THE UNIVERSITY OF MANITOBA

A STUDY OF SOME OF THE ECONOMIC AND MEDICAL CONDITIONS OF THE PUBLIC ASSISTANCE PATIENTS WHO WERE DISCHARGED FROM THE PUBLIC WARDS OF THE WINNIPEG GENERAL HOSPITAL, NOVEMBER, 1956.

Being the Report of a Research Project
Submitted in Partial Fulfillment of the
Requirements for the Degree of Master of
Social Work

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Winnipeg, Manitoba
June, 1957

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CHAPTER I

Many controversial topics are discussed, re-discussed and never settled over cups of coffee. One is, why should the taxpayer pay his earnings to support and even to hospitalize the person who cannot do this for himself. The writer noticed an inconsistency in these discussions. There was general agreement the needy should be looked after and by the government, but the heat of the argument was created by comparison of the needy on assistance, to the marginal group who could pay their everyday expenses, but found unexpected bills overwhelming. One of the unsettled questions was, why should Mr. Jones pay taxes to help Mr. Brown, when Mr. Jones earned two hundred dollars a month, had a wife and two children and a hospital bill of several hundred dollars, and Mr. Brown, on city relief, probably had as high an income and did not have to pay a cent on his hospital bill. The writer, a taxpayer, felt this was a good question. She also felt it was necessary to secure more facts before she could answer it. Consequently, she was keenly interested to take part in a study of the patients of the public wards of the Winnipeg General Hospital, who were discharged during November, 1956. Here was a group of patients who it could be assumed, were unable to pay their medical bills because they had been

assigned to the public wards, and consequently, their income was marginal. This group would also be divided into public assistance patients and patients not on public assistance and a comparison could be made. Thus, a study inspired over coffee took on a formal character.

The purposes of this study are to compare the identifying information of the patients discharged from the public wards of the Winnipeg General Hospital during November, 1956, who were on public assistance, to the identifying information of the group of patients discharged in this period who were not on public assistance; to discover if the public assistance patient group has some economic and medical problems that are more or less severe than those of the group not on public assistance; also to study the public assistance group according to program and to compare the income of this group according to program.

Public assistance in this study means, help given in cash or in kind from public funds on a means test basis. This definition excludes the patients on old age security because such patients are not required to take a means test. The definition of public assistance will be given more meaning in Chapter III where the various programs are clearly defined.

This study is a portion of a pilot study of the patients

in the public wards of the Winnipeg General Hospital, who were discharged from there during November, 1956. The information for it was taken from 371 schedules which were used for the pilot study.

Originally, the writer hoped to discover if the group of public assistance patients received sufficient allowance to maintain a decent standard of living. However, time did not allow the translation of a decent standard of living into dollars and cents applicable to the patients of the study.

It was also originally hoped, that this study would discover if the group of public assistance patients was under more strain than the group of public ward patients not on assistance. Because of the qualitative characteristics of the word strain, it was difficult to define it and therefore this word could not be applied to the patients studied.

One of the limitations of this study is that we do not know if the patient is on public assistance because he is in hospital. For instance, we do not know if he was on a marginal income without savings, and hospitalization meant his family could only carry on and he could only pay his bill, by going on assistance. We do not know if hospitalization meant a loss of employment and this in turn meant going on assistance.

Again, we do not know if he has been on public assist-

ance for a long period of time and such factors as inadequate housing, an unsanitary neighborhood and anxiety from being dependent on tax funds, have contributed to his being ill. And if they have contributed, we cannot say if they have influenced the necessity of hospitalization, because we do not know all the factors involved.

We do not know the attitude of the public assistance patients toward medical treatment. For instance, we do not know if they have put off medical treatment because they feel they do not wish to be further dependent, or whether they have accepted it because they know the hospital bill is paid by the municipality and the doctors of the public wards of the Winnipeg General Hospital do not charge medical fees. This latter fact is because the Medical Faculty of the University of Manitoba uses the patients in the Winnipeg General Hospital public wards for teaching purposes and it is customary, under such circumstances, not to charge medical fees.

We do know from the schedules the identifying information of this group of patients and the composition of the public assistance group according to program. We also know the income of the patients or of the person responsible for the care of the patient, for the month previous to hospitalization and if these patients or persons responsible had debts on entering hospital. The number of times the patients and members of the patient's

family have been in hospital during the past few years is also known. From these facts this study will attempt to answer the following questions. Are there any marked differences in the identifying information of this group of public assistance patients and the group of patients not on assistance? The identifying information will be compared according to marital status, sex and age. In the composition according to program of the public assistance patient group, how will members in each group compare and how will the income in each group compare? Do the patients in the public assistance group have some economic and medical problems that are more severe than the economic and medical problems of the group of patients not on public assistance?

Material for the economic comparison of the two groups will be based on the income of the month previous to hospitalization of the patient, or of the person responsible for the patient's care. It will also be based on the percentage of patients or persons responsible, who had debts previous to hospitalization. The income will be compared according to dependents and it will be noted if the average income increases with the addition of dependents. It is expected it will in the public assistance group, because in some programs, the allowance and the amount allowed to be earned is based on the number of dependents. It is expected it is not as likely to increase with the addition of dependents in the group of patients not on public assistance, because the income is predominantly the earnings of the breadwinner. One of

the exceptions to this is the patient in receipt of old age security whose spouse also receives old age security and therefore the income increases because there is a dependent. The comparison of the prevalence of debts in both groups, is included in the economic comparison because debts represent a demand on income received.

The medical comparison will be based on the number of times the patients in both groups have been previously hospitalized during the past five years and on the length of time of these previous hospitalizations. Also the frequency of hospitalization of members of the patient's family in the same period will be compared.

Some limitations of this study have already been stated, but three more should be added. First, the debt picture of the patients in the two groups will not be accurate because the amounts of the debts of the patients will not be calculated. However, a statement showing which group has the greater percentage of patients with debts will indicate whether this economic problem is more prevalent in one group than the other.

Secondly, it may appear from this study that an addition to the family is a less severe problem economically, for the public assistance patients than for the patients not on assistance. If this is so, how much less severe cannot be estimated because, we do not know the number of dollars and cents necessary for a

decent standard of living for an additional dependent.

Thirdly, the number of public assistance patients will probably not be sufficiently large for a scientific study but it may be sufficient to indicate a trend which would be useful for future study in this field.

The findings of this study will be described in statements and illustrated in tables. These will show the composition of the public assistance group according to program and compare the income of the public assistance patients according to these programs. Statements and tables will also compare the identifying information and some of the economic and medical conditions of the group of patients on public assistance to the group not on public assistance.

This study is introduced by a brief history of medical public assistance, also a short history of the policy of the Winnipeg General Hospital toward the public assistance patient. Also included in the second chapter is a list of goals of service to the patient on public assistance.

The third chapter describes in detail the method of this study.

An analysis of the collected data and also a description of the trends that appear, are given in the fourth chapter.

In the final chapter, the conclusions are given meaning, a statement is made indicating areas of possible future study and the limits within which any findings may apply are stated.

CHAPTER II

The present study deals with the public assistance patients discharged from the public wards of the Winnipeg General Hospital during November, 1956. It is interesting as a background to this study, to get a glimpse of the historical heritage of the public assistance patient and to speculate on what the future should hold for him.

As this is done, two points will be emphasized. First, the development of public responsibility in assisting the patients in need, and second, the attitude of the authority giving the assistance.

These two points will be illustrated by some historical facts particularly as seen in England. The author was unable to secure historical data regarding the public assistance patient in Canada, but some of the developments of the Winnipeg General Hospital will be noted. Because of the fact the future grows from the past, this chapter will contain a statement of goals for the public assistance patient, for the future.

During the mediaeval days of England giving to the needy was considered a riligious virtue. This led to the establishment of hospitals and other charitable institutions by

religious orders and lay brotherhoods. Many of the monasteries maintained a few pensions for the handicapped on a permanent basis. Charity was a private responsibility and was not what we would consider today, a well planned social assistance program.

In 1539 all monastic institutions in England were seized, which meant a discontinuance of their hospital services, and the few pensions they carried. This was one cause for the responsibility of financing medical help to the poor, changing to a public responsibility.

In 1601, through the Elizabethan Poor Law, the poor and the sick, who could not pay for treatment, became a public responsibility. The parish through local taxes cared for them. The sick were classed with loafers, vagrants, beggars and drunkards. An investigation was made to be sure the applicants were worthy as opposed to being sinful, before assistance was given. Care of the needy ill person was not a virtue, but an unpleasant responsibility of the parish. The recipient's self respect was damaged by being classed as a pauper, which bore a severe stigma.

In the eighteenth and nineteenth centuries with the growth of industrialization, there was more opportunity for the poor and some of them became affluent. This was interpreted as the Lord's approval of the industrious person who bettered himself -

and for the person who did not better himself, it was interpreted as a sign of laziness and poor management.

By the middle of the nineteenth century, a trend had developed toward a better understanding of the poor person in need of medical assistance. For example, Ireland was the first English speaking country to do something concrete to remove the stigma from the medically indigent. In 1851, the Medical Relief Charities Act of Ireland declared that "any poor person who was sick, although not necessarily a pauper had the right to free advice and medicine and such was not deemed to be on poor relief".[1] In other words, such a person's name was not published on a pauper's list.

Another example of this trend is in the minority group report of the British Royal Commission, 1906, which investigated the poor laws. It recognized the inadequate medical service given the poor on relief, also that a breakdown in health increases the number needing public assistance. This report stated "We accept responsibility for recommending the adoption of a Public Health principle of searching out disease in its incipient stages in place of the Poor Law attitude of

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1. Frank Goldmann, Public Medical Care, Principles and Problems, p. 71

waiting until the disease had gone so far as, on the one hand, to produce destitution, and on the other, to render the belated but costly treatment of no avail."[1]

This was the minority report, but it is noted here as a trend of that time, which today is generally accepted as true.

Public responsibility for medical services was increased in England in 1911 through The National Insurance Act (Health and Unemployment Insurance). This gave some medical services to wage earners below a certain wage range and supplied public assistance doctors for the destitute. In 1952 a medical officer of the Ministry of Health described the service given by these doctors. He stated, "There were the Public Assistance doctors; this was a general practitioner service for the destitute to enable them to get some sort of medical help, it was not very good."[2] Public responsibility was further increased in 1948 when the National Health Service Act provided medical and hospital services to everyone in England and Wales.

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1. Franz Goldmann, ibid, p. 73.

2. A Medical Officer of the British Ministry of Health, The National Health Service, p. 3

Turning now to Manitoba and the care of the medically needy in the Winnipeg General Hospital, we find it was organized in 1872 and was incorporated by act of the Province of Manitoba in 1875. Through an examination of the records at the Winnipeg General Hospital, there is nothing to indicate whether it was privately or publicly financed until the year 1883. In that year, the Charity Aid Act was passed by the Provincial Government and stated "All hospitals in the Province, after inspection and approval by the Lieutenant-Governor in Council, were to receive twenty-five cents per day for each day's treatment of each patient."[1]

In 1883, as stated in the Winnipeg General Hospital's minutes, "The hospital was supported by a grant from the Provincial Government under the Charity Aid Act, grants from the City of Winnipeg, and some municipalities and subscriptions from private citizens."[2] These latter contributions were based on the understanding that they were to be applied for the relief of those who could not be properly cared for at their own expense. In the same year, the Hospital Board refused a request from the Medical Board to charge patients in the public wards for their services.

These three facts would indicate that financial responsibility for hospital care of those on public assistance was

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1. J. Cosgrove, Untitled History of Winnipeg General Hospital, p.34

2. Ibid, p. 35

carried by both public and private donations. The public contribution was from the Province and the municipalities, the private contributions were from donations by citizens and the donation of free service by the medical profession.

In 1908, the contributions from the municipalities changed from grants to a rate for each public assistance patient. The municipality of Winnipeg presented to the Union of Municipalities, a recommendation that each municipality should pay one dollar per diem for all patients who were residents of that municipality. This recommendation was passed and was then presented to the Government of Manitoba. The government passed it and added a clause which stated that the Provincial Government would pay one dollar per diem for all patients who could not be classed as residents of a municipality within the province.

In 1956, an amendment to the Hospital Aid Act established the present policy regarding the financing of hospital costs of patients on public assistance. By this amendment a Hospital Rate Board was established. The function of the board is to establish each year, a rate for the hospital care of indigent, standard ward patients for each of the hospitals of Manitoba. It is according to this rate that the provincial government reimburses the municipalities of Manitoba 40 per cent of their cost for hospitalization of indigent standard ward patients.

This group includes all patients in the standard wards who within thirty days of receiving their bill have not paid their accounts and have made no arrangement with the hospital for payment. This would include all public assistance patients who cannot pay their bill. Since 1884 and at the present time, medical services are donated to the patients in the public wards by the physicians of the Winnipeg General Hospital, in return for being teaching material.

The writer has chosen two instances in the history of the Winnipeg General Hospital which illustrate the attitude of those in authority toward the public assistance patients.

First, in 1910 A Social Service Department was established by the Winnipeg General Hospital. The writer feels this indicated a recognition of the need to give the patients help with their individual problems. Thus, individualized social service was given to the patients who desired it and the public assistance patient could avail himself of this service.

Second, during the depression in the 1930's some municipalities decided that public assistance recipients could not enter the Winnipeg General Hospital and have their bills honored, unless they first received permission from the municipality. Exceptions to this rule were, accident and cancer patients or if a patient brought a letter from his physician recommending admission on a public ward basis. A similar restriction was made by

the City of Winnipeg in 1937 or 1938. These restrictions were withdrawn in 1956. One would expect that such restrictions would often increase the patient's feeling of dependency and would often postpone treatment.

Some of the historial facts regarding the public assistance patient have been stated and it seems only logical that we should add some goals for the future. This is done because the past is most useful when it is used to focus on some goals for the future which will emphasize the good points of the past and discard the weak points.

It would seem right that the public assistance patient's bills should be paid from public funds. In this way, he would be less likely to feel he was accepting charity, because at some time, through his taxes or rent he has, in all probability, contributed to public funds, whereas he may not have had the opportunity, means or inclination to contribute to the funds of private agencies.

The writer has compiled the following list of goals for service to the public assistance patient by the hospital, the social agency and the associated professions such as physicians, social workers, dentists, nurses and pharmacists. This list has been made from information written by Josephine C. Brown, Pearl Bierman and Franz Goldmann.[1]

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1. Josephine C. Brown, Public Relief 1929-1939, p.256
Pearl Bierman, "Medical Assistance Programs" Social Service Review, 1954, p. 195.
Franz Goldmann, Public Medical Care, pp. 87 and 88

1. Recipients of public assistance should be accepted for medical treatment and hospitalization without further investigation. This would include without special authorization of the municipality.

2. To prepare the public assistance recipient for medical and hospital care the social worker should make clear to him, what services are available and how the bills are paid. If a choice of medical and hospital care is available, the social worker should leave the choice to the client. The social worker should be available when needed but should not "take over" and make decisions for the public assistance patient.

3. There should be co-operation between the agency and the hospital and a quality of service given that encourages its full use. That is, an avoidance of a type of service which will deter the needy from securing the necessary medical care or deter well qualified practitioners or agencies from participating in the service.

4. Medical care of the public assistance recipient should be both preventative and curative and should be adequate. It should include general practitioners and specialists. It should provide a close and continuing relationship of patient and physician.

Medical care should be continuous, including continuity of diagnosis and treatment and an integration of

medical and social treatment. It should include home care and hospital care.

5. The administration must decide the sum of money to be spent on the public assistance patient and this sum must be acceptable to the taxpayer. As the administration does this, it should give consideration to the fact that good medical care is often the determining factor in restoring the public assistance patient to productive employment.

6. There should be reasonable payment to all participating personnel. This insures as competent service to these patients as to those not on assistance. It is also a safeguard to the patient-physician relationship.

Three studies concerning the public assistance patient and the lower income family were read, but two did not deal with the personal medical and economic problems of the public assistance patient, and the third gave a budget which could not be applied to the present study. Therefore, none of these studies could be used as a basis for the present study.

One study was, Financing Hospital Care for Non Wage Earners and Low-Income Groups[1], and it dealt with the necessity

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1. Harry Becker (ed) Financing Hospital Care in the United States, Vol. 3; Financing Hospital Care for Non-Wage and Low Income Groups

of securing sufficient funds to give adequate services to the medically indigent in the United States. Another was, Public Provision for Medical Care in Canada[1], which described the medical care available by the three levels of government. The third, a Guide to Family Spending in Toronto[2], presented a family budget which was a standard for economically independent families at a minimum level.

In this chapter we have seen some of the historical developments in the care of the public assistance patient in Great Britain and in the Winnipeg General Hospital. Some goals for the future have been stated and some related studies have been mentioned.

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1. Canadian Welfare Council, Public Provision for Medical Care in Canada

2. Welfare Council of Toronto and District: A Guide to Family Spending in Toronto

CHAPTER III

The purposes of this study were described in Chapter I. This chapter will describe the source of the data used, and will outline the method used to answer the questions previously raised. It will also define some terms used and the programs referred to.

The information for this study was taken from 371 schedules which were filled in for the pilot study of the patients of the public wards of the Winnipeg General Hospital who were discharged during November, 1956. These schedules included questions regarding identifying information such as marital status, sex and age of the patients, also regarding family composition, such as the number of dependents of the patient or of the person responsible for the patient's care. Other questions referred to the medical background of the patient, such as how referral was made to the hospital and how frequently the patient and members of his family had been hospitalised during the past five years. Income of the patients, whether through employment or public assistance, debts of the patients or persons responsible and the prevalence of insurance coverage were covered by questions on the schedule. The patient's plan for payment of his current hospital bill was also stated.

Answers to the above groups of questions were filled in by nine second year social work students, three graduate social workers, and by the interpreter of the Social Service Department of the Hospital. The latter staff member interviewed those patients who could not speak English.

The staff doctors and the Medical Records Department of the hospital from the records of the patients, filled in the sections referring to medical information. The Accounts office completed the schedules by stating the cost and length of the present illness of the patients.

Much of this study is to be done on a comparative basis and to accomplish this it is necessary to divide the patients into two groups. Group A will include those patients who are on public assistance, and Group B those patients who are not on public assistance.

The term public assistance has already been defined and before defining the various programs of public assistance, it will be helpful to define what is meant by a means test. The purpose of a means test is to determine if the applicant has sufficient income and/or assets to live according to a standard set by a municipality or province. If he has not, he is considered to be in need and consequently, he is eligible

for assistance.

Two further points which clarify the giving of assistance are, in all programs it is necessary for a person to make application before assistance is given. Secondly, in each public assistance program the recipient is permitted to add some earnings to his allowance. If more is earned tha is allowed, partial assistance is granted, up to the maximum. The amount allowable varies according to program, and in municipal assistance it varies from municipality to municipality.

It should also be noted that due to the means test being the basis for granting public assistance, it is obvious that it is not possible for the public assistance recipient to pay his own hospital bills.

The programs in Group A are recorded from the schedules as municipal assistance or relief, social assistance, old age assistance, blind person's allowance, mother's allowance, other programs and unstated programs. In the group of other programs, the interviewer listed those receiving disability allowance, one who was receiving an "Indian Ration" and those who came to the hospital from a penitentiary.

Following are the definitions of the various programs listed in Group A. Municipal assistance or relief is help given in cash or in kind to the legal residents of a municipality who are in need. Help is given on a means test basis according to rates set by the municipality and the rate increases with the addition of dependents. The funds for this assistance are given by the three levels of government, the municipality, the province and the federal government.

Social assistance in this study follows the same plan as municipal assistance with the following differences. The applicant has legal residence in unorganized or disorganized territory or has not established residence. The rates are set by the Province of Manitoba and the funds are supplied by the provincial and federal governments.

Old age assistance is an allowance given to applicants between the ages of sixty-five and sixty-nine on a means test basis. The maximum allowance is forty dollars a month and the provincial and federal governments each pay 50 percent of the amount given. Applicants are required to have resided in Canada for twenty years previous to application.

Blind person's allowance is the allowance given to those who are blind and are twenty-one years of age or over. The word blind in this instance means 10 per cent or less vision after glasses have been prescribed. This allowance is

given on a means test basis and the maximum is forty dollars a month. The federal government pays 75 per cent of the allowance and the balance is paid by the Province of Manitoba. The applicant must have resided in Canada for ten years previous to application.

Mother's allowance is financial assistance given on a means test basis according to rates set by the Province of Manitoba. It is given to a mother whose legal residence is Manitoba and when the father is dead, is permanently disabled, or has deserted his family for four years or more.

The rate of allowance is increased according to the number od dependents. It is required that the dependents be fourteen years of age or younger, or if they are older they must be physically or mentally disabled. Also if they are older and in school and doing satisfactory work, the mother may apply for a special allowance for them. The applicants must have resided in Canada ten years immediately prior to their application. The Provincial government supplies the funds for this allowance.

Indian ration is the amount paid monthly by the federal government in accordance with the Indian Act of Canada. It is paid to treaty Indians and the residence requirement is that they live on a reservation. The amount is determined by

the Indian agent of the reservation, the ration is given to those in need and is in accordance with the individual need of the recipient. This agent is appointed by the federal government. The Indian ration is given in cash or in kind. Medical and hospital assistance is provided by the federal government and hospitalization is usually in hospitals which serve only Indian patients.

The results of the schedules were first divided into two groups, 107 in Group A and 264 in Group B. Six schedules in Group A were discarded because there was insufficient information to classify them.

In the schedules in Group A, when it was difficult to classify the information about income, the following rules were followed:

1. When any part of the income for the month previous to hospitalization is from public assistance, the income is tabulated under the program named.
2. Where income is from two programs, it is tabulated under the program which contributes the highest allowance. For instance one family receives from mother's allowance sixty-five dollars and from blind person's allowance forty dollars. This income was recorded as mother's allowance.

3. Where patients receive old age security and are in nursing homes and these nursing homes are supplemented by municipal funds, income is tabulated as public assistance and the program is considered municipal assistance. This rule also applies when the amount of supplementation is not known but it is known that there is some supplementation. Old age security is not public assistance because there is no means test. It is an allowance of forty dollars a month paid by the federal government to applicants who are seventy years of age or older and who have resided in Canada for the twenty years prior to application.

4. Where one member of the family receives old age security and another receives old age assistance, the total is tabulated as old age assistance.

5. Where income is from old age security and municipal assistance, the total is tabulated as municipal assistance.

6. When on entering hospital the patient's earnings stopped and he became a recipient of public assistance, the patient is tabulated as being on a public assistance program but his income is not entered, because no part of his previous month's income was public assistance. Consequently, under income in

Group A the income of ninety-eight patients is tabulated.

As previously stated, information secured from the schedules will be organized into tables and statements in order to fulfill the stated purpose of the study.

The identifying information of Groups A and B will be compared in respect to marital status, sex and age and the data is taken from questions 2, 3 and 6 of the schedules.[1] The comparisons will be shown in three tables and in the third the comparison of age will be according to ten year intervals. All comparisons will be made on a percentage basis. The above method will enable the reader to grasp quickly the comparison of the identifying information of groups A and B. Any marked difference in the identifying information of the two groups will be noted.

To study the economic conditions of the patients in Groups A and B, where debts are concerned, question 56 of the schedules[2] is used. The groups will be studied as a whole and the percentage in each, of patients or persons responsible

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1. Appendix A, p. 1

2. Appendix A, p. 4

3. Ibid

having debts before the present hospitalization will be stated. This will compare the prevalence of patients having debts in both groups and will show in which group debts are a more severe economic problem.

Questions 11 and 68 of the schedules[1] are used to determine the income of the patients or persons responsible for the care of the patients, for the month previous to hospitalization. Groups A and B will be compared and the income will be reduced to the average income according to the number of dependents. This comparison is done according to family composition, because it was felt that income in Group A may increase with dependents more than in Group B and a breakdown according to dependents would give a more accurate picture of the severity of the economic problems of these two groups. The findings will be illustrated in a table which will compare the average income of one person, of one person and one dependent and accordingly up to one person and over four dependents.

The comparison of the medical situations of Group A and B will be according to the previous hospitalization in the past five years, of the patients and of members of the patient's family. Information for this comparison will be

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1. ibid, pp. 1 and 6

taken from answers to questions 21, 24 and 27 in the schedule.[1]

A statement will be made comparing the percentage of patients in Groups A and B who have been previously hospitalized. Then a comparison will be made of the average number of days the patients in these two sub-groups of A and B have spent in hospital during the past five years.

The percentage of patients in groups A and B who have had members of their family in hospital during the past five years will be compared. In these sub-groups the average number of times the patient has had members of his family hospitalized during the past five years will be stated.

The comparison of the previous hospitalization of patients and of members of the patients' family has been made to show whether the patient and his family in Group A is more or less prone to hospitalization than the patient and family in Group B.

Groups A and B have been compared in order to discover if Group A has some economic and medical problems more or less severe than Group B. Since Groups A is the focus of the study, it was felt a greater understanding of this group could be obtained by a study of its composition and a compari-

1. ibid, p.2

son of the income of the various programs. Consequently, the composition and comparative income of Group A will be shown in a table and the information will be taken from answers to question 42 and 68 on the schedules.[1] This table will show the percentage of patients in each of the programs and the average income per person of the month previous to hospitalization of the patients or persons responsible, for the care of the patients, according to program. The average income per person will include dependents in the family. In seven of the 101 schedules the income for the month previous to hospitalization is not used. In three cases the patients went on municipal assistance on entering hospital. In one case the patient was on social assistance and did not state the amount of income. In three cases the patients came from institutions.

It was hoped to compare the income of the programs according to dependents, which would give a comparison of income and family responsibility. However, it was found, when this information was compared that the number of patients in some of the programs was too low to make this breakdown of income significant.

In working with the schedules it was found that the following further limitations were necessary.

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1. Appendix A, pp. 4 and 6

When some of the schedules were checked with the Winnipeg General Hospital Records office, it was found there were errors in some of the patients' statements regarding previous hospitalization in this hospital. It will therefore be necessary to treat these findings as approximations rather than as accurate statistics.

In studying the schedules the number of families who went on public assistance at the time of hospitalization was discovered. However, it was still felt that it was difficult to state if these were the only cases where hospitalization caused the family to go on public assistance. For instance, an illness leading to hospitalization could have caused the patient to go on assistance two or three months previous to hospitalization. Therefore, we still do not know, except for three patients, how many patients of Group A have gone on assistance because of the present hospitalization.

The fourth chapter of this study will analyze the findings of the schedules according to the method described in this chapter.

CHAPTER IV

To present the data of the schedules, the patients have been divided into two groups. Group A includes the patients on public assistance, and Group B those not on public assistance.

Comparison of Identifying Information

Table I compares the marital status of Groups A and B and divides those in them into patients who are married, single, separated, widowed, and divorced.

TABLE I

PERCENTAGE OF PATIENTS IN GROUPS A AND B BY MARITAL STATUS

Status	Group A %	Group B %
Married	25.74	48.86
Single	28.71	27.27
Separated	18.81	9.47
Widowed	24.75	12.88
Divorced	1.98	1.52

In this table it is seen that in Group A the married, single and widowed patients are each approximately one-quarter of the group; in Group B one-half are married and one-quarter single. Reading across the table there are twice

as many married patients and half as many separated and widowed patients in Group B than in Group A. The single and divorced patients are practically the same. This would indicate that in this study the married patients dominate Group B whereas there are three dominant groups in Group A, the married, single and widowed. The marked differences in the comparison of the identifying information are that the separated and widowed patients are twice as dominant in the public assistance group and there are twice as many married patients in the group of patients not on public assistance.

Table II compares the percentage of male and female patients in groups A and B.

TABLE II

PERCENTAGE OF PATIENTS IN GROUPS A AND B BY SEX

SEX	GROUP A %	GROUP B %
Male	42.57	45.83
Female	57.43	54.17

This table shows the difference in percentage of male and female patients to be too small for any inference to be drawn from it.

Table III concludes the comparison of the identifying information. It compares the ages in Group A and B

according to ten year intervals.

TABLE III

PERCENTAGE OF PATIENTS IN GROUPS A AND B BY AGE IN TEN YEAR INTERVALS

AGE	GROUP A %	GROUP B %
up to 19 years	7.92	11.74
20 to 29	8.91	20.08
30 to 39	20.79	14.77
40 to 49	10.89	12.12
50 to 59	10.89	10.98
60 and over	40.59	30.30

This table shows a marked difference in the age groups 20 to 29 and 30 to 39. However, when the median was worked out for the age range 20 to 39 in groups A and B it was 32.5 years in Group A and 28 years in Group B. This indicates there is not as much variation as the table indicates. In the groups up to 60 years in Group A the concentration is in the 30 to 39 group, while in Group B the concentration is in the 20 to 29 group.

This table also shows that the 60 and over group is twice as large as any other group in A and in B one and one-half times as large as any other group.

The 60 and over group comprises 33.15 percent of the total 365 patients in both groups. This emphasizes the fact that in Group A the percentage is one-quarter higher than in Group B.

In studying the 60 and over group more carefully, it was found the age range in A is from 60 to 82 and the median is 68. In B it is 61 to 97 and the median is 73. Therefore the 60 and over patients in Group A tend to be younger than in Group B. A possible cause of this is that in the public assistance program, old age assistance stops at 69 and the old age security non-assistance program starts at 70. So there is more illness in the public assistance group in this age range.

The marked differences shown by this table are in the 60 and over group. The percentage is considerably higher in Group A and in this group the age range is smaller and the median age lower.

Comparison of the Economic Conditions

In the comparison of the economic conditions of the patients in Groups A and B the percentage of patients in Groups A and B having debts on entering hospital will be stated and the income for the month previous to hospitalization of the patient or the person responsible for the patient's

care, will be compared according to dependents.

In comparing the prevalence of debts in groups A and B it was noticed that the percentage of patients who did not state whether they had debts or not was 6.93 percent in Group A and 2.27 percent in Group B.

According to the schedules, in Group A, 42.58 percent of the patients had debts on entering hospital, whereas in Group B., 53.41 percent had debts on entering hospital.

This would indicate that in Group B, that is the patients not on public assistance, 10.83 percent more patients have the economic problem of paying debts. Some indication of their comparative ability to pay their debts will be seen in the following table.

TABLE IV

AVERAGE INCOME IN GROUPS A AND B FOR THE MONTH PREVIOUS TO HOSPITALIZATION BY DEPENDENTS

	GROUP A $	GROUP B $
1 Person	45.94	70.90
1 Person and 1 Dependent	71.06	109.74
1 Person and 2 Dependents	63.73	216.12
1 Person and 3 Dependents	71.42	179.22
1 Person and 4 Dependents	92.00	198.79
1 Person and more than 4 Dependents	151.28	186.48
Total Average Income	64.65	112.23

In reading Table IV a greater understanding of it will be gained if it is realized that 39 of the 264 patients in Group B have as their only income for the month previous to hospitalization their old age security allowances. Also that earnings are not as controlled as public assistance allowances. Therefore a wide variation of income is shown in Group B and in Group A there is more variation than was expected, because some of the patients have as their only income, their public assistance allowances and others have added to their allowances substantial amounts of earnings. It should also be realized that in breaking down Group A and

Group B into family composition many of the classifications have only a few patients in them.

Some examples of the above are, in the classification of One Person, in Group B, twenty-five of the eighty-four patients have an income of forty dollars a month, which is their old age security allowance. If the income of this group was discarded, the average income would be eighty-four dollars.

In the classification of one person and one dependent, two reasons Group A is higher than in the next classification are, of the eighteen patients in this group, ten are on municipal assistance and six of these also have earnings whereas in the next classification none of the five in receipt of municipal assistance have earnings. Also four of the eighteen patients received eighty dollars a month because they were in receipt of both old age security and old age assistance. The average in Group B was reduced by eight patients receiving eighty dollars from old age security and three receiving forty dollars from old age security. We thus again see the influence of the old age security patient in Group B.

In the classification of one person and two dependents, there appears no unusual schedules in Group A but in Group B, six of the twenty patients have an income ranging from three hundred to five hundred dollars for the month previous to

hospitalization.

Two known reasons contributing to the difference in the average income of one person and four dependents, and one person and over four dependents in Group B are, there are in the latter, supplemented earnings in six of the thirteen incomes and in one case the supplementation is two hundred and sixty dollars. Also the number of dependents ranges from five to nine and for twelve of the thirteen p patients in this classification, the public assistance allowance is given according to dependents.

Looking at the table as it stands, it is apparent that each classification in Group A has a considerably lower income for the month previous to hospitalization than the corresponding classification in Group B. That is they have considerably less money with which to meet the necessities of living such as food, shelter and clothing.

It is therefore true that in the group studied, the public assistance patient has one economic problem more severe than the patient not on public assistance. That is, they have less money with which to meet the essentials of living. At the same time it must be remembered they do not have to pay their present hospital or medical bills. However,

for the group of patients in Group A who have debts that require payment they have a second economic problem more severe than the patients of Group B who have debts. That is, they have less income with which to pay their debts.

Income in both groups tends to increase with the addition of dependents. Here the patients who are on public assistance do not have the advantage over Group B that was anticipated.

Comparison of Medical Conditions

To secure a medical comparison of groups A and B, the percentage of patients in both groups who have been previously hospitalized in the past five years is stated. Another comparison is that of the previous hospitalization of the patient's family.

In Group A, 75.25 percent of the patients were previously hospitalized during the past five years and the average period of hospitalization was 51.8 days.

In Group B, 62.12 percent of the patients were previously hospitalized and the average period of hospitalization was 47.13 days. Included in Group B was one patient who spent three years in a Sanatorium and this was recorded as 1100 days. When this tabulation is discarded from Group B, the average number of days of these patients is reduced to

40.68.

These figures indicate that according to this measure, the group of public assistance patients has a medical problem more severe than the group of patients not on public assistance.

That is, during the past five years a higher percentage of this group has been hospitalized. Also of the patients in Groups A and B who have been previously hospitalized, those in Group A have averaged a longer period of hospitalization.

Of the 101 patients in Group A, there were 53 who had dependents. Of this number 58.49 percent had family members who were hospitalized during the past five years. Of the 264 patients in Group B, 180 had dependents and of these family groups, 38.88 percent had some family members who were hospitalized in the same period. The average number of times these family members were hospitalized was 3.19 for Group A and 2.51 times for Group B.

From these figures the following conclusions may be drawn. In both groups it is the patient himself rather than members of his family who has been more frequently hospitalized in the past five years.

The public assistance patient has had to use the hospital more frequently than the patient not on public assistance, in the past five years.

The public assistance patient, on the average, has had to stay in hospital longer than the patient not on public assistance.

The public assistance group has had a higher percentage of dependents in hospital in the past five years than the group not on public assistance.

The last three conclusions indicate that the group of public assistance patients has three medical problems more severe than the group of patients not on public assistance. A higher percentage have found hospitalization necessary in the past five years. Of those who have been hospitalized, their average length of stay in hospital has been longer and more have had dependents in hospital.

Composition of Group A

Because the focus of this study is on public assistance patients, the composition of this group is shown according to program. This is accomplished by comparing the average income, for the month previous to hospitalization, of each person in each program. That is, the total income of the program is divided by the total of dependents and heads of families, who

benefit under this program. This is done by Table V which states the percentage in each program and the average income of each person benefitting from the program.

TABLE V

PERCENTAGE OF PATIENTS IN EACH PROGRAM AND AVERAGE INCOME FOR MONTH PREVIOUS TO HOSPITALIZATION OF EACH PERSON ACCORDING TO PROGRAM IN GROUP A

PROGRAM	% of Group A	Average Income Per Person
Municipal Assistance	58.42	$ 26.99
Social Assistance	7.92	22.86
Old Age Assistance	16.83	37.26
Blind Persons Allowance	3.96	46.25
Mother's Allowance	4.95	18.03
Other Programs	6.93	20.71
Program not stated	.99	40.00

6

From Table V it is noted that over half the patients discharged from the public wards during November, 1956, were in receipt of municipal assistance and this group is over three times larger than any other group. Of the municipal assistance group 88.14 percent are from the city of Winnipeg. Because Winnipeg is the largest municipal centre in Manitoba and the patients of this study were patients of the Winnipeg General Hospital one would expect that the municipal assistance program would have the largest percentage of public assistance patients.

The old age assistance group is second largest and this again emphasizes that the over sixty group has a high percentage on public assistance.

From Table V we also see that it is the programs where the income is not according to dependents that have the largest income per person. That is, blind person's allowance and old age assistance. This is fortunate for these recipients because they have fixed costs such as rent, which must be paid and the cost is not shared by any public assistance income from dependents. Another comparison is municipal assistance and social assistance and according to this study and this measure, municipalities on the average give more than the province. Mother's Allowance in this table is misleading because when this allowance is given there is always at least one dependent. Thus expenses such as rent would be shared by at least two people and therefore this allowance is not as low as it would appear.

In the final chapter a summary will be made of the findings described in the present chapter.

CHAPTER V

Within the limitations noted in Chapter I and III this study has shown some positive results. As they are outlined, it should be remembered this is a study in one hospital in a particular area with a local set up of programs. The results therefore would not be applicable to a different locality.

In the comparison of identifying information, the marked differences in the marital status are, first, in the public assistance group there are three dominant groups that showed a need to use the public wards, married, separated and widowed, while in the group not on public assistance there was one dominant group, the married patients.

Second, in the comparison according to age, the marked difference is in the over sixty group, with the public assistance group showing a greater need to use the hospital. The importance of this is underlined by the fact that in both groups, this is the age range which has the highest percentage of patients in hospital.

Probably the most important finding in the study is the result of the comparison of the economic conditions of the patients. Here it is seen that the average income for the

month previous to hospitalization, of the group not on public assistance, is more than one and one-half times as large as the average income of the public assistance group. And, out of this lower income close to half of the public assistance patients have a responsibility to pay debts. Therefore, the public assistance group has two economic problems more severe than the group not on public assistance. At the same time it should not be forgotten that the public assistance group as a whole, have a lower percentage who have debts and none of this group has to pay his current hospital bill.

As before stated, the comparison of the medical conditions are based on schedules which have some inaccuracies. Within this limitation it is seen, the patient on public assistance has three medical problems which are more severe than those of the patient not on public assistance. On the average, he has used the hospital more frequently in the past five years, and when in hospital he has stayed longer. It is also the group of public assistance patients, whose dependents have used the hospital more frequently in the past five years.

In both groups it is the patient rather than his dependents who has been hospitalized more frequently.

When the programs within the public assistance

group were compared in respect to numbers and income, it was seen that the number of municipal assistance patients was more than one-half of the total. The old age assistance patients, who are limited in age range, were the second largest group and were one-sixth of the total.

Income per person for the month previous to hospitalization was found to be higher in the programs where the recipient did not have dependents. For instance, they were higher in blind person's allowance and old age assistance. It was also seen that patients in receipt of municipal allowance receive slightly more than those in receipt of social assistance.

This study of the public assistance patient indicates that further study would be productive. Such study could possibly answer the following questions:

1. What are the causes of the marked differences in marital status and age of the two groups using the public wards? For example, why do the sixty and over group have such need to use the hospital?
2. How does the income of the public assistance patient group compare to a minimum standard for decent living?
3. If it is a fact that the public assistance patient's medical problems are more severe than the patient

not on public assistance, are they caused by the public assistance recipient being on assistance? Also, has illness necessitated the patient going on public assistance?

Although the writer would have liked to explore the above questions, this study was only able to conclude that the public assistance patient was economically and medically deprived compared to the patient not on public assistance, according to the measures used in this study.

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APPENDIX "A"

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 _____ (of patient) 2. Sex _____ 3. S.M.W.D. Sep. _____

4. Address _____ (street or P.O. address) 5. _____ (municipality)

6. Age at last birthday _____

7. Relationship to patient of person interviewed _____

8. Relationship to patient of person responsible _____

9. Address _____ (Street or P.O. address) 10. _____ (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 _____

_____

_____

_____

III. Medical

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. Year	23. Type of Illness	24. Approximate Stay in days	25. Type of Accom.	26. Name of Hospital
____	_____	_____	_____	_____
____	_____	_____	_____	_____
____	_____	_____	_____	_____
____	_____	_____	_____	_____

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

28. Year	29. Type of Illness	30. Approximate Stay in days	31. Type of Accom.	32. Name of Hospital
____	_____	_____	_____	_____
____	_____	_____	_____	_____
____	_____	_____	_____	_____
____	_____	_____	_____	_____
____	_____	_____	_____	_____
____	_____	_____	_____	_____

(Answers to questions 33 to 39 not to be secured from the patient)

33. Diagnosis _____

_____

_____

34. Cost of Medical Treatment $ _____

35. Drugs $ _____

36. Other $ _____
(Specify)

37. Length of stay in hospital _____ days. 38. Cost $ _____

39. Prognosis: Complete recovery _____ handicapped _____

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.