26. <u>Name of Hospital</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

27. How many times have members of the patient's family been in hospital in the last 5 years:

[illegible]

33. Diagnosis \_\_\_\_\_

36. Other \$ \_\_\_\_\_  
(Specify)

Illness likely to recur \_\_\_\_\_

IV. Employment

40. Last occupation before entering hospital \_\_\_\_\_  
\_\_\_\_\_
41. Employed: full time \_\_\_\_\_ part time \_\_\_\_\_ casual \_\_\_\_\_  
seasonal \_\_\_\_\_ retired \_\_\_\_\_ unemployed \_\_\_\_\_
42. Is he in receipt of public assistance \_\_\_\_\_  
(name of program)
43. Can he return to the same job \_\_\_\_\_
44. Can he return to another job in the same firm \_\_\_\_\_
45. Name of firm where he is employed \_\_\_\_\_  
(please print)
46. About how many employees are there \_\_\_\_\_
47. Is there a union in the firm \_\_\_\_\_
48. Is there any kind of group insurance for hospital care \_\_\_\_\_
49. Is there any kind of group insurance for medical care \_\_\_\_\_

V. Financial Status

50. Does person responsible own his own home \_\_\_\_\_
51. business \_\_\_\_\_ 52. farm \_\_\_\_\_
53. What is the amount of the unpaid mortgage \_\_\_\_\_
54. What is the amount of the monthly mortgage payments \_\_\_\_\_
55. Amount of money owing for hospital \_\_\_\_\_  
medical \_\_\_\_\_  
furnishings \_\_\_\_\_  
groceries \_\_\_\_\_  
car \_\_\_\_\_  
Other \_\_\_\_\_  
(specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
56. Total Debts \$ \_\_\_\_\_  
\_\_\_\_\_

57. Have any of these debts been amalgamated through a finance company \_\_\_\_\_
58. Amount owing monthly to finance company \_\_\_\_\_
59. How much did he pay last month on these \_\_\_\_\_  
(or last month before entering hospital)
60. Amount of savings \_\_\_\_\_ 61. bonds \_\_\_\_\_
62. Other assets (specify) \_\_\_\_\_
63. Number of bushels and type of grain in storage \_\_\_\_\_  
\_\_\_\_\_
64. Does he expect to be able to pay the hospital bill  
in full \_\_\_\_\_ in part \_\_\_\_\_
65. Does he expect to get help in paying it from:  
children \_\_\_\_\_ relatives \_\_\_\_\_  
municipality \_\_\_\_\_ Other \_\_\_\_\_  
(specify)  
\_\_\_\_\_

VI. Earnings and Income

66. Amount of earnings in last 12 months \$ \_\_\_\_\_  
(including those of spouse)

67. Amount of last month's income from:

earnings \_\_\_\_\_

old age security \_\_\_\_\_

annuity or pension \_\_\_\_\_

public assistance \_\_\_\_\_

rental of property \_\_\_\_\_

roomers and/or boarders \_\_\_\_\_

children or relatives \_\_\_\_\_

other sources  
(describe) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

68. Total Income \$ \_\_\_\_\_  
\_\_\_\_\_

VII. Insurance

69. Is there any kind of insurance which will help pay for hospital care \_\_\_\_\_ 70. medical care \_\_\_\_\_

Name of Insurance Company

No. of Policy

71. Individual \_\_\_\_\_

72. Group \_\_\_\_\_

If there is an insurance policy, record name and initials of holder \_\_\_\_\_

73. If patient is in hospital through a car accident, does he expect that his expenses will be paid through car owners policy \_\_\_\_\_

Name & initials of policyholder \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

No. of Policy \_\_\_\_\_

VIII. Health Organizations

74. Do you expect to get help from any of the following organizations:

S.C.A.A. \_\_\_\_\_ Red Cross \_\_\_\_\_ Cancer R.R.I. \_\_\_\_\_

C.A.R.S. \_\_\_\_\_ M.S. Society \_\_\_\_\_

If any of the above organizations are helping, record patients name and initials

\_\_\_\_\_

75. or from:

government insitution \_\_\_\_\_  
(specify)

municipality \_\_\_\_\_



IX. General

76. Note any special circumstances which would affect the person's ability to pay his hospital bill:

77. Note any circumstances which you believe may have affected the interview.