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VOLUNTARY HEALTH ORGANIZATIONS IN CANADA

Elizabeth S.L. Govan

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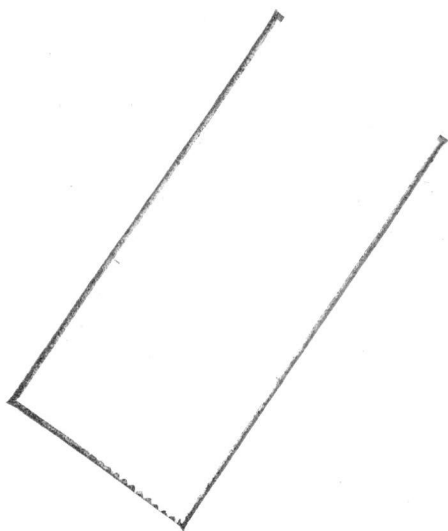


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CHAPTER 1

INTRODUCTION

The phenomenal growth of voluntary health organizations in Canada in the last twenty years and the public support which they receive reflect the increased concern of Canadians regarding the health of the nation. The public appears to be giving unprecedented support to organizations for the promotion of health, the prevention of illness, the discovery, treatment and rehabilitation of the victims of disease and disability, and the search for scientific knowledge to be used to improve health. The movement in Canada has not yet achieved the peak of activity reached in the United States of America. The presence of isolated local and provincial organizations which have national counterparts across the border suggests that the growth of national groups here will continue.

From many of the voluntary health organizations the Royal Commission on Health Services has received briefs outlining their activities and offering their answers to some of the critical questions. The Commission requested the present study to provide it with further information regarding these organizations.

This study has attempted to discover the part played by the voluntary health organizations in Canada. It presents a picture of their development, support and activity, their organizational structure as units and in relation to each other and to official agencies,¹ their financial position, their motivation and their philosophy of voluntary action. An evaluation is made of the problems of organization, co-ordination and financial accountability, but not of the standards of the services they provide. Standards vary between organizations and the divisions or branches of each, and an evaluation is impossible. Particular attention has been given to the relationship between voluntary and official activity.

Voluntary health organizations were defined for the purpose of this study as non-profit organizations operating under voluntarily organized boards with the primary or major objective of the promotion of health, the prevention of illness or disability, and the discovery, treatment or rehabilitation of persons suffering from disease or disability. Hospitals under private boards were excluded, as they

¹ "Official agencies" is defined as those under governmental auspices.

were part of a separate study, although information about their Auxiliaries would have filled gaps in the material herein. Institutions and schools caring for persons suffering from various disabilities were excluded, although the health care of the residents would be one of their major concerns. Organizations whose purpose was the prevention of accidents, undoubtedly important in the promotion of health, were reluctantly omitted. The focus was the problems of health and disability of the total population in normal times and services to special groups such as veterans and Indians, and services planned for unusual conditions such as war and disaster were excluded.

As the study proceeded, it was found necessary to apply a flexible definition of a voluntary health organization, because its strict application would exclude in one province the parallel organization in another, although both might be affiliates of the same national body. The main examples were in the fields of tuberculosis, alcoholism and cancer. It was also found necessary to include some hospitals and clinics in situations in which they could not be separated from other activities under the sponsoring organizations.

The objective of the study was to present a national picture of the activities of the voluntary health organizations. Hence the study concentrated on the national organizations, their provincial divisions or affiliates, and their local units. Where local autonomous agencies were found to have some recognized relationship with provincial or national organizations, or where they seemed to offer services similar to those of branches of the larger organizations, information was obtained from them. To complete the picture, independent local organizations in selected urban communities were included. Particular attention was given to Quebec, because of differences in the organizational pattern.

The material for the study was obtained mainly from information supplied by the organizations and prepared for other purposes: annual reports, studies of agency organization, publicity material, etc. This was supplemented by correspondence and, where practical, interviews. The information was provided by employed staff and only in organizations without staff were the voluntary leaders consulted. The material thus represents the official position of the organization to a very high degree. The variety of points of view which inevitably and desirably are represented by board members were only obtained when they were recorded in official documents.

Supplementary material was obtained from federal and provincial departments, Community Chests and United Appeals, Community Planning Councils, representative social agencies in communities in which financial federations were not organized, private foundations, the medical profession and some additional sources on special aspects. The national agencies in the United States of America from which help was sought have given generous assistance.

During the course of the study visits were made to Winnipeg, Toronto, Ottawa, Montreal, Quebec, Saint John, Halifax, St. John's and New York.

Despite the time and effort necessary to provide the information requested and the searching nature of some of the questions asked, most voluntary health organizations co-operated to the full in the course of this study. Without their generous assistance it would have been quite impossible to complete this study. Government officials at the federal and provincial levels also earned our grateful appreciation.

Mr. Donald Bellamy and Monsieur Jacques Gagné, members of the faculties of the Schools of Social Work at the Universities of Toronto and Montreal respectively, rendered invaluable assistance in the research.

The study has profited from beginning to end from the interest and assistance of Professor B. R. Blishen, the Research Director of the Royal Commission on Health Services, and from the assistance of Mrs. H. M. Roney, Acting Secretary of the Commission and her competent administrative staff.

CHAPTER 2

THE DEVELOPMENT OF THE VOLUNTARY HEALTH ORGANIZATIONS

THE GROWTH OF THE HEALTH ORGANIZATIONS

In 1962 there were in Canada 24 national voluntary health organizations. Eighteen of these had developed since 1945, three having some form of organization before 1920 but becoming national only in recent years. In some instances the organization was established nationally and later developed provincial or local units. In others, local or provincial groups were organized first and from them the national body grew. Three additional national organizations of disabled persons performed activities related to health but were not, strictly speaking, health organizations.

The movements preceding World War I were initiated at the national level. In 1896 the Red Cross Society and in 1910 the Priory of the Most Venerable Order of the Hospital of St. John of Jerusalem were organized as branches of the British societies, becoming independent but affiliated bodies in 1910 and 1914 respectively. The National Sanitarium Association incorporated in 1896, and the Canadian Tuberculosis Association, in 1900, were both stimulated by the Governor General, who had received a letter from the then Prince of Wales, later Edward VII, urging him to initiate an anti-tuberculosis movement similar to that in Great Britain. The Victorian Order of Nurses, organized in 1897, grew from the interest of women in maternal and infant welfare with the active patronage of the Governor General's Lady, the Countess of Aberdeen. A sister organization, the St. Elizabeth Visiting Nurses' Association, was founded in Toronto in 1908, received a provincial charter in 1916, but did not seek federal incorporation until 1955.

During and immediately following the 1914-1918 war, three more societies were organized. The Canadian National Institute for the Blind developed in 1917 as the result of the work of a war-blinded veteran, although its activities were never confined to veterans. The Canadian National Council for Combating Venereal Disease was established in 1919. It changed its name to the Canadian Social Hygiene Council and while retaining this incorporation, it later, in 1935,

secured a second incorporation also as the Health League of Canada. The Committee on Mental Health was organized in 1918, developing into the Canadian Council on Mental Hygiene in 1939 and changing its name to the Canadian Mental Health Association in 1950.

For the next twenty years there was little increase in the number of national organizations. Although the Canadian Mothercraft Society and the Canadian Hearing Society were incorporated federally in 1931 and 1940 respectively, both operated in Toronto as local agencies, and only began to develop branches in Ontario in 1963. In 1938 the Canadian Council for Crippled Children was formed as a loose federation of the autonomous provincial Societies, in which role it continued until 1962.

Of these early organizations, the Victorian Order of Nurses was granted a royal charter; the Red Cross Society and the Order of St. John were established by federal legislation; and the others were granted Letters Patent. The Victorian Order, the Order of St. John and the National Sanitarium Association are under royal patronage, while the Canadian Red Cross Society, the Canadian Tuberculosis Association and the Canadian National Institute for the Blind have vice-regal sponsorship.

The organization of the Canadian Cancer Society in 1938 marks the beginning of greatly increased activity. To a considerable extent this reflects similar developments in the United States of America, but specialized groups within the Canadian medical profession have also played a leading role. The Canadian Paraplegic Association developed in 1945 as a direct result of the need of war casualties for care and rehabilitation and in the following years, other new organizations emerged; the Canadian Arthritis and Rheumatism Society and the National Cancer Institute in 1947, the Canadian Foundation for Poliomyelitis and the Multiple Sclerosis Society of Canada in 1948, the Muscular Dystrophy Association of Canada and the Canadian Heart Foundation in 1950, the Canadian Hemophilia Society and the Canadian Diabetic Association in 1953, and the Cystic Fibrosis Foundation in 1960. All these organizations have American counterparts. In Canada, the last three organizations developed originally as local groups, but very quickly became national bodies. Medical leadership and stimulation were particularly important in those related to cancer, diabetes and heart diseases.

In this rush to organize nationally, the Canadian Association for Retarded Children stands out as an exception. Local and provincial organizations, inspired by their American neighbours, started to work in 1947, but the national federation was not incorporated until 1958.

The three national organizations of disabled persons – the Canadian Federation of the Blind, the Canadian Council of the Blind, and the Canadian Association of the Deaf – were all incorporated during the 1940's. Each represents an

association of local clubs through which social and other activities are provided for their handicapped members. The international organization of Alcoholics Anonymous is a forum for discussion for the leaders of the autonomous local groups which provide mutual support to their members.

In the United States of America there are reported to be 56 national organizations. Some, which do not yet have sister organizations in Canada at the national level, have local and provincial groups some of which are working towards a national society. Local Cerebral Palsy Associations are relatively numerous and are organized as independent provincial bodies in three provinces,¹ and as part of the crippled children's organizations in two others. They are also to some degree co-ordinated by the Canadian Council for Crippled Children and Adults. The Myasthenia Gravis Association was incorporated in Ontario in 1961 and in the following year was discussing federal organization. Provincial Epilepsy Societies are present in Ontario, Saskatchewan and British Columbia. The Association for Emotionally Disturbed Children is active in Ontario and there are local groups elsewhere. Isolated local associations are concerned with cleft palate and hearing handicaps. There are movements to establish societies for sufferers from Parkinson's Disease and arthritis. It is probable that other local organizations exist which have not been discovered in the course of this study. Some groups which organized locally failed to maintain interest, and have not continued.

The number of national organizations will probably continue to increase in Canada as local and provincial groups gain strength. A nominal reduction in the number occurred in the organization in 1962 of the Canadian Council for the Rehabilitation of the Disabled in which the Canadian Council for Crippled Children and Adults and the Canadian Foundation for Poliomyelitis and Rehabilitation joined forces.² However, the same Board is officially the Board of each of the three organizations, the incorporation of the two pre-existing bodies being maintained when the third incorporated.

THE TYPES OF ORGANIZATIONAL STRUCTURE

Two of the organizations operate from a central office and have insignificant or temporary activity throughout the rest of the country, a structure only possible when the objects of the association are confined to public education, social action³ or research. The Health League of Canada which is located in

¹ In Ontario the provincial federation is financed by The Ontario Society for Crippled Children.

² The Council for Crippled Children added "and Adults" to its name, since several of its provincial members had changed their names. The Canadian Foundation for Poliomyelitis added "and Rehabilitation" to its name for the same reason. Because the basic figures for this study are for the year 1961, the names of the organizations as they existed in that year are used throughout.

³ "Social action" is defined as organized pressure on government or other bodies to obtain the objectives of the societies.

Toronto, has a permanent committee in Quebec and, in a few other centres, groups responsible only for the organization of Health Week and Immunization Week. The National Cancer Institute does not need an organization for local work since it confines its activity to the stimulation and support of research, and the independent Canadian Cancer Society, with provincial and local units, undertakes the campaign for research funds for the Institute.

Four of the federally incorporated organizations are in reality local or regional in their operation. The Canadian Mothercraft Society has operated exclusively in Toronto for 25 years, only now developing its first branch. The Canadian Hearing Society in Toronto gives direct service to persons with hearing defects and hence only to those accessible to its office. It is in the process of developing a London branch. The National Sanitarium Association operates within a region in Ontario, by agreement with other tuberculosis associations which developed later. It reports that it has maintained its national incorporation in case it may at some time wish to expand its activities. The St. Elizabeth Visiting Nurses' Association of Ontario obtained incorporation also as the St. Elizabeth Visiting Nurses' Association of Canada in 1955 "to ensure that no unauthorized group may secure a Federal charter under a conflicting name". An independent association under the same name functions in Hamilton, but there is no suggestion that the Association of Canada plans to include this group, or to expand its activities on a national level.

The third group consists of those organizations which are active at both the national and local levels. In some cases, the national organization holds the authority and strength, and in others, the national body is a federation of provincial or local groups.⁴

The Canadian Red Cross Society, the St. John Ambulance Association,⁵ the Canadian Cancer Society, the Canadian National Institute for the Blind and the Victorian Order of Nurses fall into the first category. Among these, only the Canadian Cancer Society has been organized since 1919. It is probable that since the Red Cross Society and the St. John Ambulance Association are organized for war-time and disaster services, they require a centralized, partly authoritarian administration. The Victorian Order of Nurses may reflect the professional discipline of nurses, but the central authority includes not only the control of

⁴ The terms "corporate-type" and "federation-type" have been suggested to distinguish these forms. See Sills, David L., *The Volunteers* (Glencoe, Ill., The Free Press, 1957) p.3.

⁵ The Priory of Canada of the Most Venerable Order of the Hospital of St. John of Jerusalem, which has a tradition of the knights of chivalry, semi-monastic and semi-military, has established two "foundations", the St. John Ambulance Association and the St. John Brigade which are considered here to be health organizations. Although the members of each of these are not members of the Priory, the Priory controls both and they have no independent identity. For simplicity, the name of the appropriate foundation is used in the context of the discussion.

professional matters but also the development of new branches, the staff requirements of each branch, and staff assistance to provincial organizations. The Canadian National Institute for the Blind has a constitution which, if followed, would provide a highly centralized organization. The fact that the Cancer Society was initiated by the Canadian Medical Association mainly to provide research funds may account for the centralization of control.

At the other extreme are eight organizations in which the national body is a federation of autonomous provincial associations, created to facilitate and co-ordinate such projects as a national financial campaign, a centralized research fund, social action at the national level, the production of educational material and a forum for discussion. Thus the Canadian Council for Crippled Children and Adults and the Canadian Foundation for Poliomyelitis and Rehabilitation hold the rights to the campaign "trademarks". The Canadian Heart Foundation and the Canadian Association for Retarded Children pool and control the distribution of research funds. The Federation of the Blind, the Council of the Blind, and the Association of the Deaf provide for social action at the national level. Activities in addition to those mentioned are also pursued.

Between these extremes are organizations in which the national body was originally established to assist in the development of a national movement, or in which local and provincial organizations united to strengthen such a movement, surrendering their autonomy in some matters but, otherwise operating independently in their own areas. They are more democratic than organizations with centralized authority, and the surrender of autonomy is by mutual agreement. The national body has greater difficulty in obtaining conformity to its policies and works through persuasion and consultation rather than command. The group therefore exhibits considerable variation within the typical pattern suggested.

Included in this type are the Canadian Arthritis and Rheumatism Society, the Canadian Mental Health Association, the Canadian Tuberculosis Association, the Canadian Diabetic Association, the Cystic Fibrosis Foundation, the Canadian Hemophilia Society, the Multiple Sclerosis Society, the Muscular Dystrophy Association and the Canadian Paraplegic Association.

Chart 1 depicts the distribution of branches and units of the national associations in Canada. The units have different nomenclature: the terms divisions, branches, districts, chapters, units and committees are all used. The chart includes provincial and local associations which in some cases are affiliated with national organizations already discussed, and in others, may be expected to develop national organizations at a later date.

CHART 1

VOLUNTARY HEALTH ORGANIZATIONS WITH NATIONAL INCORPORATION

	Year Organized ^a	Prov. Incorp.	Sub-divisions Prov. Branches	Membership ^b	Geographical Areas	Originators
Canadian Arthritis and Rheumatism Society	1947		8	2,000; Board and Com- mittees only	Not P.E.I., New- foundland	Medical profession
Canadian Association for Retarded Children	1958	some	9	14,000; parents	Newfoundland group not members	Parents
Canadian Cancer Society	1938	x	10	1,916 880,707	B.C. includes the Yukon	Canadian Medical Association
Canadian Council for Crippled Children and Adults ^c	1937	x	14 ^d	Federation of provin- cial organizations	All provinces	Laymen
Canadian Diabetic Association	1953		3	26 3,700; patients	All provinces but Quebec	Medical profession
Canadian Foundation for Poliomyelitis & Rehabilitation	1948	x	10 ^f	No membership	All provinces	Laymen
Canadian Hearing Society	1940		1	Board only	Operates in Toronto; one branch in London, Ont. Laymen	
Canadian Heart Foundation	1956	x	6	1 Est. 1,000	Federation 6 provincials, 1 branch of national in Maritimes	Medical profession
Canadian Hemophilia Society	1953		4	4 ^g Not known; patients	Chapters in Quebec, Ontario, Man. and B.C.	Patients
Canadian Mental Health Association	1950(1918)		9	113 Est. 137,000 based on donations	Not Newfoundland	Businessmen
Canadian Mothercraft Society	1931		1	No membership	Toronto only, new branch in Ottawa	Laywomen

Canadian National Institute for the Blind	1918	8	Sub-offices	About 120 Board and Committee members	3 Maritime provinces in one division; others separate	Laymen
Canadian Paraplegic Association	1945	6	1	2,000	Not Newfoundland; 3 Maritime provinces in one division	Laymen and Patients (Veterans)
Canadian Red Cross Society	1910(1896)	10	1,152	No record	All provinces	Branch of British
Canadian Tuberculosis Association	1900	x	?	Federation of provincial associations	Prov. have locals, some only active in campaign	Canadian Medical Association
Cystic Fibrosis Foundation	1960	x ^e	9	1,120; parents	Quebec and Nova Scotia independent but related	Parents
Health League of Canada	1936(1919)	1	2	"More than 60 organizations".	Quebec only division; 2 local committees	Lay and medical
Multiple Sclerosis Society of Canada	1948		24-30	9,600; patients	Not in New Brunswick or Newfoundland	Businessmen - patients
Muscular Dystrophy Association of Canada	1954		27	Est. 3,500; no records; patients	Not in N.B., Nfld., Prince Edward Island	Patients and Firefighters Assoc.
National Cancer Institute	1947	0		40		Trustees of Fund
National Sanitarium Association	1896		None		Operates only in an Ontario region	Medical and Laymen

CHART 1 (Concl.)
VOLUNTARY HEALTH ORGANIZATIONS WITH NATIONAL INCORPORATION

	Year Organized ^a	Prov. Incorp.	Sub-divisions Prov. Branches	Membership ^b	Geographical Areas	Originators
Priory of the Order of St. John	1914(1910)		10	389j Only national		Branch of British
St. Elizabeth Visiting Nurses' Association ⁱ	1955(1908)			1,200	Metro Toronto	Catholic women
Victorian Order of Nurses	1897	x ^k	0	119 No membership	Not in P.E.I.; no provincial associa- tion in Manitoba and Nfld.	National Council of Women

^a Date of the Central organization; locals were sometimes earlier. The date in brackets indicates a previous organization from which the present one developed.

^b Membership figures given by the organization.

^c As in 1961.

^d Six Provincial organizations — Societies for Crippled Children.

Three Provincial organizations — Societies for Crippled Children & Adults, i.e., combined with Poliomyelitis Foundation.

Three Provincial Cerebral Palsy Associations.

Two other organizations.

^e In Ontario only.

^f In three provinces combined with Society for Crippled Children.

^g Ontario chapter has four auxiliaries.

^h The national organization holds two incorporations under different names.

ⁱ National and provincial incorporation held by the same organization.

^j Brigade divisions.

^k Locals are also incorporated.

THE NATURE OF THE MEMBERSHIP

Study of these organizations demonstrates that they differ in the nature of their membership. Some are organized by citizens to provide services to other people. Others – the more recent ones – are organized by patients, their relatives or their friends, to provide services to themselves. In his discussion of voluntary action for social security, Beveridge used the terms “philanthropic organization” and “mutual aid society”.⁶ For the present study citizen-member and patient-member organizations seem more appropriate designations.

The citizen-member organization is the familiar form of voluntary philanthropy. Its members are interested in community service and thus motivated to give time, thought and money to the accomplishment of an objective which they consider will promote or improve the welfare of their fellowmen. Their idealism needs practical expression and may be based on religious or political convictions. In health organizations the motivation of the members may be fear or anxiety created by the knowledge that anyone may become a victim of the disease, or it may be the desire to be identified with a “good cause” or with the people who support it. The activity is based upon the social values of the members, and these social values are identified with good citizenship, social status and public recognition. The organization draws membership from people who are interested for a variety of reasons in community service in general, and also from those who support a particular interest. To the extent that it is supported by people in the upper ranks of the power structure or the social hierarchy, it may attract the support of others who wish to be identified with the group, or to use the group for their own social, business or political ends.

The materialism of our culture is felt by many to demand a compensating balance of community responsibility. That self-interest must be balanced by recognition of the needs of others is important for our feelings about ourselves and for the social status to which we aspire. It is also important for the success of the organizations that they combine business success with idealism. They must attract people who have achieved material and social success to give status to their association, to legitimate it in the eyes of the public and to open doors to enable it to achieve its ends.

The development of a new and effective association requires strong leadership with conviction regarding its purpose and heavy investment of time, energy and money. This may come from a limited number of people who use a “front” of important names to support their efforts. In the health organizations, the leadership sometimes comes from medical personnel who need lay support to accomplish their objects, or from disabled persons whose motivation to succeed may be exceptionally high.

⁶ Beveridge, William, *Voluntary Action*, London, George Allen and Unwin Ltd., 1948.

Citizen-member organizations may attract to their ranks persons for whom a particular health problem has special meaning through personal experience. A precise line cannot be drawn between the citizen and the patient, but it is thought that handicapped persons who join the citizen-member organizations are probably able to consider the solution of the problem more objectively than are those who identify themselves with the patient-member groups.

Patient-member organizations are those in which the motivation is mutual aid. Sufferers from a disease for which there is no known cure at the present stage of scientific knowledge, or from a disability which makes one different from other people and even shunned by them, often become isolated and withdrawn, or seek the company of their fellow sufferers. They are faced with intolerable anxieties and frustration from which they find some relief in uniting to fight their common enemy, the disease. They may be able to help themselves in specific ways, e.g., by organizing better treatment facilities. They may hope to help other sufferers or their own families if the disease is hereditary. They have refused to accept the medical prognosis. They draw support from their fellow members in the knowledge that they are not alone in the problems they face. They may be seeking reassurance that they as parents are not responsible for inflicting the condition upon their children.

Their fight against frustration is illustrated by the "Hope Chest" of the Multiple Sclerosis Society, or by the statement of the Muscular Dystrophy Association that it is a temporary organization which will go out of existence as soon as the research it supports discovers the cause and cure, or by the Cancer Society's claim that it is established in the face of a "medical emergency", or by the aim of the Cystic Fibrosis Foundation to keep the children alive until the cure is found.

Some organizations recognize fully that their main purpose is mutual aid. Alcoholics Anonymous exist only to give such direct support. L'Association de la Croix de Lorraine, consisting of ex-patients of the Quebec Sanatoria, makes as a qualification for membership the willingness to give "entr'aide". A few local groups of persons suffering from mental illness seem to use Alcoholics Anonymous as their model.

The president of one patient-member group questioned the desirability of employing staff, because the joint activity of the members provided mutual support. A staff member of another organization illustrated this when she recounted that a patient attending a social evening told her, "Until I came here I thought I was the only one".

Some of the associations have developed from group sessions initiated by doctors to help parents understand and tolerate their children's condition. Recognizing the support they have obtained from this group, the parents decide to continue through an association they organize.

These factors have great significance for the patient-member organizations in relation to the manner in which they attain their objectives, and to their structure. They generate a conflict of interest between the national organization and the local group. They limit the physical energy of the membership and interrupt the continuity of their work. Because the diseases reduce or eliminate earning power, and medical care and the demands of child-patients make heavy inroads on time and money, the members are generally unable to provide the strong leadership which a national organization requires. Some of the organizations have recognized this and have encouraged the membership of interested but not directly affected persons. Some have been forced to align themselves with citizen-member organizations to ensure continuous activity.

The categorization of the voluntary health organizations as citizen-member and patient-member is shown in Chart 2. Where both types of organization are concerned with the same disease or disability, they are grouped. For certain diseases and disabilities some local groups belong to each type.

Three organizations are listed as "citizen-member" although they include many people on their staffs and boards who suffer from the particular disability in which they are interested — the Canadian National Institute for the Blind, the Canadian Paraplegic Society and the Canadian Hearing Society. In these organizations the disabled may be persons who have mastered their disability to the extent that they are able to direct their efforts to assist people with the same disability. Perhaps they do not need to draw support for themselves from the organization. Undoubtedly these organizations have elements of a mixed type.

This chapter has outlined the historical development of the 24 national voluntary health organizations, and grouped them according to organizational structure and type of membership. This provides the framework within which their objectives and the ways in which they are implemented are now discussed.

CHART 2

HEALTH ORGANIZATIONS¹ CLASSIFIED AS
CITIZEN-MEMBER AND PATIENT-MEMBER

<u>Citizen-Member Groups</u>	<u>Patient-Member Groups</u>
Canadian Arthritis and Rheumatism Society	Arthritic Clubs
Canadian Cancer Society	
Canadian Council for Crippled Children & Adults	(United Handicapped Groups of Ontario (Cerebral Palsy Association ^{2,3} (Cystic Fibrosis Foundation ³ (Epileptic Society ³
Canadian Foundation for Poliomyelitis and Rehabilitation	(Canadian Hemophilia Society ³
Canadian Hearing Society	Canadian Association of the Deaf Hearing Handicapped Society
Canadian Heart Foundation	
Canadian Mental Health Association	(Association for Emotionally Disturbed (Children (Canadian Association for Retarded Children
Canadian Mothercraft Society	
Canadian National Institute for the Blind	(Canadian Council of the Blind ³ National Federation of the Blind
Canadian Paraplegic Association	
Canadian Red Cross Society	
Canadian Tuberculosis Society	L'Association de la Croix de Lorraine
Cerebral Palsy Association ²	
Health League of Canada	
National Cancer Institute	
National Sanitarium Association	
Priory of the Order of St. John of Jerusalem	
St. Elizabeth Visiting Nurses' Association of Canada	
Victorian Order of Nurses	Alcoholics Anonymous Canadian Diabetic Association Cleft Palate Society Multiple Sclerosis Society of Canada Muscular Dystrophy Association of Canada Myasthenia Gravis Society

¹ Only nationally incorporated organizations are listed as citizen-member types although there are many other provincial and local ones.

² Some Cerebral Palsy Associations belong to one category, some to the other.

³ This society has a formal connection at the national or provincial level with the citizen-member organization with which it is bracketed.

OBJECTIVES AND DEMOCRATIC CONTROL

The Constitution of the World Health Organization defines health as the "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".¹ The voluntary health organizations have, among them, the broad objectives that this definition implies, and use a variety of structures to enable them to be implemented.

THE OBJECTIVES OF THE ORGANIZATIONS

The objectives of the organizations range from the all-inclusive to the very specific.

Three of the oldest Canadian health organizations – the Health League, the Red Cross Society and the St. John Ambulance Association – have very general objectives: those of the first named organization are public education and social action in the whole field of health; those of the other two lie in the broad field of the relief of suffering. In contrast, the Victorian Order of Nurses, the St. Elizabeth Visiting Nurses' Association and the Canadian Mothercraft Society are limited to a particular kind of service, more frequently associated with local organizations.

The objects of the Canadian National Institute for the Blind appear to encompass all possible services to the blind, except education, which had already been accepted as a public responsibility at the time the Institute was established. It provides both health and welfare services for the blind and is also concerned with prevention. The Letters Patent seem to give very broad authority to this voluntary organization: to "extend a central control and organization, to assist, utilize and co-ordinate the various public and private agencies, institutions and associations for the blind, now carrying on operations or which may hereafter be established". They confer rights "to print, manufacture, sell, distribute ... materials of all kinds suitable for the blind; ... to purchase or otherwise acquire ... patent rights, trade-marks, formulae, licenses, protections, concessions and the like; ... to establish and support ... associations, institutions,

¹ *World Health Organization, What it is: What it Does; How it Works.* Geneva, Switzerland, October 1956. (Pamphlet).

funds, trusts, workshop industries, and conveniences; ... to subscribe or guarantee money for charitable or benevolent objects; ... to subscribe towards or subsidize any proceeding or undertaking; ... to hold shares in any association which may seem calculated directly or indirectly to benefit the Institute". It is allowed to make profits which are to be used to promote its objects. Such wide powers given to a voluntary association should be conferred by Act of Parliament rather than by Letters Patent, since they include matters which seem to affect the rights of other groups.

Practically all of the organizations established more recently follow one pattern. Some of them are identical, except for the particular disease or organ to which they are related. There are variations, of course, and, even when the same objects are stated, the emphasis in the activity may be different. There is no marked difference between the stated objects of the citizen-member and the patient-member organizations.

The following listing covers in general terms the objects of the large group which conform to this pattern:

1. public education and the dissemination of information, "public" including both lay and professional people;
2. social action, sometimes specified, and sometimes implied;
3. research — the collection of statistics of incidence; the investigation of reported "cures"; surveys of facilities and needs; the encouragement, support and assistance of basic and clinical research;
4. the provision, or the encouragement of the provision of facilities and services for diagnosis, treatment and rehabilitation of the sufferers;
5. the prevention or eradication of the disease or disability;
6. the establishment of divisions, branches, etc.;
7. the co-ordination of public and private agencies with similar interests;
8. the raising of money for these purposes.

The total list is not included as part of their objectives by all the organizations, and there are naturally variations between those which are national, provincial or local.

In two organizations in British Columbia, the Tuberculosis Association and the Foundation for Poliomyelitis and Rehabilitation, the first object is the raising of money, and the second, its disbursement for a variety of purposes. This implies an approach to the public which should not have been approved in an application for incorporation. A voluntary organization exists to promote certain objectives, and to do this it requires money and engages in fund-raising. The reversal of the order suggests that the main purpose is fund-raising and that when it is obtained ways must be found to spend it.

DEMOCRATIC CONTROL

It is customary to think of voluntary agencies as a vital force in a democracy, enabling citizens to participate in community activity and to give direct expression to their philanthropic interests. Membership figures as reported by the voluntary health organizations are given in Chart 1, but they must be taken with considerable caution.

As noted earlier, some of the national agencies are corporate and some federated in structure. In the former, membership will normally be in the national body, and in the latter, in the local or provincial body, with the national body consisting of member organizations, supplemented by selected individuals. Some confusion arises when a local or provincial organization is affiliated with one provincial organization, such as the Society for Crippled Children and Adults (which in turn is a member of the national Council) and is also a member of its own national organization.

In corporate agencies, the Boards, which may be the only members at the provincial or local levels, are sometimes appointed by the national Board, in consultation with the local group.

Since the concept of membership differs in the citizen-member and patient-member organizations, they are discussed separately.

Citizen-member Organizations

In some citizen-member organizations, the members of the Board, or of the Board and its committees, are the only members of the organization. Sometimes membership of the Board is the definition of a "member"; in other organizations, a payment of a small fee is requested, but not necessarily enforced. In organizations seeking broad support, the payment of a fee or a donation is the criterion of membership and often the members have no other connection with the organization. Membership figures may be considered important for publicizing community support, but are difficult to calculate when they are based on donations. When other organizations are used to raise money, their combined membership may be quoted. When funds are obtained through a federated campaign, an estimate of local "members" may be made, although there is no way of ascertaining the particular interests of the donor. The constitution of the Canadian National Institute for the Blind provides that all blind persons may be associate members, but this is interpreted as being eligible for service, a different kind of membership from that held by the Board.

Constitutions must lay down the membership of the Board, and in federated organizations, this is usually representative of the constituent bodies. But it is customary also to provide for "Directors-at-Large" in order to secure the services of particular individuals, and to have in one locality sufficient persons to

form the Executive. In practice this is likely to mean that the effective governing body consists of individual members rather than representatives, a situation which is undesirable but difficult to overcome with the geography of Canada and the limited funds available for travel. The representativeness of the Board is also a problem in corporate organizations.

Some organizations provide for or limit the representation of certain interests. The Canadian National Institute for the Blind and the Canadian Hearing Society lay down that a proportion of Board members – but a minority – should, if possible, be drawn from the handicapped group. The Cancer Society specifies that of the two delegates from each provincial organization, only one can be a physician. Other organizations have a majority of physicians on the Board, with their constitutions silent on this point.

The desire to impress the public with large membership figures comes into conflict with the practical necessity of a quorum at the various meetings. The figures here suggest how inactive the membership is, and the degree to which large organizations may be managed by very small groups. Thus the Health League of Canada, which claims 60 organizations as members, requires a quorum of 7 for its annual meeting; the Canadian Heart Foundation with 1,000 members, 10; and the Canadian Mental Health Association, with 137,000 members, 12. The Canadian Cancer Society, with over 880,000 members, has an annual meeting of the representative Council, and then leaves the conduct of its business to a Board, of which the required quorum is 3. The Canadian Arthritis and Rheumatism Society has a quorum of 6 for both its annual meeting and the meetings of the Executive.

Three organizations stress the need for “grass roots” participation in order to attain their objective. The provincial tuberculosis societies and the crippled children’s societies use other organizations to collect their funds, and the former argues that this widespread mail campaign is an essential medium for the public education necessary for its work. The Canadian Mental Health Association, also concerned with widespread public education, seems to recruit volunteers partly to educate them. The Canadian Red Cross Society which informed the Royal Commission on Health Services that it had no formal membership although it quotes membership figures in its annual reports, uses the figures of volunteers as a more reliable indication of its activity.

Since the organizations under discussion are concerned with health, the degree of partnership between the laymen and the health professions is a matter of importance. The Victorian Order of Nurses, by its constitution, gives the professional staff full control of professional activity. The Director-in-Chief is responsible for all professional matters, assisted by an advisory Council of staff nurses and an advisory medical committee. The Canadian Tuberculosis Association states in its constitution that the Executive Director shall be a physician;

its Council and Executive have majorities of professional people, and the Canadian Thoracic Society, financed by the Association, acts in an advisory capacity to it. Although the constitution does not specify this, the Health League of Canada has always had a medical director, the Chairmen of almost all its committees are physicians, and its report states that the program is planned by the "medical board". The Canadian Mental Health Association has had from its inception a physician as Executive Director at the national level. At both the national and provincial levels, it has advisory scientific councils composed of representatives of all the professions concerned with mental health. The importance of these councils is suggested by the fact that the Brief to the Royal Commission on Health Services was presented by the Advisory Council and not by the Association. The National Heart Foundation, of which the major responsibility is the distribution of research funds, has naturally very highly placed representatives of the profession as Board members.

Patient-member Organizations

Patient-member organizations exist to provide mutual aid or support. Their membership requirements are thus rather different from those of citizen-member organizations. They start as groups of patients or parents of patients. They may include families and relatives who have a special interest in the disease. In some cases they include "friends".

The seriousness of the disability of patients who are members of these organizations creates certain common problems. Since the organizations recognize, at least to some extent, that mutual support is an objective, the local units are planned to make attendance at meetings possible. In some cases, this means local units represent very small geographical areas (and hence numbers) with provision for several units within a large community. For example, the Multiple Sclerosis Society sets three members as the minimum for a local unit. The small number of victims of certain diseases means that chapters are apt to be limited to the larger centres and that isolated patients are served by correspondence through the provincial office, as in the Cystic Fibrosis Foundation.

The physical condition of the patients and the heavy responsibility of the parents of child-patients, reduce the dependability of the membership and the energy and time they can invest in the organization's activities. In small chapters, the illness of one or two leaders may disrupt the entire group, and several of the organizations report that chapters are active, become disorganized and later re-organize in such rapid order that they cannot be certain how many there are at any point in time. Some organizations, such as the Hemophilia Society, urge their chapters to maintain a balance between patients and non-patients on the Board to ensure continuity, or to balance the emotion of the patients with the greater objectivity of the non-patients. The patients' mutual support comes, however, from association with other patients and they appear to recognize this

in what seems to be resistance to the inclusion of a broader membership. Where others are admitted they must at least be "friends".

Another factor which is undoubtedly operating is that, as patients and relatives cease to need the support of the "in-group" of fellow sufferers, they are likely to want activity with the "out-group", with other people in the community who are not suffering from the same diseases. While some members will be sufficiently dedicated to continue as the "givers" in mutual aid when they have less need to be the "receivers", others at this stage cease to identify themselves with the patient-member groups, although they may continue to contribute money.

The associations recognize the financial drain on personal and family income which care of the patient frequently entails. Membership fees may not be required from anyone or not required of any patients. Where several members of a family are members, the fee may be reduced. In some instances membership is a prerequisite for service. A few organizations "blanket in" all patients they can identify, but generally the members are actively involved, in contrast with those of many of the citizen-member organizations.

The problems which affect chapter organization become much more pronounced at the provincial and national level. The local chapter in the large community tends to develop into a provincial chapter by providing some service by correspondence in areas in which there are no chapters. The effective national body is likely to be "national" in name only. The organizations are not generally financially able to pay travelling expenses and both patients and parents have other difficulties in travelling. The incentive to activity is strong and many of the original members of the Boards continue to be active from the establishment of the society. One or two of the organizations make pleas in their annual reports for persons willing to serve as board members and there is an occasional comment that the people they want are already board members of other organizations.

It should be noted that the majority of these patient-member organizations are related to diseases of which the incidence is relatively rare. Feeling neglected by the medical profession or by official and voluntary organizations, the patients decided to organize.² The motivation for mutual aid, which demands personal companionship, seems to create a conflict of interest between the provincial and national leadership and that of the local unit. Mutual support is the goal at the local level, research at the national. But the fund-raising for the research provides an activity through which the local members can gain mutual support.

A considerable number of local organizations are not members of the national body, or have no national body. In some cases the main objective has been

² The Diabetic Association is an exception. It has been fostered by the medical profession.

the provision of local services, such as a clinic or a school for the children, or sheltered employment, recreation and social adjustment for adolescents and young adults. These activities have demanded the full attention of the local membership. In other groups, such as those related to epilepsy, diabetes and hemophilia, patients suffering least from their disabilities were reported not to want to be with their fellow patients because of the attitude in the community which would, they felt, be less likely to accept them if it were known they had the disease.

Some of the local or provincial groups have linked themselves with other organizations, partly because of financial difficulties. Thus epilepsy and cerebral palsy provincial associations have united with the new British Columbia Neurological Institute and Foundation to share accommodation and staff. The Cystic Fibrosis Foundation at the national level and some of the cerebral palsy provincial associations have sought assistance from the Canadian Council for the Rehabilitation of the Disabled, obtaining staff and accommodation they could not otherwise afford. The Blind Clubs are financed, accommodated and assisted with staff consultation by the Canadian National Institute for the Blind. Some of these alliances appear to be misalliances, since the objectives of the patient-member organization may be different from those of the citizen-member organization with which they have joined.

The constitutions of the patient-member organizations provide for Medical Advisory Committees at all levels of the organization. At the local level, only one medical specialist in the disease may be available and, in some areas, even one may be lacking. It is relatively common for the national Medical Advisory Committee to include the chairman (or a representative) of the provincial committee, and for expenses to the national meetings to be paid. For these little known diseases treatment may be to some degree experimental, and the medical advisers of different groups may give different advice. For example, some groups in the Multiple Sclerosis Society provide physiotherapy for their patients, while in others this is considered to be useless or even harmful. The Hemophilia Society suggests that the patients, through their own knowledge of their condition and their experience with what is helpful, must inform doctors of the treatment they require.

A somewhat unusual clause appears in the constitutions of a number of the organizations, giving the Board of Directors authority to declare a seat vacant if the incumbent becomes a "lunatic", or to suspend or expel a director or a member. Sometimes formal provision is made for a hearing or for advance notice, but in others no procedure is laid down. The one illustration obtained was in regard to a person advocating a drug of which the medical advisors did not approve. It is possible that the health organizations may attract persons with pet theories regarding treatment, and that some patients or their families are so personally involved that their participation presents difficulties for the organizations. If constitutional controls are necessary, safeguards against their misuse should be provided.

CONCLUSIONS

The foregoing has concentrated upon organizations with national bodies, but some of the same problems are evident in those with provincial organization.

National organizations, although often endeavouring to be representative and democratic, are handicapped by distance and lack of time and money to enable members to attend national meetings. Citizen-member organizations, which are more likely to include persons who are able to travel and whose expenses may be met from their own or business corporation funds, are better able to get nationally representative meetings than are patient-member organizations. But in both cases, with the exception of annual meetings and board meetings held immediately before or after, the management of the national business is likely to be in the hands of a small group of local people and the staff employed by them. The volunteers are often individual members and not representatives of their constituent bodies. The staff, whose direct contact with the membership may also be limited by the budget, must interpret to the board the varying points of view. Some of the patient-member organizations have no national staff and others, very limited resources.

As a result, the national organization often has difficulty in its relationship with local units. Its controlling body is not representative of its membership. Whether it is constitutionally the powerful body or not, it tends to limit its jurisdiction to matters which can be handled by a small inner group – national publicity for a campaign, the administration of a research programme and occasional conferences.

Social action at the national level must almost of necessity be taken by a small group. National membership figures (the accuracy of which has to be questioned in most instances) have no meaning when they are used to support such action. They may indicate interest of the public in a certain matter, but they cannot be relied upon as indicative of the support which the official position taken by the national group has in the community. The geography of Canada and the fact that health, welfare, education and professional standards are provincial matters, mean that the health organizations exercise their influence largely at the local and provincial levels.

The activities of these organizations are discussed in the following chapters.

ACTIVITIES OF THE VOLUNTARY ORGANIZATIONS

I. DIRECT SERVICES TO PATIENTS

The direct services given to patients by the voluntary health organizations constitute an extremely comprehensive list. The present chapter endeavours to give the over-all picture. The implications are discussed in succeeding sections.

The policy of all the patient-member organizations, and most of the citizen-member ones which pay for services under other auspices, is that such services are to be financed by the organization only if they are not available elsewhere from public or private funds.¹ Hence the listing shows the gaps in medical care and rehabilitation services in the public programmes and in voluntary welfare provisions. Since health is a provincial matter, and welfare organizations providing direct service are largely local in their coverage, it is obvious that the provision of service by the health organizations will vary in different provinces and even in areas within a province. If public services change, either through a national programme or increased provincial services for indigent patients, the health organizations will undoubtedly change their programmes also. This has taken place already with the establishment of hospital insurance, free blood transfusion, and increased provision of drugs, home nursing, etc., in certain provinces.

A. MEDICAL AND DENTAL SERVICES

(1) Medical Clinics

Many of the organizations are concerned with early detection of disease, or identification of persons with disabilities. They are involved in diagnostic assessment and in total evaluation of disabled persons to determine what services the organization should provide or to what other sources of treatment the patient should be referred. Regular clinics may provide treatment as well as diagnosis. Organizations operate clinics which are full time or at definite intervals, for tuberculosis, alcoholism, hearing defects, or crippling conditions. The facilities

¹ Although this is national policy, some local chapters of patient-member organizations are not aware of what is available from public sources, and hence use their own funds unnecessarily.

of a hospital or a health centre may be used with the organization providing the professional staff, or a mobile unit, such as a dental car, may be taken from one centre to another. Travelling clinics may visit a particular area at regular intervals or occasionally. The service may be planned as a demonstration for a limited period in order to estimate the incidence of disability or disease or to show the need for a more permanent service. The Diabetic Association even provides a "mail order" diagnostic service. An Ontario report, commenting on the availability of medical attention for handicapped children, states: "Travelling diagnostic teams sponsored by service clubs and/or voluntary health agencies, still conduct clinics in both the southern and northern areas. These teams were appreciated both by the profession and those working in the official and voluntary bodies."²

Travelling clinics may be staffed by specialists who donate their services, receive a modest honorarium, or are paid a set schedule of fees. The team may include paramedical personnel, such as the physiotherapist, occupational therapist, speech therapist, nurse and social worker, to assist the patients through instruction in home care. Part of the staff, particularly the nurse and the clerical staff, may be recruited locally. Arrangements are frequently made through the local public health services and medical men are encouraged to send their patients for specialist consultation. Procedures are worked out to report findings to the referring physician, or to plan with him the recommendations for specialized care.

The time and expense of such clinics in the more isolated areas must be very heavy in proportion to the patients served, and in many instances the specialist must be handicapped by the lack of equipment and supporting staff. Since the voluntary organizations are generally interested in a particular disease, or in children or adults, more generalized clinics would seem to be desirable and more economical.

With the scattered population in many areas in Canada, travelling clinics would appear to be essential, and, as regional hospitals are developed, they might be a regular part of the hospital service. They would of course identify patients who need to be brought into the hospital for more thorough diagnostic procedures. The use of the "M.V. Christmas Seal" in Newfoundland for the identification of handicapped people by the Provincial Department and for testing for diabetes, in addition to its primary function regarding tuberculosis, is an illustration of the value of co-operative work in the less accessible areas.

² *A Program for Handicapped Children*, sponsored by the Ontario Medical Association, Child Welfare Committee, and the Atkinson Charitable Foundation, October 1962, p. 9.

(2) Hospitals and Medical Treatment Centres³

In-patient care may be provided by the voluntary organizations either in hospitals, sanatoria, or rehabilitation centres under their own auspices, or by the payment of the costs of care to other institutions. Where the hospital makes charges beyond those covered by hospital plans, the voluntary agency sometimes meets this cost, e.g., the Paraplegic Association pays additional costs in Quebec.

The Diabetic Association reports that hospital insurance does not cover the admission to hospital for the periodic readjustment of the insulin injections and diets. In Alberta the Council for Crippled Children advises the local committees of service clubs to pay the insurance premium for medical care when the child is not covered, and to defer surgery, if this is not harmful to the child, until the waiting period has elapsed.

The tuberculosis societies quickly attained their original objective of public responsibility. In some provinces government assumed the administration and paid the costs of sanatoria, while in others it designated the Sanatoria Board as its agent and financed the operation of the institutions entirely through tax funds. In Quebec some of the sanatoria are provincially administered and others are under private Boards.

The legislation in Saskatchewan set up a public Board, representing various public interests and including one representative of the Anti-Tuberculosis League. Supported by tax funds, it still considers itself a voluntary health organization, runs a financial campaign for voluntary funds for the preventive programme, and is a member of the Canadian Tuberculosis Association. In Manitoba, a public act established the Sanatorium Board, with a majority of elected members, and makes it the government agent for tuberculosis control. It highlights its status as a "voluntary non-profit organization", runs a campaign for voluntary funds and is a member of the national organization. With less need for hospital beds for tuberculosis, it has developed a section for the chronically ill, a social adjustment unit for Indians and Metis, and has undertaken the administration of the new Rehabilitation Centre built by the government. Both these organizations are in reality public bodies, financed almost completely from public funds.

In Ontario the ten boards responsible for the sanatoria are similar to public hospital boards, and in some cases are now operating institutions for patients other than those suffering from tuberculosis. Financed basically by government, they participate in the campaign for voluntary funds and are assisted further by

³ As noted earlier, hospitals were not included in this study, but since some of them are established or administered by the voluntary health organizations included for other purposes, it was necessary to give them some attention. Rehabilitation Centres have been included when they are not directly under governmental auspices.

the county Tuberculosis Associations in their areas. The National Sanitarium Association, federally incorporated, plays a similar role within its geographic region.

The Red Cross Society is the other organization which has developed hospitals or contributed to their support. In Calgary the Junior Red Cross Hospital for crippled children was opened in 1922, and received substantial support from both Junior and Senior Red Cross funds until 1958, when it was taken over by a private board. In Saskatchewan a children's ward, opened in 1924, later became the Red Cross Hospital Wing of the Regina General Hospital. The Junior Red Cross continued to assist with transportation, education and recreation facilities, and the provision of prosthetic appliances.

Red Cross outpost hospitals were developed in isolated areas. Some of these have been taken over by the provinces. Nursing stations operated in areas in which there were no hospital facilities, are financed in varying degrees by the provinces. If regional hospitals are developed, it would seem logical that the administration of outpost hospitals and nursing stations come under them. This would foster a desirable administrative relationship with the hospital system, and reduce the isolation of the staff from professional colleagues.

(3) Rehabilitation Centres

Rehabilitation Centres are a relatively new development, but some facilities are now available in each of the provinces. Some Centres seek to provide rehabilitation services for the physically handicapped children and adults of the entire province, and others for a limited geographical area. Some serve children only and a few provide treatment for particular conditions, such as alcoholism. In-patient care is included in the provincial hospital services plan but most of the treatment is given to out-patients and, in some Centres, to out-patients only.

In two provinces the Centre is a provincial institution. In Saskatchewan two Centres were developed by the Society for Crippled Children and later taken over by the province. In Manitoba the building was erected and financed by the province, but the administrative responsibility has been given to the Manitoba Sanatorium Board.

In the other provinces the auspices vary. In Newfoundland, where the Centre is for children only, it is the main activity of the Newfoundland Society for the Care of Crippled Children and Adults, a joint organization of the Society for Crippled Children and the Foundation for Poliomyelitis. In Alberta the services are provided by rehabilitation units of hospitals in Edmonton and Calgary. In British Columbia the G.F. Strong Rehabilitation Centre seeks to centralize services for the entire province. It provides accommodation for the Paraplegic Association and the Cerebral Palsy Association. While in-patients are financed by the Hospital Plan, out-patient treatment is paid for by fees of patients or on their behalf by such organizations as the Foundation for Poliomyelitis.

The Centres in Halifax and Fredericton developed from the activities of the provincial co-ordinating Councils for rehabilitation, but became autonomous incorporated bodies. In Nova Scotia the Board is appointed by the Council. Each of these Centres serves children and adults from anywhere in the province. The Nova Scotia staff also provides in-patient and out-patient service to the Children's Hospital and a chronic hospital in Halifax.

The Rehabilitation Institute of Montreal is associated with the French-language university and hospitals, and the Occupational Therapy and Rehabilitation Centre with the English-language institutions. Patients of either language are accepted by both. The Centres are financed partly from the federated campaigns but receive government grants, and small amounts from the voluntary health organizations for particular disabilities.

The Ontario picture is given in more detail because of the availability of local material. The Rehabilitation Centre for Crippled Children in Toronto, opened in 1962, is incorporated under a Board of Trustees appointed by the Board of the Society for Crippled Children, which also holds the incorporation of the Centre. It provides both in-patient and out-patient services and includes a school. Two of the Cerebral Palsy Clinics have been moved into the building and are an integral part of the operation. This is the first Centre accepted by the Ontario Hospital Services Commission as a hospital, and the difficulty in assessing budget, etc., led to an agreement that the Society would cover all costs not covered by hospital insurance.

An Ontario survey⁴ of the facilities for handicapped children reported 21 Rehabilitation Centres in 1961, including hospital units, out-patient centres for adults and children, and some under such organizations as the Cerebral Palsy Associations and the Red Cross Society. Where children attend regularly, the programme includes schools. In some areas, although organized by a parents' society, they admit all handicapped children.

In commenting on the standards of the Centres for children, the report mentioned above states:

These centres function as out-patient departments where they do not exist in local hospitals, or as a supplement to these facilities supplying care usually on a long term basis. Ordinarily they are located in separate buildings removed from the active treatment or convalescent hospitals with one or two exceptions notably London and Brantford. In the latter city the treatment centre is located in the chronic wing of the general hospital and utilizes the services of the active treatment hospital for physical and occupational therapy This is a pattern that might well be adopted in other active treatment or convalescent hospitals located in smaller cities and larger towns of the province.

⁴ *A Program for Handicapped Children, op. cit., p. 10.*

The report discusses standards of treatment and concludes "It is doubtful if more than a few of these Children's Treatment Centres would qualify completely in each or all of these respects. The reasons for this are related to the availability of properly trained personnel, plant and equipment." Comments heard elsewhere suggest that they are also related to the fact that many under patient-member organizations are affected by the emotional involvement of their membership.

The small Centres sometimes seem to be in competition. In St. John the Association for Retarded Children and the Cerebral Palsy Association both have schools and "treatment services" on different floors of one building, the accommodation being supplied by government. In Windsor, Ontario, the Cerebral Palsy Centre cares for all handicapped pre-school children and young adults in the Red Cross building, while the Red Cross Centre cares for the school-age child: to some extent they share staff and facilities. In Winnipeg, the Association for Retarded Children accepts in its school children excluded from regular schools who are capable of "self-care", and admits to its workshop for training and treatment any handicapped older children. The parents of the cerebral palsied who became inactive when this arrangement was made are now re-organizing to provide some care for the group which the present school excludes.

A few adult Centres are limited to those suffering from particular diseases. The five Cliniques de Réhabilitation Domrémy provide for alcoholics. Associated with them in Quebec, New Brunswick and Ontario are after-care Centres for former clinic patients. Les Cliniques provide in-patient care at a cost of \$6 a day, the cost being subsidized by the province for patients who cannot pay the full charge.

In Toronto, Lyndhurst Lodge for paraplegics was established by the Department of Veterans Affairs during the Second World War for the in-patient rehabilitation of war casualties. In 1950, the Lodge was sold for \$1 to the Canadian Paraplegic Association which provided service to veteran and civilian paraplegics and quadriplegics from any place in Canada which lacked local facilities. Most patients at the Lodge are now from Ontario.

A number of voluntary organizations pay for hospital care for persons not eligible under provincial hospital plans. Hospital Plans have made this a minor budget item for organizations like the Societies for Crippled Children. In rehabilitation centres, if patients are not covered, and particularly if they attend as out-patients, the charges are frequently paid by a variety of organizations. The G. F. Strong Rehabilitation Centre in Vancouver, for example, has one unit which is used by the Cerebral Palsy Association for treatment, and also as a school. There seems to be a complicated method of financing by which the Association pays the Centre for certain costs, but the Centre pays the Association for other costs. The same arrangement is made for the Paraplegic Association: its patients

are allowed to use the Centre's hydro-therapy facilities, but the Centre's patients use and pay for some services provided by the Association. The Centre publicizes its charges, saying that no patient will be refused service because he cannot pay, but that the matter will be referred to a sponsoring organization. The only organization named is the Poliomyelitis and Rehabilitation Foundation, which paid \$23,000 in fees in 1961, an amount reduced from \$76,000 the previous year.

While some of the rehabilitation centres seem to be specialized hospitals, others are clinics, or a combination of clinic and school. This makes it difficult to suggest how they might be included in an extended health plan. Where one centre is serving a wide area, the distinction between in-patients and out-patients in a proportion of the cases is based on the place of residence rather than the medical needs. If the treatment facilities are not available in the locality which is "home" for the patient, he may be admitted, whereas if he lived in the city he might receive treatment as an out-patient, often attending each day. This would suggest that some modification in the hospital insurance regulations might be made to include treatment in an out-patient clinic when the patient's medical prescription demands that he spend a certain proportion of time at the clinic. Since special transportation to the Centre must be provided in most cases, the differences in cost of in-patient and out-patient treatment may be minor.

It should be borne in mind that handicapped children should remain at home wherever possible. This points up the need for rehabilitation centres or units in hospitals in any area large enough to justify the necessary equipment and staff. Since the same types of treatment are required for children suffering from many different conditions, the development of centres for those suffering from one condition does not seem justified. It would seem logical also that adults and children be treated at the same centre in the smaller communities. Differentiation on an age basis is, however, more practical than differentiation on the basis of disease or disability, since both groups require an "atmosphere" suitable to their age, and the children need a school. Although classes must be small, a school is likely to be more effective and economical when it has several classes. Schools connected with the Centres should be financed and staffed in the same way as schools now provided in hospitals.

(4) Psychiatric Care and Treatment of the Emotionally Disturbed

Voluntary health agencies have not played a major part in the institutional care of the mentally ill and the mentally defective; a type of care which has for a long time been recognized as a public responsibility. Community Planning Councils in some cities have been very active in urging upon government the need for more out-patient clinics and diagnostic centres. The Association for Retarded Children and the Canadian Mental Health Association are the major organizations concerned. Health organizations giving service to the physically handicapped also recognize the need and have some access to psychiatric consultation, assessment and treatment for the people they serve.

Recent recommendations of the Scientific Planning Council of the Canadian Mental Health Association⁵ may increase the part of the voluntary organizations. These recommendations support strongly the development of community mental health facilities, and the provincial and local branches have in some cases been working for their implementation. The emphasis is upon the treatment of the patient within his own community, continuity of care during the whole process of treatment and the co-ordination of services.

Nova Scotia⁶ has made considerable progress in developing this plan, under the leadership of the Provincial Mental Health Services Division of the Department of Public Health. The province has been divided into nine regions, in eight of which a Community Mental Health Clinic has been established. The Department decided that it wanted to secure active community support, and the local Branches of the Canadian Mental Health Association have been used to obtain this. In each region a local Board is set up, on which the Branch, the Department and the local Medical Society are represented, as well as citizens. The clinics are financed heavily from public funds.

Saskatchewan is reported to have approved, in principle, the development of regional hospitals, and the Mental Health Association seems to claim the credit for this.

Mental Health or Child Guidance Clinics are available in numerous communities, under their own Boards or as travelling clinics from provincial hospitals. Their number has been greatly increased by the federal health grants. Various reports emphasize that the present provision is still inadequate. No attempt has been made to include them in this study.

The British Columbia Alcoholism Foundation, established by the province but incorporated as a voluntary agency, operates an out-patient clinic in Vancouver to provide psychiatric and social work treatment. The similar Foundation in Alberta has clinics in Edmonton and Calgary.

Closely related to psychiatric treatment centres are the social treatment centres for emotionally disturbed children, under social work direction with psychiatric consultation. In Montreal the Society for Emotionally Disturbed Children was organized in 1956 by a group of parents, with the support of a strong medical advisory committee. In 1958 it was able to establish a day school which now has 27 children, mostly pre-school in age and both French and English. Working with the director, who is a social worker, are six registered teachers,

⁵ Canadian Mental Health Association, *Mental Health Services in Canada: Interim Report*, 1962. The final report was published under the title *More for the Mind* in 1963.

⁶ Clyde Marshall, M.D., *The Nova Scotia Mental Health Plan*, published as a Supplement to *Canada's Mental Health*, May, 1962.

two part-time social workers⁷, a part-time psychiatrist, and 12 volunteers who assist the teachers. This staff complement shows the amount of individual attention required for this work. The Society has among its objectives the establishment of a small institutional treatment facility and it reports that one other small school for the mentally handicapped, which includes 12 disturbed children, is the only other educational facility for this type of child in Montreal.⁸

A small number of residential centres⁹ have developed in Ontario in the last few years. Such centres can have only a small number of children if they are to provide effective treatment. The costs are very high, because of the staff required and the long-term care usually needed. Because of the cost, parents are seldom if ever able to meet the charges, and the per diem amounts paid for children who are wards of the Children's Aid Societies are subsidized by funds from the United Appeals. Although treatment methods are experimental at this point, the problem of the care and treatment of this group is a very serious one. Families are unable to cope with it, foster homes are generally unwilling to attempt it, and mental hospitals in many cases are the only alternative.

An example of a social treatment clinic is the Marriage Counselling Service in Montreal, developed by the Mental Hygiene Institute under the aegis of the Department of Psychiatry of McGill University. The primary objective of this Institute is the prevention of mental illness, and a large part of its work is the provision of consultation and training to the staffs and diagnostic and short-term treatment services to the clientele of the social agencies. The Marriage Counselling Service seeks to give help with marital relationships to forestall the development of problems of greater intensity in the marriage partners and in the children upon whose mental health the parents' influence has paramount significance.

Such services, at present available in only a limited number of urban communities, are an essential ingredient of the network of treatment facilities for mentally disturbed persons.

(5) Dental Care

The provision of dental care by voluntary organizations, except as part of the treatment provided for persons given service because of other health conditions, is limited. The Red Cross Society in Ontario operates dental coaches in the northern part of the province, providing 4,217 dental appointments in 1961,

⁷ One English-speaking and one French-speaking.

⁸ Some expansion of services has occurred since this material was obtained.

⁹ A residential treatment centre for emotionally disturbed children provides a small institution designed and staffed for treatment by social workers with psychiatric consultation. The children attend school within the institution or in the community, generally depending upon the degree of their disturbance.

and also assists with the dental department of the Hospital for Sick Children in Toronto. In some other provinces Junior Red Cross funds are used to provide dental treatment including orthodontia for needy children.

The Cleft Palate Association in Windsor obtained dental equipment through federal health grants, and this is used also for the children in the Red Cross and Cerebral Palsy Centres for handicapped children. Orthodontic service is given through the same clinic.

From the relatively minor references to dental care, it must be assumed that there is considerable need for further service.

B. METHODS OF MAKING MEDICAL SERVICES ACCESSIBLE

(1) Transportation

Because of Canada's geography, distances and large areas of sparse population, accessibility of specialized medical care poses a problem. Travelling clinics, discussed above, are one means by which voluntary organizations are trying to help. Another contribution lies in their provision of transportation and, in a limited number of centres, of accommodation while persons attend as out-patients or escorts await their discharge. Although there is some public provision, for example in Newfoundland and in the "air lifts" in the far north, the problem of the sick person getting to the medical centre is very real, even in urban areas such as Toronto.

Transportation is arranged through the public transportation systems, through special buses, taxis, ambulances, or volunteer drivers. In a few instances it is paid for by public funds but administered by the health organization. Provision for the costs of indigent patients is made by some provincial welfare departments, as in British Columbia.

In many communities the Cancer Society makes transportation one of its major projects. In Toronto 500 volunteers drove over 700 patients to and from clinics and hospitals in one year, with an average of 20 visits per patient. The public Ontario Foundation pays the cost of coach fare, with the Society providing a berth when necessary for needy persons and escorts travelling to medical centres. In Nova Scotia, the provincial government covers transportation to the Tumour Clinic in Halifax for persons with incomes below \$3,500 a year. The fund of about \$35,000 is administered by the Society, which receives a grant of \$2,000 for administrative costs. All divisions assist with the travel of indigents when other provision is not made and the payments from the voluntary funds throughout Canada amounted to \$65,000 in 1961.

In New Brunswick the St. John Ambulance Association provides transportation by ambulance for a patient living in an area in which a commercial ambulance service is not available. The ambulances are donated by service clubs. The drivers are paid and the Association receives a provincial grant of \$5,000 and some municipal grants to cover the costs. The average trip in 1961 was 107 miles.

Through the Canadian Passenger Association, the Canadian National Institute for the Blind arranges for concession fares for the blind and their escorts for all travel. This involves no cost to the Institute and is in effect an indirect government subsidy to the blind, to the extent that railway deficits are paid from government funds. Its purpose is to reduce the costs of living for the blind.

The transportation of handicapped persons in regular attendance at schools or treatment centres is another problem. In British Columbia, the main activity of the Society for Crippled Children has been the provision of a fleet of 23 buses for the use of all handicapped persons in a number of areas. The buses served the out-patients attending the G. F. Strong Rehabilitation Centre and retarded, cerebral palsied and other handicapped children attending special classes in public schools or in those under the auspices of the voluntary organizations. During 1961, over 400,000 miles were covered by the fleet at a gross cost of \$97,356. The Society decided in that year to cut down its service and apparently some of the school boards immediately provided their own, while the Cerebral Palsy Association and the Association for Retarded Children made independent arrangements. This example suggests how large an item the transportation problem can be for organizations providing treatment centres and schools for handicapped adults and children.

In many of the children's centres, parents are asked to contribute to the transportation costs when they are able. In the patient-member adult groups, in which social or educational meetings form an important part of the programme, transportation is frequently provided by volunteer drivers. In camps for the handicapped, buses are usually used.

Another service of the volunteers is available in some communities through the "Callow Bus". Originally designed for wheelchair patients, it has provided in some places, such as Halifax, a service to a wide variety of institutions for the physically and mentally handicapped, to enable them to have an outing, to go to a concert or a football game, see the Christmas decorations or have a picnic.

Where volunteers can provide transportation this seems a logical and effective activity for the voluntary organization. Where travel has to be undertaken to obtain specialized diagnostic or treatment services by persons living in areas in which such services are not available, provision of transportation becomes an essential component of medical care and cannot be left to the initiative of

of a voluntary group. Transportation must be available if regional hospitals are developed, including ambulance service throughout the geographic area. Since a patient ought not to be deprived of the appropriate medical care because of his physical inability to get to the centre, payment must be made for a method of transportation suitable for him and in many cases also for an escort. Public funds should be available where necessary, if the cost is not included in the benefits of a medical care plan. In some cases, the provision of escorts and the transportation arrangements for the return trip would be a suitable activity for a volunteer group anxious to provide assistance to the sufferers. This could be done through a disease-focused organization or through a hospital auxiliary.

(2) Accommodation

The question of accommodation at the medical centre is receiving increasing attention. Unless a patient requires admission to hospital during the diagnostic or treatment procedures it is costly for him to occupy a hospital bed merely because he comes from out of town. It is also undesirable that a sick person should be friendless in a strange city. Where the mother of a child needs training for his care in the home, she also requires residential provision close to the hospital or rehabilitation centre.

In a number of centres the Cancer Society provides residences both for patients who can attend the hospital as out-patients and for their escorts. In some cities the Societies arrange or pay for boarding home accommodation. The Red Cross Hostel in St. John's is used by patients of all kinds, together with their escorts, with the payment made in some instances by other voluntary organizations.

Obviously only a large, specialized hospital or clinic would justify the provision of a residence for patients suffering from a particular illness. Hospitals providing a variety of specialized services need arrangements which could not be made by a voluntary organization focused on one disease. For care at a regional hospital the residence could be attached to the hospital. For the smaller hospitals arrangements for boarding homes might be the responsibility of the hospital auxiliary. Provision of the costs for the patient in the residence might be part of a medical care plan, or might be provided in the same way as transportation, with the alternatives suggested above. Where an escort is considered necessary by the doctor, his costs should be covered also. The inclusion of these costs of residence in a medical care plan is logical if the alternative is admission to the hospital as an in-patient.

C. MEDICAL NECESSITIES

(1) Blood and Eye Banks

The Blood Bank is organized by the Red Cross Society, the St. John Ambulance Association having agreed to give up this activity in areas in which it had

commenced the service. The Bank is organized in all the provinces, with the co-operation of the provincial governments, the hospitals and the universities, and with the provinces participating financially in the provision of accommodation, equipment, etc. The hospitals agree to provide the blood free to patients. The complicated organization of obtaining the blood from voluntary donors, its grouping, storing and processing, and making it readily available to patients in need of transfusions has been described in detail in a submission of the Society to the Royal Commission on Health Services. The organization has been developed under the leadership of the Red Cross, with the assistance of thousands of volunteer workers and the enlistment through widespread publicity and public education of a continuous supply of voluntary donors. Hospitals publicize to their patients the contribution of the Red Cross Society.

The provision of free blood has considerably reduced the medical expenses of certain illnesses. The Canadian Hemophilia Society is particularly appreciative, comparing its preferred position with that of the American organization which sometimes has undertaken to pay for the large number of transfusions some of its members require.

The St. John Ambulance Association agreed to assist the Red Cross Society in this service by encouraging its members to give blood and by giving volunteer service in the Blood Donor Clinics where this was desired.

The Eye Bank is also one of the products of modern science. It is organized by the Canadian National Institute for the Blind in conjunction with the Medical Schools of the universities. Approaches to the provincial governments have led to the passage of Acts in all provinces to authorize persons to bequeath their eyes to the Bank without consent of their next of kin. This is particularly important because of the delay involved if such legislation is lacking. Ontario has widened its Act to include all tissues. The Institute urges people to make this bequest and sets up the organization in co-operation with the Medical Schools. It is also responsible for the organization through which the surgeon requiring the tissue is immediately notified of its availability.

Both of these Banks are notable achievements of which the voluntary organizations are justifiably proud.

(2) Surgical Dressings

Surgical dressings are made and distributed free by the Cancer Society to patients referred by doctors. The provincial divisions (except in Manitoba, where this is done by the Order of the Eastern Star) buy the material wholesale and distribute it to the local branches. Volunteers, provided to a large extent by other organizations, meet for a "working bee" to make the dressings. When a request is received, it is checked with the doctor and the dressings are provided as long as they are needed. The provincial divisions keep themselves informed about local

supplies to be sure they are adequate, and take responsibility for distribution to patients in areas in which there are no branches.

Since many of the recipients have not been told they have cancer, the name of the Society is not used and the contact is largely with doctors and relatives. For the same reason, volunteers who wish to visit patients are discouraged from doing so.

Dressings are free, but recipients who wish to pay are encouraged to make donations. The cost of such dressings in the retail market would create real financial problems for many of the patients. The manufacture of them, on the other hand, gives the volunteers a satisfying experience of contributing to the work and an enjoyable social occasion, and gives the Society an opportunity to publicize its work. Dressings are also made by the Women's Work Committees of the Red Cross Society.

(3) Drugs

The provision of drugs is a service which most organizations consider to be beyond their means. It is one in which the patient-member organizations show particular concern.

Diabetic Associations have made representation to provincial governments for the free provision of insulin. In Nova Scotia, the Association was able to interest the province, which agreed to provide insulin for persons where the family income was under \$3,500. Its estimates of cost proved far too low, as many diabetics not previously identified applied for the drug.

Local chapters of the Cystic Fibrosis and Multiple Sclerosis Associations have been able to arrange for discounts of as much as 35 per cent from particular druggists for their members as has the provincial Myasthenia Gravis Society in Ontario. Some druggists have asked the organizations not to publicize the service beyond their own membership because the other druggists would not like this arrangement. The rates given suggest that the profit made on drugs needs investigation.

The Cancer Society gives pain-killing drugs on medical prescription to a limited extent. Junior Red Cross funds are available in some areas for children. Rehabilitation centres sometimes provide drugs for out-patients as do the growing number of community mental health clinics.

Comments have been made that medical practitioners assisted their patients by giving them the samples they received from the drug companies. In New Brunswick, the St. John General Hospital used to provide drugs free to out-patients, but because of its financial difficulties has discontinued this practice. Reports were received that this was causing difficulty and that even the relatively small cost

of the drugs for glaucoma patients was beyond the means of some people who came to the city from the rural community and were in danger of becoming blind through lack of the drugs. (It should be noted that other factors, such as ignorance and the inadequacy of local public assistance programmes in this province, would also affect the situation.)

(4) Prostheses and Equipment

Injection equipment for insulin, wheelchairs, colostomy bags, hospital beds and other equipment required for care in the home, and prosthetic appliances for people suffering from particular disabilities are provided by numerous agencies. Many of these are requirements for a number of physical conditions, and many different agencies are trying to supply them in each community for their own patients. This is probably the area of direct service in which there is the greatest need for co-ordination and some degree of control. In a few cases, provincial public welfare departments make provision for persons receiving public assistance, and as the Federal Vocational Rehabilitation Services Act of 1962 comes into general use through federal-provincial agreements, part of the solution will be co-ordination through the provincial rehabilitation services. This Act provides only for those articles which will restore the disabled person to economic usefulness, and hence does not apply to children, the aged, or those with progressive diseases.

The contribution of the voluntary groups is different in the citizen-member and the patient-member organizations. The patient-member organization sets out to get these necessities for its members, not to supply them. Where the patient-members are themselves involved in the work — the situation in most local and provincial chapters — they are very much identified with the patient making the request. In some instances at least, they consider that their knowledge of the disease is such that they can judge the need without reference to a doctor. The doctor may want to keep the patient out of a wheelchair as long as possible, knowing that this may defer his growing incapacity, but the patient or his family may think the chair will be less difficult. Or, because of the failure to obtain professional advice, the equipment may not be that best suited to the patient's condition. The organization conscious of the medical costs and the lack of earning power of the patient tends to assume that he cannot pay.

Patient-member organizations do not always know the community sources available. The Muscular Dystrophy Association advises its chapters to obtain the help of someone in the community who knows the services, but the local chapters do not always follow this advice.

Chapters of different societies develop contacts with other organizations, sometimes urging their members to become members of other groups in order to facilitate these contacts. They work through service clubs, fraternal organizations, etc., presenting to them the case of a fellow member in order to obtain the money

or the article for him. In a few cases where the chapter is identified with a particular clinic, the equipment is procured and given to the clinic to administer, which brings it under medical direction.

Since most of the diseases in which the patient-member organizations are interested are progressive and eventually fatal, the equipment is often needed for a long period of time, but eventually is supposed to be returned to the chapter. The chapters do not seem to have a supply sufficient for their needs, although they pass an item on to another patient as soon as it is returned. They have little need of storage facilities. In Southern Ontario one of the functions of the part-time national Muscular Dystrophy Association staff member assigned to the area is to facilitate the movement of equipment among the four branches in the region. In most societies, the provincial office attempts to serve patients in areas in which there is no local chapter, sometimes working through the public health authorities.

While the effectiveness of the work of some of the organizations is open to question, that of the Cystic Fibrosis Foundation seems to have been valuable to its members. The treatment of the child involves sleeping inside an inhalation therapy tent and the use of an inhalation mask at regular intervals during the day. The Foundation reports that, through the efforts and ingenuity of one of its members, the tent, which formerly cost \$400, can now be obtained through the Society for \$250. From the suggestions made by the parents improvements have been made in its construction. Part of the reduction in cost has come from the arrangements for the remission of customs duties and sales taxes. These are given on condition that the tents remain the property of the Foundation, a condition which is carefully observed by a legal contract with the parents, who assume responsibility for transportation, repair and maintenance, and agree to return the tent to the national office on its request. The contract also protects the Foundation from liability for injury or accident through its use. The parent is expected to contribute to the cost according to his ability, and the balance is met by procuring some "sponsoring organization". The tents are sold by the national office to the provincial groups and to the two organizations which have not joined the national body. The money received in payment is placed in a revolving fund for the purchase of others. The parents can also purchase the masks, spare parts, etc., through the Foundation. The cost of the tents is beyond the means of most families also faced with the purchase of costly drugs;¹⁰ hence the organizations are continually soliciting sponsors. Several of the divisions report that they could use many more tents than they have been able to purchase.

In spite of all the difficulty and the continual solicitation for funds or for donations of equipment, the patient-member organizations obtain a great deal of satisfaction from this direct service activity and many of them would be loathe to give it up. When it was called to the attention of one group that the provincial

¹⁰The organization estimates that the average cost of the drugs is \$75 a month.

department was prepared to provide wheelchairs to public assistance recipients, they replied that they "liked" to do it anyway. Yet harm can be done to the patient when equipment is given without a medical prescription or technical consultation, and in some instances the money could be spent more effectively.

Citizen-member organizations are more frequently guided by professional advice, although local committees of service clubs may fall into the same difficulties when they undertake, without staff guidance, the care of handicapped children. The policy of the Ontario Society for Crippled Children (and of some others) is to have a nurse in a regional area to help the local groups. All assistance must be approved by the nurse and reported to the provincial office. Some Societies, however, have no knowledge of what their local groups do.

Most of the citizen-member groups are insistent that they will not duplicate services available from other sources, public or voluntary. However, the voluntary group may be more flexible than government regarding the definition of financial need. While Junior Red Cross funds are used to provide various medical needs for needy children, the Society for Crippled Children covers some of the same group, and in some provinces provides all services free. The Foundation for Poliomyelitis and the Cerebral Palsy Association may provide services for children who may also be cared for by the Society for Crippled Children. The Canadian National Institute for the Blind in its preventive programme provides the medical prescriptions for pathological eye conditions while the Junior Red Cross supplies glasses for other needy children.

Some home care¹¹ equipment is needed on a short-term basis. The Red Cross Loan Cupboards provide equipment for a maximum of three months. In some places the Cancer Society advises its patients to make use of these services, and takes over the responsibility after the three-month period if the patient still needs the equipment. The Ontario Society for Crippled Children also lends equipment.

The trend towards home care will lead to a greater demand for equipment and it would seem logical to locate it in one place in a community, under one auspice, and without an arbitrary time limit. The care and repair of the equipment is a constructive volunteer activity which could be continued with its location at the administrative centre of a home care programme.

The commercial aspects of the manufacture or provision of some prosthetic appliances are the concern of some citizen-organizations. The policy of the Ontario Society for Crippled Children calls for tenders and refuses to compete with commercial companies. It has a small shop at the Rehabilitation Centre, which experiments in the development of unusual devices. In contrast, the Alberta Council

¹¹Home care is used here to mean the care in his own home of a patient who is under medical supervision. A home-care programme is the organized co-ordination of all the services required to enable a patient who would otherwise require hospital care to remain in his home.

for Crippled Children and Adults has established and subsidized the Canada Brace and Limb Company as an incorporated subsidiary through the initiative of a particular manufacturer. This was planned initially as a profit-making enterprise, with the profits paid into the Council funds but, in its last report, the organization questioned whether it should make profits. This company is also engaged in the sale of wheelchairs and has extended its sales into British Columbia. The Nova Scotia Co-ordinating Council for the Rehabilitation of the Handicapped developed a brace shop as an incorporated subsidiary, and federal-provincial grants subsidize the wages to reduce the cost. The Newfoundland Council buys braces from the shop at the Orthopaedic Hospital, thus taking advantage of the Hospital's exemption from custom duties.

The St. John Ambulance Association has provision in its incorporation to permit it to manufacture and distribute ambulance equipment. The Canadian National Institute for the Blind negotiates for exemption from duties and sales taxes for equipment especially designed for the blind, such as Braille watches, talking-book machines and housekeeping aids.

Because the commercial products are considered unsuitable, expensive or not readily adaptable to individual requirements, The Canadian Arthritis and Rheumatism Society advises the family regarding home construction of such aids as ramps and raised toilet seats.

The Department of Veterans Affairs manufactures its own braces and artificial limbs which are provided for non-veterans' use in some provinces. In 1961, the total Department of Veterans Affairs expenditures on prosthetic appliances was \$1,606,925, of which \$211,540 was recovered from outside organizations.

It is apparent that there is no general agreement about the place of public and private enterprise in the manufacture of prosthetic appliances necessary for handicapped persons. In some cases government is subsidizing through exemptions from sales taxes and duties, grants, or its non-profit manufacture. Government is increasingly involved in paying for appliances through its own services, the Vocational Rehabilitation Services Act, and the federal-provincial sharing of public assistance costs. These articles are not luxuries for the persons who buy them, and the need of them in many instances is an indication of limited earning power. It would appear that a more uniform policy should be established under federal leadership.

D. HEALTH SERVICES OUTSIDE THE INSTITUTIONS AND CLINICS

(1) Home Nursing and the Costs of Home Nursing

The voluntary health organizations are providing or paying the costs of home nursing to a far greater extent than are any of the official agencies. Some

public health units provide bedside nursing, and some public welfare departments pay for this service for indigents. The Department of Veterans Affairs and the Workmen's Compensation Boards purchase the service from the voluntary agencies, as do some industrial corporations.

The increasing demand for part-time bedside nursing has been created by a number of factors – the shortage of household help, the cost of full-time professional or practical nursing, the increased number of chronic patients, the shortened stay in hospital and the emphasis on early ambulation after illness, the recognition that some patients respond better to treatment within their family group, and the desire to use beds in acute hospitals only for acute patients. Since the voluntary organizations are the main source of this service, they are used by industry, insurance companies, and families of all income levels.

The Victorian Order of Nurses is the only organization providing this service on a nation-wide basis. The St. Elizabeth Visiting Nurses' Association operates in Toronto, and a similar association serves Hamilton, Ontario. These Associations are Roman Catholic and take the point of view that since illness and death have religious significance, a nurse of one's own religion can be of more assistance to the patient, but they do not limit their service to Catholics. In Quebec, Les Infirmières Visiteuses is a provincial federation of societies serving a population of almost 1,500,000 people in and around Montreal. The Canadian Mothercraft Society in Toronto sends its nurses to families who can pay the full cost of care. No other organizations giving professional service have been identified, although a few of the disease-focussed societies pay for practical nursing service.

Since the Victorian Order of Nurses has services in areas which include 51 per cent of the population of Canada, and since home nursing is a service which might be included in a Health Services Plan, the Order is discussed in some detail here. It has branches in all provinces except Prince Edward Island, and the percentage of "covered" population by provinces ranges from 25 in Newfoundland to 54 in Manitoba. The branches are basically in urban areas and hence in the areas of greatest population density. Although the branches are incorporated as autonomous societies, they are controlled by national policy and supervised by the national office. The ability of a community to provide financial support and the need of the area for service are the main criteria by which the national office determines whether it will authorize a new branch. The national policy requires that the service of a branch must be available to anyone in the geographic area, regardless of age, sex, race, creed, or financial status, for any kind of illness including maternal and neo-natal care; the service be available 24 hours a day and seven days a week,¹² the need of the patient determines the amount of

¹²This provision makes it necessary for branches with no clerical staff to arrange for telephone calls to be received either by a Telephone Answering Service, a hospital, a fire department, etc.

service given; all patients be under medical supervision;¹³ and the nursing care be provided, administered and supervised by qualified nurses.

The professional service is solely the responsibility of the professional staff. All nursing appointments must be approved by the national office, and public health training is essential for permanent appointment, although the Order has not been able to limit the staff to such appointments because of the shortage of personnel. Toronto, Vancouver and Montreal have a limited number of nursing assistants. Vancouver has employed a physiotherapist, and Toronto has a consultant in physiotherapy. One of the national staff, a specialist in rehabilitation nursing, assists in training the local staffs. The national professional staff of 12 includes nine Regional Directors with responsibility for supervision and consultation at the local and provincial levels.

Although the 119 branches employed 648 nurses in 1960, 345 of these were in Ontario, and 119 in Toronto. Thirty-six branches had nursing staff of one, and 97 less than six. The national policy requires such branches to be supervised by the Regional Director, but on the grounds of logistics, the effectiveness of this supervision must be questioned. For example, one Regional Director in Fredericton is responsible for the supervision of eight branches in New Brunswick, two in Newfoundland and three in Nova Scotia, and tries to visit each twice a year.

In the 69 smallest branches, no clerical service is employed, and in the remaining 28 supervised branches only part-time service is available. The nurses undertake clerical duties, work with the Boards, assist in the raising of money, etc., in addition to providing professional service. Units of this size are costly to administer, make adequate supervision impossible, and cannot use professional staff to the best advantage.

The Order was originally established to provide maternal and neo-natal care, but since 1918 heavy emphasis has been placed on health education and hence on the employment of staff with public health nursing training. Branches were established in many areas before the development of official public health services, and although the basic functions of the Order are now bedside nursing and health education of the patient and his family, various branches also provide health services now generally recognized as a public responsibility. The policy is to avoid duplication and to work out co-operatively with the official agencies the area of service of the branch. In St. John's, because the Health Department provides bedside nursing to the indigent, the service of the branch is limited to patients who are able to pay the fees. Thirty-six branches have recently developed a hospital referral service in which the nurse visits the hospital for regular periods to arrange for the care of discharged patients. In five branches the Order participates in home-care programmes.

¹³Comments have been received of increasing difficulty in some areas of maintaining this policy, since the medical practitioner does not always consider it necessary to visit certain categories of "chronic" patients.

Since the financial statements include all fees in one item, without distinguishing the source of payment, the extent to which the bedside nursing service is given to people who can pay the full fee cannot be determined. Charges are based upon the local unit cost, calculated by a formula developed by the National League for Nursing in the United States.

(2) Public Health Nursing Services

The term public health nursing services is used here to cover the community nursing functions which have generally been accepted by government as its direct responsibility, but which are being carried out in some areas by the voluntary agencies. These agencies undertake such service with the agreement, and in some instances at the request of the public authority, but appear to be in competition to some extent with that authority. The Atlantic Provinces show this pattern most clearly.

The Victorian Order of Nurses provides in different areas school health services, pre-natal instruction, child health conferences,¹⁴ instruction in the care of the newborn, and follow up of tuberculosis patients. Twenty-two branches are engaged in child health activities that generally have been officially accepted as a public responsibility and in most, if not all, of these areas there is an official agency providing a similar service in other sections of its territory. In the consolidated statistics provided by the Victorian Order for 1960, the visits made for "health instruction" were given as 11 per cent of the total. Visits made for maternal and neo-natal care were an additional 18 per cent and, since very few confinements are now in the home, this must also be regarded as mainly health instruction. In Newfoundland, Nova Scotia and New Brunswick, the visits under these two headings were 30, 43 and 45 per cent of the total visits and only in Manitoba (8 per cent) was the figure less than 25 per cent. A similar breakdown is not given for those services, such as schools and clinics, which require time rather than a visit as the unit of calculation.

The St. Elizabeth Visiting Nurses' Association also gives pre-natal and post-natal instruction, and staffs child health centres in St. Michael's Hospital and in 16 suburban municipalities in and around Metropolitan Toronto. In the latter the nurses are under the supervision of the Medical Officer of Health and are paid by the municipality on an hourly basis.

Comments were received that bedside nursing presents a heavy physical strain upon the nurses, particularly when most of the patients are suffering from chronic illnesses, and for this reason, as well as the monotony of the work, the voluntary organizations like to have other activities for their nurses. It is probably also true that those trained in public health nursing want to make full use of their specialized training.

¹⁴A "child health conference" is similar to a well-baby clinic but is conducted by the nurse without a doctor.

The voluntary organizations and the government often provide similar services in communities where the branches of the Order are too small for economic operation. This emphasizes the desirability of one unified service. Although the Order receives grants from the provinces, municipalities and school boards, sometimes calculated on an hourly basis for the service received, the proportion of voluntary funds required to cover its budgets suggests that the "public" services are being subsidized substantially by private funds. Unless there is resistance from the "vested interests" of the Order, or unless the government feels it is getting a "bargain" because of subsidy by voluntary funds, it is difficult to suggest why the Health Departments do not undertake the responsibility for this work.

A lack of distinction between public and private responsibilities is also evident in the work of the Tuberculosis Association in some areas. In Saint John, New Brunswick, the "Tuberculosis Nurses" follow up the patients attending the Association's clinic, of which the provincial Director of Tuberculosis Control is the Medical Director. They conduct the tuberculin testing in the schools, accompanied by the city public health nurse who is responsible for the school health services. The Gyro Club in Moncton has its own clinic with nurses who follow up the patients in their homes. A few small Victorian Order Branches in New Brunswick conduct the Seals Campaign for the Tuberculosis Association and retain "donations" from the returns for their own funds. In the clinics in four centres the Alberta Tuberculosis Association has public health nurses who are doing work similar to that done by the Health Department in other areas. The report says "These nurses are designated 'Kinsmen Nurses' to add prestige to the clubs who are identified with the Seal Sale and this is one way of showing the public how their moneys are spent". This suggests – and other illustrations could be given – that the desire for campaign publicity is one of the factors which determine the kind of activity in which some of the associations engage.

The Society for Crippled Children and the Poliomyelitis Foundation in some areas have nurses visiting the homes of patients. In Ontario, some of their work is reported to duplicate that of provincial welfare officers in ascertaining the eligibility of handicapped persons for vocational rehabilitation services.

One can assume that where a voluntary agency has worked hard to establish a service which is of benefit to the public, it resists withdrawal when the Provincial Health Department established such a service. A successful organization inevitably develops vested interests and when the leadership remains in the hands of a small group – sometimes one person or one family – over many years, a personal interest may develop and change be resisted. From the point of view of the government, the use of the existing organization may seem cheaper, since it is partly financed by voluntary contributions, but the politics of the situation may also make the government hesitate to enforce a new regime. The point of view expressed here is that where responsibility has been assumed by government, it should be carried by the appropriate government department, either directly if this

is administratively sound, or through the purchase of service at full cost where there seem to be advantages in using the voluntary organization.

E. OTHER PROVISIONS FOR THE BED-PATIENT AT HOME

(1) Home Care Programmes

Although home care programmes have not been studied in detail, some reference to them is necessary because of their relationship to voluntary organizations. As noted above, the Victorian Order of Nurses is involved in five, and there are plans for development in other areas.

These programmes require the teamwork of a number of services. They may be hospital-based, as in Winnipeg and Montreal, or community-based as is the one under the Department of Health in Toronto. They are planned in order to provide the services needed to keep the patient out of hospital, to facilitate his discharge from hospital, or as a substitute for nursing-home care where this is considered desirable by his medical advisor. They are mainly for chronic patients for whom prompt admission to hospital may be necessary at any time, and hence require an arrangement with a hospital. For an effective programme it is desirable, if not essential, to have available a considerable variety of services such as medical service in the home; the drugs and equipment necessary for home care; bedside nursing on a part-time basis; homemaker or housekeeping service; social work; transportation to bring patients to the out-patient department for certain treatment or procedures; and physiotherapy. Most of these services are drawn from existing voluntary community resources.

One illustration is the Home Care Programme of the Winnipeg General Hospital, organized under the Director of the Out-Patient Department, with medical care given by staff doctors. The Social Service Department of the hospital provides social work. The Victorian Order of Nurses has placed a senior nurse full-time in the hospital to act as co-ordinator, and to arrange with the Branch for bedside nursing. When a homemaker is required, the Family Bureau – the voluntary family welfare agency in the community – is used. The Red Cross Loan Cupboard lends the necessary equipment, which is supplemented by more unusual articles bought by the hospital for the use of certain patients. The Canadian Arthritis and Rheumatism Society provides physiotherapy and some occupational therapy. The Society for Crippled Children and Adults provides bus transportation for patients whose disabilities make travel by taxi difficult. Drugs and supplies are provided by the hospital to indigent patients from a provincial grant.

In the year ending September 30, 1961, the programme served 148 patients, 102 of whom were 60 years of age or over. Fifteen were referred by private medical

practitioners, the others being indigent hospital patients. The services required were:

Home nursing	125 cases
Housekeeping	61
Equipment	20
Transportation	83
Physiotherapy	8
Supplies	33
House calls by medical staff	83

This programme is financed by Federal Health Grants with patients paying fees for service when able to do so, and the province assisting indigents under the Social Allowances Act. The Victorian Order, the Family Bureau, and the Arthritis and Rheumatism Society are paid in full for their services.

The Toronto Pilot Home Care Program was set up in 1958. It differed from that in Winnipeg in that the administration was centered in the Toronto Health Department. Medical care in the majority of cases was provided by private physicians. In addition to the voluntary agencies, commercial organizations were used to provide housekeepers and for renting equipment. When they were able to do so, the patients paid directly for the services they received. For part of 1961, two hospitals co-operated in extending hospital treatment into the home – i.e., the earlier discharge of selected patients from hospital on a voluntary basis, when under other circumstances the patients would have continued in hospital. Since these patients were covered by hospital insurance, the plan was worked out with the Ontario Hospital Services Commission and the provincial government. All costs, regardless of the patient's ability to pay, were paid through a provincial grant. Detailed figures were obtained in order to compare the costs of the two methods of care. In the short period of time covered it was estimated that about two per cent of the hospital patients could be given and wanted this type of care. It was estimated that, when the programme was well established the total per diem cost (without the doctor's fees) would be \$6 or \$6.50, as compared with \$27.60 in an acute hospital.

(2) Homemaker Services

Homemaker Service is provided in a limited number of urban communities in Canada. In a few cities, such as Winnipeg where it is under the voluntary family service agency, it is considered an essential service with the aim of maintaining the family as a unit when the normal homemaker is unable to function. In Ottawa and Toronto it is a separate agency. In 35 centres it is one of the functions of the Red Cross Society. Some child welfare agencies provide a service from a roster of available people rather than from their own staff. In Alberta the Poliomyelitis

Foundation and the Cancer Society, and in British Columbia the latter organization employ housekeepers. Some other organizations, such as the Cancer Aid League in Montreal, pay the cost if the family can find a person willing to act as homemaker. Ontario legislation allows municipal welfare departments to pay for or provide this service.

Homemakers, housekeepers, or "home-helps" may be needed on a part-time basis to do the heavy work for an elderly couple, for example, or for a full day, to take charge when the breadwinner is working, or for 24-hour duty when there is no able-bodied adult to care for the children. The purpose is to enable the family to be maintained as a unit when the normal homemaker is unable to function, a purpose which is not only socially desirable, but often more economical than paying for the care of the dependent members of the family elsewhere. The need arises not only in cases of illness in the home but in families where the mother dies, is in hospital, or deserts. It is important therefore that the services be organized in such a manner that they are available when needed for reasons related to health or to the social situation. Because social problems are often the result of the mother's absence or incapacity, the service should be under social work direction.

(3) Training in Home Nursing

The St. John Ambulance Association and the Cancer Society stress the value of training in home nursing in their Briefs to the Royal Commission on Health Services. The former is heavily involved in the training programme as is the Red Cross Society. The presence in the home of one person with such training may reduce considerably the service required from the visiting nurse.

(4) Practical Nurses

A few local groups, such as the Cancer Society, sometimes pay the cost of practical nurses. Whether the organizations providing bedside nursing care could make fuller use of nursing assistants and practical nurses was a question raised by members of both the medical and nursing professions during the course of this study. Many families who need and can afford full-time nursing care for the chronically ill employ practical nurses on the advice of the medical profession, and it would seem possible that there is a larger place for part-time service by these women, supplementing that of the professional visiting nurse.

(5) Physiotherapy and Occupational Therapy

The importance of physiotherapy in the treatment and rehabilitation of patients suffering from a wide variety of diseases and disabilities is receiving increasing recognition. The shortage of trained personnel in this field is reported to be a major problem.

Treatment is most frequently available through the rehabilitation centres already discussed, or the rehabilitation units of hospitals. Some types of treat-

ment are available only in such institutions, although the Canadian Arthritis and Rheumatism Society has developed mobile units for rural communities working in co-operation with the local hospital or the public health unit. They are similar to travelling clinics although home treatment is sometimes provided. One of their purposes is to demonstrate the effectiveness of the treatment in the hope that the hospital may develop its own service. Some hospitals contribute to the cost. This Society is mainly concerned with patients suffering from the diseases, but in British Columbia it estimates that about 20 per cent of its patients suffer from other conditions.

In some provinces the Society for Crippled Children provides physiotherapy in the home. In Newfoundland one of the members of the travelling clinic is a physiotherapist whose function is to teach the parent to help the child continue his exercises at home. A study undertaken by the Quebec Society showed that parents of children seen at a Montreal clinic were often unable to persevere with the treatment at home and a follow-up service was strongly urged. In the cystic fibrosis clinics also parents are instructed by the physiotherapist in home care. Camps for crippled children are used, in part, to provide intensive physiotherapy for a limited period.

The Societies for Crippled Children, the Association for Retarded Children, the Poliomyelitis Foundation and the Cerebral Palsy Association have shown particular interest in remedial swimming classes.

Occupational therapy does not seem to be provided in homes to any extent, although "diversional therapy", which can be the beginning of income-producing industry for the home-bound, is undertaken by the home teachers of the Canadian National Institute for the Blind and, in Ontario, by the Cancer Society.

A few provinces pay fees for physiotherapy for indigent patients on medical prescription, but the importance of this form of treatment is not recognized in most legislation. Thus the voluntary organizations are now providing most of the funds to cover the cost for these services. The federal Vocational Rehabilitation Services Act limits this service, as others, to persons who will be employable after treatment, and children, chronic patients, the aged, and women who are not seeking work and who have no family responsibility are excluded.

Some voluntary organizations are contributing to the costs of the new schools of physiotherapy to augment the supply of therapists. The shortage of personnel emphasizes the importance of efficient use of the staff. One organization states that a physiotherapist is able to give 20 treatments a day in a centre while averaging only five in the home. For this reason, if for no other, patients who are able to go to a centre as out-patients should generally do so. Home treatment then will largely be for the home-bound, and it would seem appropriate to link it with the organization providing bedside nursing. This combination of services seems to be

more desirable than the provision of treatment by organizations focussed on specific diseases, since patients for whom the treatment is prescribed are suffering from a wide variety of conditions.

(6) Social Work

Only a few of the voluntary health organizations provide social work services to patients in their homes: in Montreal, the Poliomyelitis Foundation; in some areas, the Canadian Arthritis and Rheumatism Society; in some provinces, the Society for Crippled Children and Adults and the Canadian National Institute for the Blind; in Toronto, the Association for Retarded Children. Some of the patients receive this service from the hospital. A few other organizations mention their need and desire to include social workers on their staffs.

In the Societies for Crippled Children where the committees of local service clubs take a direct interest in the children, the need for provision of social work appears to be great but difficult to obtain in a small community. The Ontario Society's pattern of employing nurses to help the voluntary committees within a region could be used to make social workers available. In some urban home care programmes social workers from the family welfare organizations are used.

Patient-member organizations like to provide the direct service themselves but the local groups are small and in most cases could not use a full-time social worker. Social workers attached to some community agency could assist the membership in providing more effective service.

(7) Dietary Service

The Canadian Diabetic Association employs two professional dietitians to give counselling service for the benefit of diabetics. This includes assistance to hospitals, physicians, visiting nurses and other agency staffs. Where individual patients or their families request help in establishing a diet, the Association always seeks written approval from the patient's doctor.

F. SOCIAL, EDUCATIONAL AND VOCATIONAL REHABILITATION

(1) The Concept of Rehabilitation

Rehabilitation involves the return to as normal a life as is possible of the person who, through accident or disease, incurs a disability which requires adjustment in his way of living. The term is also used to include the preparation for independent living of the person born with a disability or defect. The extent to which normal life is possible varies with the physical or mental condition and with the personal qualities of the patient.

The rehabilitation of a patient may require any of a wide variety of facilities and services: medical care to return him to the optimum physical condition or to prevent progression of the disease; training in health care for the maintenance of optimum health; provision for continuing medical care or re-assessment; academic education adapted to the needs of the child or re-education or "up-grading" of the adult; vocational assessment, guidance, training for earning his living, and help in obtaining and holding a position; training in homemaking; training in self-care and the use of "aids to daily living"; assistance in social adjustment to gain or regain confidence in relationships with other people; help in his personal adjustment to his condition and to himself as a handicapped person.

Some of these varied services are needed by the able-bodied in the community and used also by the disabled; others are needed only by the disabled. Other special services include academic education for children and adults in residential and day centres; vocational assessment, guidance and training; job placement; sheltered employment for work adjustment, training on the job and terminal employment for those unable to work in competitive industry; employment of the home-bound, with outlets for their products; financial assistance for the ordinary costs of living during rehabilitation, and for the extraordinary costs created by the condition; tools, equipment, and capital for entry into industry or business; social centres and recreational facilities, and provision of the means for pursuing recreation and cultural interests; housing adapted to the needs of handicapped persons; the "gadgets" and other equipment necessary to enable the person to live as full a life as is possible; and social work to assist in social and personal adjustment.

These services and facilities are provided by the voluntary health organizations in some areas for people suffering from some handicaps. With the leadership and financial participation of federal and provincial governments in the last decade, public funds are paying for an increasing proportion of the costs. Government departments are co-ordinating services required by individuals, but most services are provided by non-governmental bodies. The government's participation on behalf of the child has been concentrated on education, and for the adult, except for those disabled through war or industrial accident, upon services which will lead to economic independence. Federal and provincial governments frequently purchase services from the voluntary organizations or give grants in lieu of individual fees. When the person is not eligible for government assistance, a voluntary health organization may pay the costs of the service.

Some organizations are not involved in rehabilitation. The disease entities with which they are concerned may by progressive and medical knowledge insufficient to alter their course. In this group are the societies interested in muscular dystrophy, multiple sclerosis, cystic fibrosis and myasthenia gravis. In other cases, such as cancer, diabetes and some heart conditions, the disease, if controlled, does not require of the patient a radical readjustment in living and, if not controlled, offers little hope of rehabilitation. In some societies, such as those focused on epilepsy and mental illness, a main concern is to alter the attitudes

of the public to the condition in the hope that when this is accomplished, the sufferer will be accepted in employment and other activities. In other societies, however, the rehabilitation of the sufferers is one of the main concerns, although the programme may include education concerned with changing the public's attitude to those afflicted.

(2) Services to the Physically Disabled

The organization providing the most complete services for rehabilitation is the Canadian National Institute for the Blind. With the exception of education, its activities aim at an inclusive service, but its scope varies between provinces depending on the financial strength of provincial divisions. The service may include work with pre-school children and their parents; home teaching; a national vocational training school for staff and for dictaphone transcribers; the preparation and provision of Braille books and music, and of "talking books"; discounts and concessions both on equipment necessary for the blind such as Braille watches, and a wide variety of appliances, travel costs, etc., to reduce the cost of living for the blind; recreational centres and programmes; holiday and social adjustment centres; vocational counselling and job placement; sheltered employment in concession stands and cafeterias, broom factories, etc.; home-bound or workroom crafts with outlets for the sale of products; residences, particularly for the elderly; social work; financial assistance. Service is purchased by the federal government for the war-blinded, and by Workmen's Compensation Boards for those blinded in industrial accidents.

The function of the Foundation for Poliomyelitis in rehabilitation in most areas is one of making grants to other organizations, such as local rehabilitation centres in Ontario, or of paying for the services given to individual patients for whom other sources of payment are not available, as in British Columbia. In the latter province, after some years of uncertainty about its role, the Foundation predicts that its chief function will likely be in vocational adjustment, including the sponsorship of sheltered workshops. In Newfoundland the service for adults is very limited, and in Nova Scotia is still concentrated upon polio victims. In Quebec, the organization gives some direct service as, for example, the arrangement with the Hemophilia Society to provide the services of a staff social worker to its members.

The Tuberculosis Associations have been involved in rehabilitation within sanatoria, largely through educational courses. The cost of the teachers' salaries has frequently been assumed by the province, and the effectiveness of the programme has been radically altered by the shortened period of hospital care.

In Newfoundland the Association provides a Director of Rehabilitation and three officers to work in the sanatorium, but the Province makes a grant towards the Director's salary. In Nova Scotia the Association's Director of Rehabilitation formerly supervised the work of the provincial government's rehabilitation officers

in the government institutions, but in 1956 he became a provincial civil servant. In Quebec, L'Association de la Croix de Lorraine has as its primary purpose vocational rehabilitation, including the gaining of public acceptance. The local committees provide some financial assistance to help the patient become re-established and offer him help in getting a job. Where professional vocational guidance service or training is needed, referral is made to community agencies.

The Paraplegic Association, while engaged in helping persons re-establish themselves vocationally, is faced with particular problems in teaching patients the skills and helping them to obtain the equipment necessary for a degree of independence. The Rehabilitation Centre, Lyndhurst Lodge, in Toronto, is used for patients who can not be treated adequately in local facilities. Some of the sufferers are employed by the Association itself. Others have been established in businesses such as Tourist Bureaux, or in work which is done by telephone. Their mobility depends on special equipment, as does the development of ability in self-care. Continued medical supervision, periodic hospital care and home-nursing care are needed. The branches of the Association become involved in providing, or paying for driver-training, the purchase of cars, and the subsidization of taxi costs. Efforts to provide suitable housing have also been made.

It is estimated that only about five per cent of the sufferers are war-disabled and hence war-pensioned. The majority are the victims of accidents. In some cases insurance payments are available, but the heavy extra costs of living present a serious problem.

(3) Services to the Mentally III

The work of the Canadian Mental Health Association in rehabilitation is different from that of other associations. Mental illness frequently causes the patient to withdraw into himself, and part of professional treatment is to help him regain normal relationships with other people. Lengthy hospitalization may also make him a stranger to community living. With the changing emphasis in treatment many patients now remain in the community or are hospitalized for shorter periods than formerly, and one objective is to keep them in contact with the community throughout the entire treatment. The Association has enlisted volunteers to help the hospitals and the psychiatrists in this phase of the patient's recovery.

In the White Cross Centres and the "Patient's Friend" programme, the provincial and local chapters of the Association enlist and select volunteers who, with some training, provide the patient with informal contacts in the hospital or in the community to build up his interest in other people.

The Association emphasizes that the volunteers do not give treatment. They are the representatives of the community who assist the patient to return to it. They provide recreation, crafts, etc., within the hospitals, and sometimes donate furnishings and equipment, clothing and "comforts". In some hospitals they are

assigned to take a special interest in selected patients, or to take them out into the community.

White Cross Centres assist in the rehabilitation of the patients by providing a social centre with a comfortable undemanding atmosphere. The effectiveness of this service depends on the relationship of the organization with the treatment facilities for the mentally ill, and the staff effectiveness in selecting, interpreting and training the volunteers. There is danger that the Association's desire to provide its members with satisfying activity, to "give them something to do", may have led to a more rapidly expanded programme than can be used adequately and productively.

(4) Schools for Children

The organizations concerned with the retarded and the cerebral palsied have concentrated upon children although some local groups are beginning to develop limited services for the young adult. These include services to assist the members in social adjustment, and to provide occupation, diversion and supervised care. Some are planned to relieve the parents temporarily.

For the retarded children the schools have been the primary emphasis and the progress in their establishment has been phenomenal. While in a few areas there has been difficulty in obtaining interest, most parent-members are enthusiastic. The movement started with the objective of demonstrating that education of the retarded should be accepted as governmental responsibility. In many areas, local or provincial governments are now helping financially and in some, paying the major costs, with the voluntary group providing such services as transportation.

In Toronto, the Association has a residence planned for children whose homes are too distant to make school attendance possible, but used to a large extent for those whose parents need to be relieved of their care, or for wards of the Children's Aid Societies who are on the waiting list for admission to provincial training schools. This combination of purposes shows the need for more appropriate facilities for such children, recognized in Ontario by the recent provincial agreement to contribute 50 per cent of construction costs of facilities. Some other local associations hope to establish sheltered workshops.

The Schools of the Cerebral Palsy Associations are generally associated with medical care facilities and correspond to "hospital schools",¹⁵ with their programmes sufficiently flexible to allow the patients to undergo treatment. Some of these schools serve the cerebral palsied only, but sometimes all handicapped children. Similarly, the schools for retarded children sometimes accept cerebral palsied children. In some cases, where small separate schools operate, competition has developed.

¹⁵ For example, the educational programme in children's hospitals or the children's units of hospitals.

Increasing public educational grants support these schools, and in some areas the regular school system now provides classes. The grants are based on a teacher's salary, a per diem attendance rate, or a lump sum. The educational authority should require standards in those schools to which it gives grants or, alternatively, incorporate the school into the regular school system, following the pattern generally established for the provision of hospital schools or the teaching of the home-bound. When these children have been excluded from the regular schools on the basis of "ineducability" and the educational authority subsidizes their "education", one must assume that the authority has excluded them because it has not the facilities or staff appropriate for their education, or that, in giving grants, it has altered its definition of "educable". It is a long established principle that where grants are given to private schools, the schools must conform to standards. In some instances the province now requires "certified teachers".

In some areas the pre-school handicapped child is receiving attention. The care of the pre-school child in a few branches of the Canadian National Institute for the Blind is designed to assist parents in their training and to prepare the children for admission to the official residential schools for the blind. This valuable programme can only be implemented when there are sufficient young blind children accessible to a school centre. Pre-school activity for children with hearing handicaps is provided in a few cities. The Richmond School for emotionally disturbed children in Montreal has both pre-school and school-age children. As schools for the older age groups become better established, this work for the younger age groups can be expected to increase.

The development of schools for the educable leads naturally to the provision of programmes for the "trainable", for whom educational authorities have not yet assumed responsibility. Centres for the grossly retarded and the grossly involved cerebral palsied combine the function of training with the relief of parents. At present the emphasis appears to be on the latter. Such centres need trained leadership and should combine the training of both children and parents. The parents through work in the centre, and participation in discussion groups and counselling services, can be given valuable help.

(5) Vocational Assessment and Training

Vocational testing by psychologists is usually arranged through community resources, but vocational assessment which includes physical and social factors may be undertaken by an agency in consultation with the specialists involved. In some instances the adult can return to his old occupation, or to a position in which his previous skill and knowledge will be valuable. In others he requires re-training for which his previous academic education is often inadequate. This is a major problem in the rehabilitation of older persons who are unable to do manual or outside work.

Training courses in the community are frequently used, with living allowances and fees increasingly paid under the federal Technical and Vocational Training Assistance Act and the Rehabilitation Services Act. The only residential centre identified was Variety Village administered by the Ontario Society for Crippled Children, financed largely by the Variety Club, and providing training for a small number of older adolescent physically crippled boys. Training "on the job", or training in work adjustment is provided by some local voluntary organizations, generally classified as sheltered workshops. Examples are the Society for Crippled Civilians in Toronto, and the workshop of the Society for Crippled Children and Adults in Winnipeg. These organizations do not limit their employees to persons suffering from a particular disability. They fit the trainee into their activity to test him and hopefully prepare him for employment in competitive industry, and at the same time provide terminal employment for the more seriously handicapped. While some of them accept people with physical disabilities only, a few include patients with some degree of mental disturbance. If the province accepts an organization as a training centre, fees and living costs during training can be paid by the federal-provincial agreements regarding vocational rehabilitation.

(6) Sheltered Employment

Sheltered workshops provide a protected environment to help a man move back into industry (e.g., to build up work tolerance, or confidence in his ability to compete) or to provide "terminal" employment for the person who is permanently unable to compete in the labour market.

In the Canadian National Institute for the Blind such workshops are limited to blind persons, but a high proportion of the sighted has to be employed to make it possible for the blind to work. The Institute also has concessions for stands, canteens or cafeterias in federal and provincial buildings. Some of the contracts provide for the sharing of responsibility for the provision of equipment. In some there is a sharing of profits and in others the Institute takes the full profit. The blind are paid full wages, whether a profit is made or not, and profits may be shared with the workers.

These are business undertakings to provide earning opportunities for blind persons. Consultation and supervision is provided by national or divisional staff. The canteens and cafeterias employ an average of three and a half sighted persons for each blind person. Supervision is not included in the costs. The Institute argues that these undertakings provide employment and that even if wages are subsidized, the expenditure is justified in that it gives the blind man the feeling of complete independence. Comments received also suggest that in some instances the emphasis upon the employment of the blind is resulting in their assignment to inappropriate work. Only the figures of net profit or loss are given in the financial reports. Profits are spent on further development of industrial undertakings, while losses are covered by other revenue. The annual reports

highlight the number of blind employed in these undertakings and their earnings, and compare the total income of the employed blind (including blind staff of the Institute) with the operating budget of the Institute.

The Institute has placement officers to find jobs for the blind in the open labour market. It considers this is a specialized service (as do the Canadian Hearing Society and the Paraplegic Association in the placement of their patients) which should be undertaken by the organizations rather than by the Special Placements Division of the National Employment Service. The Institute's officers visit industries, note a particular job which they think could be done by a blind man, sell the idea to the employer, select the man for the job, help train him and continue to keep in touch with both the blind man and the employer as long as the former continues to work. During 1962, 476 blind men were employed in the community throughout Canada, seemingly a small number as compared with 976 employed by the Institute itself. The explanation given for this disparity in numbers was that many factories were in buildings in which it was difficult for the blind to work, even if they could do the job. One gets the impression that the concentration has been on creating employment through the Institute's own activities.

It is the policy of the Institute to use blind persons wherever possible in its own work. This is justified partly by the argument that a demonstration of what can be done independently by a blind person is extremely effective in helping the newly blind to aspire to relative independence. It is also "enforced" by the Blind Clubs who act as a union.

This whole situation suggests that a study should be made of the business enterprises of the Institute to assess the validity of their undertakings. It is generally accepted that in sheltered employment a person should be paid in wages what he earns and that a clear distinction between earnings and subsidization should be made to enable the man to face the extent of his disability realistically, provide fair competition with private industry and identify the amount to which subsidization is necessary from public or voluntary funds. The necessary employment of a considerable proportion of sighted persons also suggests that commercial enterprises for the handicapped should not be under one disability-centered organization, but should be developed so that the handicap of one worker is compensated for by the abilities of another otherwise handicapped person. The extent of government subsidization through the terms of the contracts for concessions should also be studied. If there is an indirect subsidy it should not be provided for only one group of the handicapped. If the Canadian National Institute for the Blind continues to operate commercial establishments, the suggestion is made that these should be separated from its other activities as profit-making corporations in fair competition with other business organizations.

Theoretically it would appear that the Special Placements Division of the National Employment Service should be able to study the kinds of jobs in any industry which could be undertaken by a person with any type of disability.

Although in some instances very intensive help in placement of an individual may be necessary, it should be unnecessary for voluntary organizations to provide a placement service when the federal government has assumed responsibility in this field. The National Employment Service should be strengthened to enable it to fulfil this function more adequately.

Sheltered workshops which are completely independent operations have not been included in this study. In a few cases, such workshops are part of the activities of the health organizations. There appears to be general agreement that many communities lack sufficient facilities to provide for the handicapped who are only able to work under protected conditions.

A number of groups of handicapped persons have combined to develop their own industries. Some of these seek to capitalize on their handicaps to make their appeal to the buyer. The attempts to sell articles on the basis of their production by handicapped persons should be discouraged and when the representation (as reported by the Better Business Bureau in Toronto¹⁶) is fictitious, legal action should be taken.

Industries for the home-bound have a therapeutic as well as an economic significance, but the economic possibilities are limited and the income cannot be expected to exceed "pin money". The cost of material may be reduced through wholesale buying by the organization, as it would be in any commercial company, and the sale assisted by the provision of outlets. The profit should be a real one and the articles made worthy of the price charged and not used as a way of disguising charity.

The Canadian National Institute for the Blind encourages home crafts, supplies material wholesale and provides the outlet through its sales rooms. The overhead costs are reduced by the use of volunteers. The Canadian Council for the Rehabilitation of the Disabled has assumed the responsibility nationally for "Marina Creations", a trade-mark enterprise organized by a group of volunteers who prepare the designs, purchase the material wholesale, teach the workers in their homes and insist on a "perfect" product. The present intent is to develop this nationally through the member organizations of the Council.

(7) Social Activities

Social, cultural and recreational activities are provided by many of the organizations. The monthly meetings of adult patient-member organizations are partly social, with volunteers providing transportation. Provincial organizations sometimes have Christmas parties or summer picnics in which they try to include more distant patients than those who can attend local affairs. Donations of food, presents and entertainment are solicited from merchants, service clubs and other organizations.

¹⁶Better Business Bureau of Metropolitan Toronto, *The Bulletin*, 28:2 (January, 1963).

Some of the social clubs of the blind and deaf or hard of hearing, organized by the disabled themselves, are able to adapt social activities so that their members can participate. In the Canadian National Institute for the Blind, for example, fishing, golf, and bowling are made possible by special arrangements. The Boy Scouts and Girl Guides have developed special programmes for handicapped children.

Some of the activity, such as wheelchair team games, is considered good publicity to show what people can do in spite of serious handicaps. Physical activity of various sorts may help to maintain health, but is more difficult for certain handicapped groups to obtain.

Some of the social activity is planned as therapeutic, to assist children or young adults to develop social skills in a group of persons with similar problems with the goal of helping them move on to relationships with people who are different.

Camping for both children and adults is a form of social recreation widely sponsored, not only as an enjoyable holiday, but as presenting opportunities for social adjustment, intensive physiotherapy, training in taking responsibility for self-care, the learning of skills which will add to the enjoyment of life, and the relief of the family for a limited time. Some camps are built with special attention to the needs of the particular groups. The local branches are generally expected to pay the camp fees or to interest some other organization in doing so. Camp operations are often distinct from other activities, with both capital and operating funds raised separately.

(8) Housing

Some organizations recognize housing as a problem when the physical condition requires special arrangements and facilities. One has leased three apartments in a block to be sublet to handicapped persons. Others have made special representation to housing authorities to plan units suitable for the handicapped. Some organizations have also stressed the need for designing public buildings so that they are accessible to the handicapped and can be used by them.

The Canadian National Institute for the Blind has residences largely for the elderly ambulatory blind and those without sighted relatives to assist them. Most provinces supplement what they expect the blind person to pay from the Blind Allowance, so that the operating costs are covered. In Ontario, the Institute does not think that a blind person without other income should be expected to pay 85 per cent of the allowance as laid down by the province. It asks for 75 per cent and pays the difference between this payment and the provincial calculation for

the supplement out of voluntary funds. The Institute has argued for a long time that because of blindness a person automatically has extra costs, and that public financial provision should recognize this. The same argument could be used regarding a person suffering from any disability which rendered him incapable of complete independence in daily living or which involved him in special diets, transportation difficulties, special equipment, etc.

ACTIVITIES OF THE VOLUNTARY ORGANIZATIONS II. INDIRECT SERVICES

The previous chapter has discussed the activities of the voluntary health organizations in providing or paying for medical and ancillary services for the patient. This chapter outlines the other activities which include prevention of disease and disability, health education of the community, professional education, the support of research, grants to other organizations and co-ordination of effort.

A. THE PREVENTION OF DISEASE

(1) Primary Prevention

According to their stated purposes, prevention is a goal of a considerable number of the voluntary health organizations and it may be assumed that others, particularly those with research as a special interest, share this objective.

Organizations interested in public health are, of course, concerned with the prevention of disease and the promotion of health. The Victorian Order of Nurses, the St. Elizabeth Visiting Nurses' Association, and Les Infirmières Visiteuses all pursue this objective through the health education of the patient and his family, and through group instruction. Some local organizations such as the Child Health Association of Montreal also provide a maternal and child health service. The Health League of Canada seeks "to promote personal and community health and the control and elimination of communicable diseases", and to "promote the discoveries in the field of preventive medicine". It has had active campaigns on fluoridation, pasteurization of milk, water pollution and food handling, matters on which public support is necessary to obtain legislative action. It has organized National Immunization Week since 1943, to encourage protection through personal action.

One of the objects of the Canadian Heart Foundation and the Canadian Arthritis and Rheumatism Society is to "aid in promoting measures and facilities

for prevention and diagnosis..." The Canadian Hearing Society seeks the prevention of deafness through legislation and prompt treatment. The Canadian Mental Health Association gives prevention as one of its reasons for promoting research.

The British Columbia Society for Crippled Children goes to an extreme in its first objective: "the eradication of conditions which cause crippling and physical handicapping", but it does not seem to have undertaken activity in this area. In contrast, the Canadian Tuberculosis Association, the Canadian Cancer Society, and the National Cancer Institute are perhaps more realistic in their efforts to "reduce the morbidity and mortality" caused by these diseases.

Two Quebec organizations have prevention as the main focus of their activities. The Mental Hygiene Institute in Montreal has the prevention of mental illness and the promotion of mental health as its central aim, and it also seeks to train people in various professions to promote mental health and recognize incipient mental illness. It also conducts mental health examinations in "well-being clinics", and gives diagnostic, consultative and advisory service to the staffs and clients of the welfare agencies. It has fostered two organizations, the Marriage Counselling Service, and the Family Life Education Council, which conduct discussion groups to prepare people for marriage, or to assist them to attain healthy marital relationships.

La Ligue d'Hygiène Dentaire is interested in the promotion of dental hygiene and the prevention of dental disease, and concentrates upon the education of persons who have the greatest responsibility for the dental health of young children, mothers, nurses and teachers. Professional staff throughout the Province of Quebec educate the public through mass media, and seek to improve the "environment" through such methods as persuading manufacturers of gum to use a sweetening less harmful than sugar.

The Canadian National Institute for the Blind has undertaken a public education campaign with industrial safety councils to encourage vulnerable workmen to wear protective glasses. Membership in the Wise Owl Club is given as an award to a person who was unharmed in an accident because of his foresight.

The Canadian Paraplegic Association is also interested in the prevention of accidents, the cause of the disability in a large proportion of cases. It works through organizations concerned with accident prevention, such as the Highway Safety Councils.

(2) Secondary Prevention

Early diagnosis is considered by health authorities to be secondary prevention in that it gives the medical profession the opportunity to use its knowledge to stabilize, cure or reduce the progress of certain diseases. Case-finding for these

purposes is emphasized particularly by the Tuberculosis Associations, the Cancer Society, and the Arthritis and Rheumatism Society.

Although the pattern differs somewhat, the provincial Tuberculosis Associations generally work with the Departments of Public Health, which seem to welcome their co-operation. It is possible that because of their earlier successful activities in promoting the assumption of public responsibility, they are continuing to "co-operate" in programmes which some of the Departments could undertake alone. Their reports arouse a suspicion that their activities are partially designed to bring the organization before the public in order to encourage the contribution of voluntary funds. The Association may provide the "mobile X-ray van" which it pictures in the annual report with the identifying name and symbol prominently displayed, while the staff, equipment, etc., may all be provided by the provincial department. The Association may provide the "mass survey organizer" who goes to the region in which the Health Department plans a mass survey to organize a door-to-door canvass to get participation. There seems no reason why a staff member of the province might not equally well – and perhaps with fewer administrative complications – perform this work.

The Associations have undoubtedly given very valuable service in earlier years. Perhaps the lack of a tradition of a government department making use of volunteers, or a tacit assumption that volunteers will not give their services to such a department, has led to insufficient consideration by the departments of enlisting volunteers without the intermediary of a voluntary organization.

The Association has also worked with hospitals to persuade them to take routine X-rays at admission. The Alberta Association, for example, has given X-ray equipment to 39 hospitals – "public" provincial and municipal, at a cost of about \$203,000. This is a substantial donation from voluntary funds to the hospitals for what is considered essential equipment.

The Cancer Society seeks to acquaint the public with the symptoms which may be significant, and urges the medical profession to undertake routine cytological examinations of women. The Arthritis and Rheumatism Society's educational efforts also put heavy emphasis upon early diagnosis.

The Canadian National Institute for the Blind concerns itself with prevention by providing glasses, drugs, etc., to needy persons when eye examinations show a pathological condition.

B. PUBLIC EDUCATION

The educational programme may be directed to the public in general, to the medical profession, or to other professional groups. In some organizations initiated

by the medical profession, the motivation has been to enlist the lay public in order to promote the aims of the medical group. In some patient-member organizations the motivation has been to bring pressure upon the medical profession.

When the Tuberculosis Association was formed, the prevailing fatalistic attitude of the public (and of many of the medical profession) had to be overcome if progress was to be made. People had to demand treatment facilities and the control of infection, and to submit to mass diagnostic surveys. The people therefore had to be convinced that the objectives of the medical men could be accomplished.

The Canadian Mental Health Association faces the same problem today — a similar need to teach people to accept the possibility of cure and seek early treatment, and to change the traditional attitude to mental illness. The Association for Retarded Children, organized by parents when professional people were not aware of the readiness of parents to publicly identify themselves, has fought against the lack of acceptance of these children, the failure of the community to provide adequate care and the stigma which the community placed upon them. The provincial Alcoholism Foundations sponsor the education of the public regarding temperate drinking and of professional people regarding treatment. The fulfilment of the objectives of all these societies depends upon public education.

Some of these educational activities are directed particularly towards overcoming discrimination in employment. La Ligue de la Croix de Lorraine in Quebec bands the ex-tuberculosis patients together to promote an attitude of acceptance by employers. The Epilepsy Societies have in some areas been working towards the same end.

The health education of the Newfoundland Tuberculosis Society has grown to cover the whole field of health, including dental care, nutrition, etc. "Health", the magazine of the Health League of Canada, is distributed free to doctors to place in their waiting rooms for the education of their patients.

Through the efforts of the Cancer Society, facts about cancer appear regularly in many of the newspapers. Films and speakers are made available to such organizations as women's groups and schools.

Education may be through training courses offered to the public, particularly in home nursing, first aid and water safety, and in the newer area of baby-sitting. The Red Cross Society and the St. John Ambulance Association are the two organizations most active in this field. Although an agreement¹ has been in operation between these two organizations for more than ten years with the object of avoiding competition, it is reported that competition still exists, particularly in Ontario.

¹ The agreement defines the functions of both organizations regarding training courses, first-aid services and the Blood Transfusion Service, and sets up a National Joint Operational Committee to consult on matters of mutual concern.

Both organizations are anxious not only to train the public in what they consider an important skill, but to use this training as a way of interesting people in enrolling in the Red Cross Corps and the St. John Brigade.

The St. John Ambulance Association co-operates with the schools in encouraging teaching in first aid. Junior Red Cross activity, which in all the provinces is conducted in classroom time by the teachers in the elementary schools and as an extra-curricular activity in high schools, provides health education but is also planned to promote international understanding and sympathy towards suffering and to inculcate democratic principles. This arrangement with the schools seems to give the Red Cross official recognition and a "preferred position" among voluntary organizations in attracting public support, recruiting for its programmes and utilizing the fund-raising abilities of the children. The activities of both these organizations are reported to have had great influence upon health teaching in the educational systems.

Canvassers enlisted either to raise money or to mobilize the community for case-finding surveys are given some training. When The Tuberculosis Association arranges a meeting of women from local organizations to help in a mass survey, a talk, sometimes the showing of a film on tuberculosis, precedes the discussion of plans. Some of the material suggest that the mass survey is justified because of the opportunity it gives to provide this education.

Educational material is included in campaign literature and some organizations charge a percentage of campaign expenses to "public education", 40 per cent being the highest noted.

Some people question the effectiveness of public education efforts. Is the material creating public anxiety, an over-consciousness of symptoms, an ever-present awareness of disease, rather than a positive approach to health? To what extent does the fact that fear may increase the contributions to funds influence the educational programmes? Most of the literature is not "emotional", but some part of the population is likely to react to it in this way. No answer can be given to these questions; a study of the subject would be helpful. It must of course be recognized that comparable material is also used widely in commercial advertising.

In patient-member associations much of the education is directed to the members to help them understand the disease from which they or their families suffer. The information may be included in the newsletter or bulletin or be distributed in the form of a pamphlet which has been prepared by the association, bought from the American sister organization, or obtained from other sources. While some organizations use material provided by the federal or provincial health departments, in other cases these departments also help distribute material provided by the organizations. It is a general rule that all material published must have the

approval of the medical advisory committee of the organization and frequently it is written by this committee or one of its members.

Meetings of the local chapters are often devoted in part to education. The manual of one organization suggests that the programme should provide wider health education than that related to the particular disease. Chapters may be advised to use speakers from other communities since the use of one local doctor might appear to the membership to be selection of one man as the specialist in the field and thereby encourage members to consult him, thus offending other medical practitioners in the area.

The Diabetic Association in one area reported that efforts to reach the diabetic patients in a hospital were frustrated by medical ethics which protect the identity of the patient. They arranged for the nurses to put leaflets on the trays of patients who might be interested. The Red Cross Society is reported to have been able to obtain the names of persons receiving blood transfusions so that it might approach them with its publicity.

There is undoubtedly duplication and overlapping in the provision of educational pamphlets, leaflets, etc., between voluntary and official agencies and even commercial companies. Although this duplication has been criticized, it is not necessarily undesirable, and certainly would be very difficult to control.

G. PROFESSIONAL EDUCATION

Fellowships, scholarships and bursaries are provided by a number of the organizations although specific figures are not always given. Generally the programmes are relatively small. The fellowships are often provided for research assistance in projects which the organization is financing and are frequently grouped with "research" in the financial statements. Only two organizations have provided scholarships or bursaries with commitments for staff service, although in some other cases this may not have been identified.

The Victorian Order of Nurses has the largest bursary programme, financed at the national level with some earmarked donations and provincial grants. About 50 bursaries are awarded annually, with the recipients committed to work in the organization for a period of one year in whatever locality the national office determines. Most of the awards are given for public health training to nurses already employed by the Order; in 1961, 47 per cent of the staff had secured this special training through the bursary programme. Grants have been given for advanced study in administration, supervision and rehabilitation nursing. The total amount granted in 1961 was \$49,138 and the Order gives credit for its relatively good staffing position to this programme. Some branches also offer bursaries to ensure that the nurses come back to them, but these are not reported in the national statement.

La Ligue d'Hygiène Dentaire, with provincial and later federal assistance, assisted five dentists in post-graduate training in dental hygiene in order to obtain its staff.

Other organizations provide fellowships to enable medical and other professional personnel to specialize. Thus, since 1950, the Arthritis and Rheumatism Society has given 64 post-graduate fellowships to doctors to enable them to specialize in rheumatic diseases. Most of the recipients returned to be attached to teaching hospitals. The Cancer Society spent \$30,000 in 1961 to enable six or seven physicians to undertake specialist education, and an additional amount for technicians. The National Cancer Institute provides post-graduate fellowships for medical men and other scientists and follows this with "Associateships" for three-year periods. It has also given post-graduate opportunities to radiation physicists. The Heart Foundation spent \$49,000 on fellowships and similar grants in 1961 and the Multiple Sclerosis Society about \$33,250 for the same purpose over a period of six years. The Muscular Dystrophy Association financed educational projects for eight men in 1961.

Organizations with a particular interest in research give fellowships to people working on projects which the organization is assisting. The Canadian Heart Foundation, the Muscular Dystrophy Association and the Multiple Sclerosis Society have all contributed in this way.

Provincial organizations sometimes have small programmes of bursaries or grants to assist individuals to attend conferences or to visit clinics elsewhere. Some of these are given to rehabilitation officers and physiotherapists.

In 1961 the Poliomyelitis Foundations in British Columbia and Quebec gave grants of more than \$5,000 to university schools of rehabilitation and physiotherapy.

The contribution to professional education is much broader than this account would indicate. A considerable amount of the activity classified as public education or public information is directed towards the medical and other professions. The voluntary organizations related to particular diseases or to specific organs attract the medical specialists. These men are the pioneers familiar with the latest diagnostic and treatment methods who explore new frontiers of medical knowledge. Sometimes the incentive to form the new organization has been to convince other members of the professions of the effectiveness of the new method, or to help finance research work so that the frontiers of knowledge can be moved forward. These specialists, and the groups that support them, may want to convince or to inform other medical men to get the support of other professions, to ensure that medical students are receiving adequate teaching on the subject, and to enable general practitioners to diagnose the presence of the disease, and then to treat, if this is within their competence, or refer the patient for specialist service. Hence, a considerable amount of the organizations' efforts are devoted to the education of the professional man and the undergraduate medical student.

This type of education depends upon the relationship of the organization with the medical profession. Where it is established as a partnership, the lay partner may be financing the efforts of the medical partner. Thus in the Canadian Tuberculosis Association the so-called "Medical Section" of the Society was synonymous with the tuberculosis section of the Canadian Medical Association's annual conference. In 1957 this developed into the Canadian Thoracic Society, staffed and financed by the Tuberculosis Association and recognized as the medical advisor to the organization. Provincial societies have developed, and in most provinces have the same relationship to the provincial Tuberculosis Association. The national association also pays for a lecturer at the College of General Practice in Ontario. It publishes "Abstracts" of literature on the disease, which the provincial associations supply to the doctors. It should be noted that doctors are not always in agreement. The British Columbia Association withheld two issues of the "Abstracts" because the material was "in conflict with acceptable practice in the province".

The Heart Foundation started as a medical committee which ceased to exist when the organization was established. The Foundation circulates a digest of recent research, provides travelling lectureships and arranges exhibits for medical conventions. The Arthritis and Rheumatism Society sends a "Bulletin on Rheumatic Diseases" and other publications to 7,000 physicians. The Cancer Institute provides all general practitioners with the Journal of the American Cancer Society, and other material. The Diabetic Association sponsors seminars on diabetes at medical conventions and is encouraging the development in a Toronto hospital of a specialized teaching centre for medical students. Organizations like the Canadian Mental Health Association and the Health League provide, through their committees, for the study of particular problems by small groups of specialists.

Some organizations provide material to other professions to assist them in their work. Thus, the British Columbia Tuberculosis Association has provided the Tuberculosis Handbook for Public Health Nurses. The Hemophilia Society, assisted financially by the Red Cross Society, has sent to the dentists of its members a pamphlet on dental treatment of hemophiliacs, and to teachers of the child-patient information necessary to deal with an emergency. The Hearing Society provides pamphlets for teachers, nurses and parents.

Workshops, seminars and conferences are organized for professional staff. Their expenses are paid to conferences and bursaries are given. The Canadian Mental Health Association has sponsored courses to train teachers as mental health consultants in the schools, for policemen to assist them in dealing with mentally ill and disordered persons, and for public health nurses to assist them in their professional practice. The Arthritis and Rheumatism Society provides slides and films to teach medical students and physicians.

Some organizations provide instruction for students in recognized professional educational programmes. Rehabilitation centres are used for undergraduate and post-graduate medical students. Public health nursing education uses the Victorian Order of Nurses. Physiotherapists, occupational therapists and social workers are given similar opportunities.

D. RESEARCH

(1) The Organizations Interested

The interest of the voluntary health organizations in research is relatively recent, and although there is general recognition that public funds must carry the major responsibility for its support, the success of a few of the organizations in interesting their membership in supporting research is quite startling. Part of this is probably due to the scientific spirit of the age and perhaps represents an effort to ensure that science be used to reduce the suffering from disease. In some cases, the movement appears to have been spearheaded by members of the medical profession to obtain the funds they need.

For such conditions as cancer and heart diseases, the goals of research have personal implications for everyone. Where the incidence of a condition is low, the patient-member group demands attention be given to the disease, urged on in the hope that research may bring something as revolutionary in its effects as Salk vaccine for polio.² Two organizations, the Cancer Society and the Muscular Dystrophy Association, say boldly that they are only temporary organizations to meet a "disease emergency" and that as soon as research finds the cause and cure the organizations will go out of existence. However, while the national organizations in some of the patient-member groups put research first and try to ensure that it shall have first claim on the money raised, some of the provincial and local groups are more interested in direct services to follow members, so that research receives only those refunds that remain after other expenditures have been made.

The common, frequently fatal diseases, such as those which are the interest of the Heart Foundation and the Cancer Institute, have had a special appeal to the public as the two major "killers". Although these organizations have been classified as "citizen-member", their supporters come from both citizens, patients, and friends, since the public is now aware that these two are the major "killers" among the diseases which have not been conquered or brought under control by science.

Mental illness and retardation have the same connotations, since their incidence is heavy and anyone may be a victim. Here, however, is the additional problem that so little is known of the causes that research is difficult to focus.

² The National Foundation in the United States claims that its research funds produced the vaccine.

In illnesses with low incidence such as cystic fibrosis and muscular dystrophy, the patients and their parents have been roused to force their concern on the scientists and the medical profession because they feel they have been ignored or forgotten. The relatively few medical men who have been interested have given them strong support. The Hemophilia Society claims that its members know more about their needs than do most doctors and that they must inform the medical profession.

In the publicity for the financial campaign some of the health organizations face a conflict. If they stir up feelings of fear and personal danger, their appeal for funds may be more productive. If they seek to relieve anxiety, the appeal may not be successful. The emphasis upon a specific disease about which the public has anxiety undoubtedly brings more money for research than would any general campaign for a medical research fund.

The Canadian Heart Foundation was established, with research as its basic activity, as a federation of provincial bodies. In the Maritimes where no provincial organization was formed, the national body formed a branch for campaign purposes only. Partly because of the number of sufferers, the possibility of direct service to patients seemed too much for any group to undertake, so that the research emphasis has become the main activity. Its Executive Director said that "When the cause of a group of illnesses is not well understood, research would seem to be the most direct approach to prevention".

The Canadian Cancer Society channels the money it collects for basic research through the National Cancer Institute, which also receives federal and provincial grants. The Society itself supports clinical research directed towards causes, improved forms of treatment and the early detection of the disease.

Research is the main purpose of these two organizations. For the Canadian Arthritis and Rheumatism Society, it is one of several. Its Executive Director expressed little hope of the early discovery of a cure, but predicted the alleviation of symptoms and the prevention of crippling effects. This point of view is hard to interpret to the public in a campaign for support, or to the patient who is hoping for a "miracle drug". But, while the purpose of research is to advance knowledge, the end result may not be cure or a radical discovery in treatment or prevention. "There is no doubt in the mind of anyone concerned with modern diagnosis and treatment of patients that the quality of medical care in any country is directly proportional to the volume of first-class clinical research conducted in its hospitals, and to the extent of the facilities placed at the disposal of its clinical investigators."³

³ Jacques Genest, M.D., "Clinical Research in Canada", reprinted from the *C.M.A.J.*, 86, 679-695 (April 1962), under the title of "Symposium on Clinical Research in Canada", p. 3.

Three⁴ of the older citizen-member organizations have only recently become interested in the support of research. The Canadian Mental Health Association established a Research Fund in 1958, but its amount is still low and it would appear that the Association is having some difficulty in interesting its divisions, except perhaps Saskatchewan. In that province in 1961, the sum of \$100,000 over a five-year period was pledged to construct a research institute within the University. Previous to the reorganization of the Association in 1950 and to the establishment of the Fund, the staff of the Association had undertaken a great many surveys and studies, some of which might be described as research.

The Canadian Tuberculosis Association established its research fund in 1959, when its affiliates agreed to give to the national fund one per cent of the revenue from the Seals Campaign, but in 1961, according to the financial reports, quite a number did not fulfil their commitment. One reason for establishing the fund was that the national Association was concerned that some of the provincial groups were having difficulty in finding legitimate ways of spending their money, but the interest in research does not seem to have been great.

The National Sanitarium Association in Ontario designated the money received from the purchase by the province of the Muskoka Hospital in July 1960 as the Muskoka Hospital Memorial Research Fund for projects related to tuberculosis and other respiratory diseases. This fund amounted to \$935,000 in 1961. Grants of \$29,700 in 1961 and \$41,855 in 1962 were given. Information about grants was distributed throughout Canada, and since the Association can spend capital as well as interest, one must assume a lack of interest or of personnel for research in this area.

At the provincial level, some of the Alcoholism Foundations spend small amounts on research, as do the Foundations for Poliomyelitis and Rehabilitation. In British Columbia, the latter has assisted in establishing a Chair in Neurological Research at the University of British Columbia.

Three patient-member organizations have research as a major interest at the national level. It is the main emphasis of the Muscular Dystrophy Association and the Multiple Sclerosis Society. The Canadian Association for Retarded Children, established in 1958, is now planning an ambitious programme with a campaign objective of \$1,000,000 for research. At the present time a contribution of \$40,000 has been made by the Ontario Association to start the Fund and to employ a director of research, who will be responsible with the Board for its development and administration. The Cystic Fibrosis Foundation, the Hemophilia Society, the Diabetic Association and the new Myasthenia Gravis Foundation are all interested in research. The first three have contributed small amounts to projects, but they

⁴ A fourth, the Canadian National Institute for the Blind, established the E.A. Baker Foundation for Prevention of Blindness in 1963.

are very limited financially. In some areas the Cerebral Palsy Association has also made small grants available.

The interest of the Health League of Canada is of a different nature. It seeks to assess research already done to enable it to take a stand on such questions as fluoridation and to educate the public regarding its value.

Several organizations, including the Canadian Mental Health Association, the Tuberculosis Association, La Ligue d'Hygiène Dentaire, the Canadian National Institute for the Blind, and the Canadian Diabetic Association, regard the securing of more reliable data regarding the incidence of the conditions in which they are interested as one of their important functions. From their own contacts with sufferers they add to the knowledge of classification of the disease entities. Some of them, either on their own initiative or, at the request of government, use their staff to survey the incidence and the available facilities in a geographic area, and to assist in public and voluntary planning to improve service.

Frequently, where an organization has assisted in the development of specialized clinics, these are planned, located and staffed so that they can be used for teaching purposes and clinical research. The Canadian Arthritis and Rheumatism Society has concentrated upon the development of clinics in teaching hospitals to which most of the rheumatologists holding fellowships from the Society return. Similarly the Cystic Fibrosis Clinic in Montreal has become a centre of clinical research and has received financial assistance for equipment from voluntary organizations.

Patient-member organizations are playing another part in research in that they interest their members in participating in it. Thus the Montreal Neurological Institute, with research grants from the Multiple Sclerosis Society, has been assisted by the participation of the members in the clinical research programme. The same Society is providing some funds and encouraging its members to participate in an international study. The Diabetic Association is participating and helping financially in the Family Tree Study, one object of which is to discover inheritance patterns which may provide information useful in the choice of a mate.

(2) The Selection of Research Projects

The national bodies all demand that research projects should be recommended to the board by a national medical (or scientific) advisory group. They stress the need for expert knowledge to assess a project or the abilities of a research worker. Generally the chairman of the advisory group is an ex-officio member of the national board and, when there are provincial associations, the chairman of the similar group is an ex-officio member of the national advisory committee. It is the practice of the larger organizations to pay the expenses of these scientists and medical men to attend meetings of the national committee at least once a year. The boards are not bound by their constitutions to act only on the recommendation of these committees, but it is reported that this is the practice.

The organizations emphasize the need for co-ordination of the research, and the futility of spending money to explore a line already proved unrewarding, or to duplicate projects unless such duplication is planned. A number of the organizations have cross-representation on the advisory committees of the American sister organizations and contact with, if not representation upon, international bodies. There is also close co-ordination with the Canadian Medical Research Council.

Some of the organizations allow provincial or local groups to ask that their research contributions be earmarked for particular projects, and they may allow the local group to make a public occasion of the presentation of the cheque to the local recipient as a publicity device. Some of the provincial groups stress in their campaign publicity and in their appeal to a local Chest that the national funds returning to their area for research are greater than the amount collected in that area. While it is natural that the local groups should take special interest in local research projects, there is also some danger that the single specialist, who is medical advisor to the chapter and also the personal physician of each patient-member, is likely to be the local person active in the clinical research. This is a factor to be considered when the disease is uncommon.

In basic research the organizations are faced with the complicated question of whether they should support a project or a person. Most of the funds go to universities or research institutes, with some organizations specifying that no salary payment will be made to the research director. The same organization, however, will give grants or fellowships to persons to enable them to be employed on the projects, and sometimes to undergraduate medical students for the double purpose of assisting the project and hopefully developing in the men the desire to specialize in the research field. Since the project may be within the area of interest of more than one of the health organizations, there are instances of funds coming from several sources to support one project.

At the local and provincial levels money is given for research facilities (capital construction) or equipment.

It is increasingly recognized that most of the projects must have assurance of support for more than one year and commitments are made for the estimated length of time, subject to annual review. The longest time noted was 10 years.

(3) The Amount of Support

The research grants made by the six organizations with significant expenditure for this purpose totalled about \$2,800,000 in 1961. The National Cancer Institute and the Canadian Cancer Society (which provides the Institute with most of its funds) disbursed about \$1,500,000. The Canadian Heart Foundation gave about \$703,000 to research, including \$221,000 on research fellowships. The Canadian Arthritis and Rheumatism Society awarded about \$186,000. The Muscular Dystrophy Association does not separate research and fellowships and lists \$308,000 as the total. The

Multiple Sclerosis Society gave \$61,000, also for research and fellowships. Some other organizations gave small grants.⁵

It should be noted that these sums include grants for research projects, research fellowships, and capital grants for construction and equipment of research facilities. It has not been possible to isolate the amount spent on research specifically. One source⁶ gives the figure from national voluntary funds to support medical research in universities and hospitals as \$2,880,000 in 1961-62. This includes grants from the above-mentioned national agencies but also from the Banting Institute, but it excludes local support. The total national research fund is given as \$10,610,000, the balance coming from the Medical Research Council, the federal Departments of National Health and Welfare and Veterans Affairs and the Defence Research Board.

The amounts given by the voluntary organizations since their establishment are impressive. From 1947 through 1962, the Cancer Institute has contributed a total of \$7,508,000, of which \$7,184,000 was provided by voluntary funds given to the Institute by the Cancer Society. Up to the end of 1961 the Society spent an additional amount of about \$2,500,000, approximately two-thirds on capital grants for research facilities, and the balance on local research projects. From 1955 through 1962 the Heart Foundation disbursed \$2,788,000 on research, some of this being public money. The Arthritis and Rheumatism Society expended \$1,047,000 from 1950 to 1961. The disbursements of the Muscular Dystrophy Association from 1954 to 1961 totalled \$2,244,000 and, with the decision in the last year to support projects for more than one year, it has commitments of \$579,000 for the period 1962-65. The Multiple Sclerosis Society made grants totalling \$408,000 and an additional \$33,000 on fellowships from 1948 to the end of August 1962. In this instance McGill University and the Montreal Neurological Institute have received almost \$250,000, 56 per cent of the total.

Some of the voluntary funds for research come to Canada from the United States. Only one instance was discovered in which the Canadian voluntary organizations had been directly involved in obtaining the money for research from the United States.

It must be repeated that these figures include fellowships and capital grants as well as direct grants to research projects. It has been difficult to extract the figures because of variations in reporting. In some instances the amounts appear to be the money allocated, although the full amount may not be disbursed if the estimated budgetary requirements for the project prove to be excessive. In some

⁵ The Canadian Foundation for Poliomyelitis and Rehabilitation lists an expenditure on research by the provincial foundations of \$110,249 in 1959 and \$37,429 in 1960. Figures for 1961 are not available for all provinces and were very small or absent in those for which they were obtained. In 1959, British Columbia gave \$80,000; in 1960, \$5,000 and in 1961, none.

⁶ R.F. Farquharson, M.B., "Support of Medical Research in Canada", reprinted from the *Canadian Medical Association Journal*, *op. cit.*, p. 11.

cases, particularly in the annual figures, the amounts sometimes seem to include the totals of the allocations, although some projects extend over several years. Separate publicity material of one organization gave four different figures to the public for the same year. In some of the organizations the reports regarding the support of research do not conform to the figures given in the financial statements. The factors mentioned above must be the explanation for the discrepancies. But even with these reservations in mind, the approximate total of \$16,500,000 since these organizations were established is impressive.

The commitments of these organizations are almost entirely commitments of future revenue. Research reserve funds, where they exist, are very small or are not distinguished from other reserves. The only substantial fund is that of the National Sanitarium Association which has \$935,000. The Cancer Institute has a reserve fund of about \$100,000.

Two of the national voluntary organizations interested in research have established policies that they should not participate in federated financial campaigns, the Heart Foundation and the Cancer Society. Although the latter made this decision in 1956, 26 of its units (mainly in small communities) received \$83,520 from these funds in 1961.

Three others support membership. The Arthritis and Rheumatism Society is a member of 37 federated funds, from which more than half its income is obtained. Approximately one-sixth of the total income is spent on research and fellowships. Since 1959 the chapters of the Multiple Sclerosis Society have been encouraged to join the funds and about two-thirds have done so. The national Muscular Dystrophy Association and some of its local units are also members. The problems of allocating money for research by federated funds is discussed in the next chapter.

E. GRANTS TO OTHER ORGANIZATIONS

Many organizations pay fees on behalf of individuals in whom they are interested to the agency providing the service needed. For example, the Victorian Order of Nurses receives fees from almost any of the organizations giving direct service, for the patient who is not able to pay. The Arthritis and Rheumatism Society is paid for physiotherapy. Camp fees are paid by the Diabetic Association. Although agency reports mention that such service is bought, the sources of the fees are generally not recorded by the receiving organization. These "exchanges" of voluntary funds represent a double count of unknown amount in the total voluntary agency revenue. Probably the largest payments are made to rehabilitation centres and to treatment centres for cancer by the Cancer Society.

In addition to fees, however, a few organizations make grants to other agencies and to government for both capital and operating costs, and state in their constitutions that this is one of their objectives. They are organizations whose ability to raise funds exceeds their need to spend them on direct activities. This applies in the main to three organizations, and only in some provinces: the Foundation for Poliomyelitis and Rehabilitation, the Society for Crippled Children, and the Tuberculosis Association.

The British Columbia Foundation for Poliomyelitis revised its grant policy in 1962. As its ability to raise money decreased, it decided not to give grants, except to honour previous commitments. It says in one of its reports that it used to be "an easy touch". In an official statement as to why it was not a member of the Community Chest, one reason given was that it gave capital grants which the Chest would not allow. Reports for previous years were not obtained, but for some years, \$50,000 was given to the G.F. Strong Rehabilitation Centre for operating costs, and \$75,000 for capital construction. In 1960 the money paid to the Rehabilitation Centre was \$76,000, including fees paid for individual patients. In 1961 the Society's total grants amounted to only \$14,333, not including fees. Of this total, \$10,000 was divided equally between the Health Centre for Children and local health centre construction projects under public auspices. The Hemophilia Society received a small grant of about \$100; the Home for Emotionally Disturbed Children, \$2,193; and the University of British Columbia School of Rehabilitation, \$2,000. (The latter might be considered an educational grant.)

In Ontario, the same organization gave grants amounting to \$113,000 to a number of rehabilitation centres under local boards, and a newspaper report giving publicity for its 1963 campaign spoke of it as "supporting" these centres. The Quebec Poliomyelitis Foundation in the same year gave grants totalling \$17,536 to two rehabilitation centres, the Hemophilia Society, the Paraplegic Association and two hospitals. In this province the Cerebral Palsy Association also gave grants to the rehabilitation centres, which may have been to cover the care given the cerebral palsied.

In Alberta, the Council for Crippled Children and Adults gave grants to the Children's Hospital Aid Society (really the Hospital Auxiliary of the hospital originally developed by the Junior Red Cross), four local Cerebral Palsy Associations, and the Crippled Children's Camp Council, an autonomous organization.

In 1961, the Ontario Society for Crippled Children gave grants of \$57,300 to the Ontario Federation for Cerebral Palsy and two Toronto cerebral palsy associations, and \$2,500 to a swimming club for a programme for the handicapped. It lists other grants but these appear to be contributions to the programmes of its local committees.

The Tuberculosis Association's grants are largely to hospitals and health facilities, frequently under government auspices. For example, the Alberta Association gave \$9,225 to four hospitals – almost half of this to the federal Indian Health Services Hospital – and installed X-ray equipment in 39 other hospitals, including many municipal ones. The Ontario local associations, whose financial reports have not been obtained, spent considerable money in providing the sanatoria with equipment such as a dishwasher and television sets. Manitoba reported that the Association of Commercial Travellers pledged \$85,000 towards the cost of a Physiotherapy Occupational Therapy Unit at Assiniboine Hospital (federal) and \$100,000 for equipment for the Rehabilitation Hospital (provincial). The British Columbia Association in 1962 records \$34,347 given to the construction of local health centres. These are health centres in small local communities, and an article written by the Executive Secretary explains:⁷

In 1951 a programme designed to correct the shortage of facilities was initiated, with Dr. G.R.F. Elliott, Deputy Provincial Health Officer, playing a major role in the stimulation and co-ordination of official and voluntary agency financial support. Progress was slow at first but gradually gained impetus so that today British Columbia can probably claim the best local public health facilities in Canada. Since 1951, a total of 52 local community health centres have been built throughout the province. Another 13 are under construction or are on the planning boards. The construction cost of those built to date is close to three million dollars.

Before 1951, the local health departments worked with inadequate facilities. Travelling clinics had to work in an ever-changing variety of inadequate quarters. The local voluntary health agencies did not have permanent offices and their efficiency and effectiveness were decreased because they were separated from the local official agency and from each other. Now, all of these agencies and services are in operation under the same roof.

Those most intimately concerned with this programme have been the officers of the Provincial Department of Health, however, a number of other organizations and individuals were also involved. It was the hope of many to have buildings that would be true community health centres from which all local preventive health services might emanate, not just those provided by the official health department.

The British Columbia Tuberculosis Society was the first voluntary agency to voice its interest and to lend its support. The T. B. Society was anxious to have better local public health facilities for several reasons, among them the hope of better T. B. control. Assistance in the construction of such facilities was in direct keeping with the Society's basic objective of the eradication of tuberculosis. It provided a means whereby a permanent system of accelerating tuberculosis control could be forwarded by the Society. The Society needed local facilities for carrying on its part of the province's T. B. case finding, mass X-ray, and tuberculin testing surveys, tuberculosis education, etc. Also, these health unit buildings could provide the centres from which the local Christmas Seal committees could carry on their activities. The British Columbia Tuberculosis Society has contributed over a quarter of a million dollars towards this building programme.

The British Columbia Division of the Canadian Cancer Society had similar interests. The local health centre could provide the needed space for the travelling cancer clinics, "bandage bees" and other local Cancer Society activities. The Red Cross

⁷ D.A. Geekie, "The Community Health Centre Construction Program in British Columbia", *Canadian Journal of Public Health*, July, 1962, p. 290.

and the Poliomyelitis and Rehabilitation Foundation organizations had also realized the advantages of such a centre. The local communities were intimately involved, of course, in that they were to reap the major benefits.

There were, and still are, available from the National Department of Health and Welfare financial grants according to the formula: "Up to \$2,000 for every 300 square feet of service area, up to \$15,000" (provided that this does not exceed one-third of the total construction cost). These grants are dependent upon a matching grant being given by the Provincial Department of Health. To date the Government of British Columbia has limited its grant to \$1,000 per 300 square feet.

The British Columbia Tuberculosis Society agreed to pay 10 per cent of the total construction cost, the Cancer Society 7 per cent. For several years the Red Cross provided a grant in keeping with the two-year rental for an office, the Poliomyelitis and Rehabilitation Foundation of British Columbia now provides a grant of 29 per cent of the total construction cost.

The British Columbia Tuberculosis Society is guided by a medical advisory committee composed almost entirely of public officials. It has already been noted that the distinction between the official and the voluntary services in this area is far from clear. The agreement of the various agencies to provide voluntary funds in place of available public money raises basic questions of public policy.

The Province of Nova Scotia pays 80 to 90 per cent of the operating costs of the community mental health clinics, which are under private boards on which the Government is represented, and the Mental Health Association and other local groups help to provide the buildings. In contrast, some levels of government, such as the Province of Newfoundland, provide free accommodation in public buildings for voluntary organizations.

The Manitoba Association for Retarded Children has given considerable assistance to government institutions in the provision of essential equipment, as well as "extras". This Association started as a sort of auxiliary to the provincial hospital for mentally defectives and has continued in this role, but has expanded its activities to include the Broadway Home for Girls, Winnipeg (a "half-way house"), and the St. Amant Ward in a general hospital. At the same time it has developed the school for the retarded.

The Red Cross Society also gives grants to other organizations. During the 1920's, it apparently did this to a far greater extent than at present, probably because of the funds it had available following World War I. The greater part of the grants now come from the Junior Red Cross: e.g., \$10,000 to the Ontario Cystic Fibrosis Foundation to assist with drugs for the child sufferers. In many instances its assistance is given to the children in need and does not appear in the receipts of the organization helping the child, because the payment is made direct to the vendor of, for example, glasses or hearing aids.

A different kind of assistance is provided by the Canadian National Institute for the Blind to the Clubs for the Blind. Although the Canadian Council of the

Blind, a federation of the local clubs united in provincial associations is an autonomous incorporated body, its budget at all levels is met by the Canadian National Institute. It uses the Institute's centres for its meetings and according to its own wishes can use the staff for consultation.

It is to be noted that three of the organizations which give grants have their own nationally organized campaigns and are not in federated funds. Some of the services to which they give grants are in federated funds, but serve people outside the region covered by that form of financing. In the case of the Ontario Society for Crippled Children, the projects which it supports are directly related to its own work. The Foundation for Poliomyelitis in the different provinces seems now to be uncertain of its focus, and supports almost any service for the handicapped which is not otherwise financed. In some areas its ability to raise money is decreasing and its grants have been curtailed.

The "financial exchanges" between government and the voluntary agencies raise a serious question. Should money donated by the citizens to a voluntary organization with a specific disease focus be used to assist in the construction of public buildings, such as a community health centre? Should it be used to purchase essential equipment for public institutions, such as hospitals? Should government expect voluntary funds to provide the building for services for which it has accepted responsibility?

In the British Columbia situation, it is hard to imagine that the contribution of the various voluntary organizations is merely the equivalent of rent for their use of the accommodation, and this claim is not made. The buildings necessary to provide a public service are part of that service. When equipment in a hospital or other institution is essential for the modern concept of treatment (which includes a "therapeutic environment") it should be considered a normal charge against the budget. It is possible in some instances that the well-intentioned efforts of voluntary agencies to provide "extras" postpones the public acceptance of the fact that such equipment and the activity for which it is used is essential. In two situations in which "private" buildings under voluntary boards are being used for the provision of recognized public services, informed opinion stated that the reason was the unwillingness of medical doctors to accept appointment as civil servants although they were prepared to accept salaries from the voluntary organization to which government gave the money.

When the voluntary health and welfare agencies are having difficulty in raising funds to support their activities, it seems reasonable that public funds should pay for facilities and services for which public responsibility has been clearly accepted. The idea that voluntary funds will make a community consider a health centre "theirs" in a way that public funds do not, assumes an attitude of mind on the part of the citizens which, if it exists, should be changed rather than accepted.

F. CO-ORDINATION OF EFFORT

A number of the national organizations have as their objective "co-ordinating and correlating efforts". Some of those focused upon a particular disease or organ have attempted to pre-empt the field nationally and have had considerable success.

The Canadian National Institute for the Blind is given authority in its Letters Patent to "extend a central control and organization to assist, utilize and co-ordinate the various public or private agencies, institutions and associations for the blind, now carrying on operations or which may hereafter be established". It has become the only voluntary organization for the blind⁸ except in Quebec province. In eight provinces the Tuberculosis Association is an organization of the all local groups, although in Ontario the national Sanitarium Association is a nominal member only. In Nova Scotia the Halifax Society has remained independent⁹ although it is franchised for the campaign. In Quebec several independent tuberculosis organizations operate. The Canadian Association for Retarded Children has been able to bring into the federation all the provincial groups except Newfoundland. The Cystic Fibrosis Foundation has not had the New Brunswick¹⁰ and Nova Scotia organizations as members since they objected to the amount of control the constitution gave to the national body, but it has made its services regarding the sale of tents available to these groups.

The interrelationships between the Societies for Crippled Children and the Foundations for Poliomyelitis and their relationships to other groups are particularly complicated. Changes were made in 1962, and it is necessary to discuss first the position in 1961.

The Canadian Council for Crippled Children and Adults in 1961 was a federation of Crippled Children's Societies which held the legal control of "Easter Seals", assisted with national campaign publicity and held an annual conference. Because of the differences in the present activities of provincial societies, nationally prepared publicity is not always suitable for provincial purposes. All provincial societies are autonomous and the national body is a loose, non-authoritative federation which, however, controls the right to campaign through Easter Seals. The definition of "crippled", originally taken as musculo-skeletal defects, has been broadened in some provinces to include all physical disabilities.

The provincial Foundations for Poliomyelitis and Rehabilitation have been groping for new functions since the development of the vaccine, and in some provinces have found the children's field covered at least nominally by the

⁸ Other organizations of the patient-member type are active.

⁹ The Halifax Society surrendered this franchise in 1963.

¹⁰ New Brunswick decided to join in 1963 when the national constitution was amended to meet some of its objections.

Societies for Crippled Children. The trend has been towards what is practically an amalgamation of the two provincial organizations into a Society for Crippled Children and Adults. Each organization, however, maintains its own identity and incorporation to avoid legal complications regarding legacies, and particularly to maintain the rights to the names of their separate campaigns – “Easter Seals” and “March of Dimes”. This arrangement appears to justify two appeals to the public under distinct names, although the appeals are sometimes run by the same staff at the provincial office and in some cases by the same service clubs and other organizations at the local level. In the financial reports the donations are listed under each of the campaign names as the revenue of the amalgamated Society and no distinction is made in the disbursements.¹¹ The trend towards amalgamation has reached different stages in different provinces.

In Nova Scotia, Ontario and Quebec the two organizations are distinct and separate. In Nova Scotia discussions have taken place but the Society wants amalgamation and the Foundation a form of joint functioning which preserves the separate identities. In Ontario the Society has refused the suggestion of the Foundation that they join forces. A division of responsibility has been agreed upon, the Foundation assisting persons 19 years of age and over, and the Society the younger group with a very inclusive definition of “crippled”. Three members of the Foundation’s Medical Advisory Committee are also members of that of the Society and an inter-agency committee facilitates referrals of patients. In Quebec the Easter Seals Committee is an independent organization, which runs the campaign. It engages in some direct service, and distributes most of the money raised to the Society and other organizations. The Foundation is completely separate and consists of Legion members.

In Newfoundland, Saskatchewan and Manitoba the Societies and the Foundations have united to form one organization. In each province the two campaigns are conducted each year under the legally established names and the relationship with the two national organizations is maintained. The revenue goes into one fund and there is no distinction made in the use of the money. Each of the Societies includes children and adults in its name, but Newfoundland has been able to offer very little service to adults because of shortage of funds. No distinction between the staff and activities of the two organizations is evident.

In Manitoba the Society for Crippled Children and Adults is recognized as the “agent” for the provincial government for rehabilitation except for services to the blind, the tuberculous and the victims of industrial accidents. It receives the federal-provincial rehabilitation grants and works closely with the province regarding the medical and rehabilitation provisions of the Social Allowances Act. As government’s agent, it exercises some supervision over other organizations – the Paraplegic Association, the Multiple Sclerosis Society, the Muscular Dystrophy

¹¹ In spite of this, the Canadian Foundation for Poliomyelitis gives figures of cases assisted and a breakdown of provincial expenditures under a number of headings.

Association and the Cystic Fibrosis Foundation – since it is responsible for the expenditure of public money on behalf of their patients. The Society takes responsibility for the cerebral palsied children and the activity of the parents' association is linked with that of the Association of Retarded Children, which accepts some of the cerebral palsied in its school. Thus the Society exercises a degree of control over local and provincial associations which are branches of independent national organizations and which conduct their own fund-raising activities.

In New Brunswick and Alberta, Rehabilitation Councils¹² have been organized and include the Society, the Foundation and others interested in the disabled. At the time of the study, New Brunswick's Council was discussing a report of the Executive Director of the Canadian Society for Crippled Children and Adults which recommended a merger of the Society for Crippled Children and the Foundation with each keeping its own identity for campaign purposes. In Alberta the Council for Crippled Children and Adults, organized in 1951, accepted as members both organizations and individuals, each member in each category having a single vote. The minutes suggest considerable conflict within the organization because this constitution gives an inequitable distribution of power. The member organizations consist of the 15 "franchised members" (i.e., the local groups throughout the province who run the Easter Seals campaign), and the Foundation for Poliomyelitis, the Children's Hospital Aid Society, four Rehabilitation Societies for the Handicapped, four local Cerebral Palsy Associations, two local Multiple Sclerosis Societies, two local Paraplegic Association branches, the Alberta Crippled Children's Camp Council and the Edmonton Welfare Department. The Council wanted to extend its membership to other groups and decided to approach first the Association for Retarded Children which was considering the invitation. The budgets of the Cerebral Palsy Associations, the Children's Hospital Aid Society and the Camp Council are submitted to this Council for approval and grants are made to them from the Easter Seals Fund. The work to help individual crippled children appears to be handled largely by the voluntary committees of the franchised members and financed by the proportion of the campaign revenue they keep. The activity of the Council seems to be to distribute the proportion of the funds turned over to the provincial body by these local groups and to take social action at the provincial level. The Foundation, while a member of this Council, is otherwise independent, runs its own campaign with the help of the Canadian Legion, and disburses its own funds.

In British Columbia the two organizations have been nominally separate, but share one building and one staff. They have separate Boards with a "Joint Management Committee" and each uses the same Medical Advisory Committee. Their constitutions are identical except for the necessary change of certain words. The

¹² Rehabilitation Councils are operating in some other provinces but do not have particular importance for the two organizations under discussion.

report of the Joint Management Committee in 1961, in discussing the proposed national merger of the Canadian Council and the Canadian Foundation, said:

We do not believe that a similar merger at a provincial level is desirable, particularly in view of the fact that the provincial organizations each have a separate fund-raising appeal and there would be danger that a provincial merger would adversely affect such appeals. Nevertheless, your Committee has for some time considered it necessary that there should be more formal recognition of our joint management arrangements and it would be most desirable to have some organization to permit formal association without the necessity of joint administration such as exists between the Society and the Foundation... The Provincial Joint Management Committee, therefore, proposes that the Society and the Foundation initiate an organization to be known as 'The British Columbia Rehabilitation Council for the Disabled' or other suitable name, that the Society and the Foundation participate fully in the development of this Council and that the Joint Management Committee be authorized to proceed with the detailed development and incorporation of such a Council.

The President supported this proposal in his report: "We should have no hesitation in supporting the proposal to take this logical administrative arrangement one step further into a more formal association open to other agencies with common overall aims." The Committee suggests tentatively an organization of participating members "which act fully in all Council activities, benefit fully from them and share any costs involved in the Council", and associate members "who had an interest in the overall field of rehabilitation and would wish to share in the overall planning and discussions of the Council ... but would not participate directly in the services of the organization." This seems to show a failure to appreciate that for effective co-ordination all organizations should be members on equal terms.

The Canadian Council for Crippled Children and Adults and the Canadian Foundation for Poliomyelitis and Rehabilitation have each taken steps to give leadership to some of the patient-member organizations. The Council organized a Cerebral Palsy Section to bring together the similar sections of some of the provincial Societies for Crippled Children and the three independent provincial Cerebral Palsy Associations which lacked a national body. Some of these associations are citizen-member and some patient-member. In Ontario the Society finances the Federation of Cerebral Palsy Associations. In its Rehabilitation Centre it now provides for the two Cerebral Palsy Associations which were previously separate organizations in Toronto. The Society's policy is to discourage the development of such centres under parents' Associations and to encourage the parents to serve as auxiliaries to the schools.

The national Council agreed to the request of the Cystic Fibrosis Foundation for help in its financial difficulties, and provides it with office accommodation, staff and other services in return for the payment of \$8,000 a year. The Executive Director of the Council is designated "Consultant Executive Director" to the Foundation. He reports that the Council is in fact subsidizing the cost of operation

of the Foundation. The Council is also studying the desirability of undertaking some activity in regard to epilepsy.

The national Foundation for Poliomyelitis was approached for help by the Canadian Hemophilia Society when it was in financial difficulty, and in 1960 the national Board urged its autonomous provincial bodies to allow the provincial groups of that Society to become affiliated with them. Affiliation has taken place in British Columbia and Manitoba, and the Quebec Foundation gives part-time service of a staff member to assist hemophiliac patient-members.

After five years of discussion the Canadian Council for Crippled Children and Adults and the Canadian Foundation for Poliomyelitis and Rehabilitation joined forces by decisions made at their annual meetings in May 1962, becoming incorporated as the Canadian Council for the Rehabilitation of the Disabled. Each of the organizations retained its own incorporation, so that the rights to the names of the two campaigns are nominally under different auspices. The Council also holds the trade name of "Marina Creations" which will now be developed throughout Canada by the affiliates of the Council. During the period in which amalgamation was discussed, very strong feelings were engendered within some of the Societies, and there were accusations by one of the provincial groups of "empire building" and lack of concern for the disabled. The proposed bylaws were changed to alter parts of the constitution which seemed to limit the autonomy of the member organizations.

It has been impossible to obtain details regarding the work of the Canadian Foundation for Poliomyelitis and Rehabilitation previous to the change. Some comments were received that it did very little to aid the provincial Foundations, some of which, in their financial reports, itemized their payments to the national body as the purchase of franchise rights.

The new Council would like to become the national body of which all voluntary agencies concerned with rehabilitation would be members. While it is responsible for the two nationally co-ordinated (but provincially and locally conducted) campaigns, from which its funds would mainly come, it would also have members who would be interested only in a forum for discussion of common problems. Since some of the local and provincial members of other national organizations, such as the Multiple Sclerosis Society and the Paraplegic Association, are also members of the constituent bodies of the new Council, the possibility of confusion of roles and loyalties seems very great.

Some of these developments are the result of government action, as in Manitoba. Others would appear to have been the result of the relative affluent financial positions of the Societies for Crippled Children and the Foundation for Poliomyelitis as compared with most other organizations.

An effort has been made in this chapter to outline the very complicated picture of the activities of the voluntary health organizations in addition to direct services to patients. The variety of the activity is such that no summary is possible. It must be emphasized, however, that these activities are not carried out by each organization throughout the whole country or, in some cases, in all parts of a province. The total picture presents some degree of duplication and overlapping.

The last two chapters have outlined and illustrated the wide variety of services provided by the voluntary health organizations. The very great contribution they are making to the people of Canada is obvious. Yet their services are only available in some areas and for some people. No outline of public services is provided here but such an outline would still demonstrate gaps and inadequacies.

Attention is now directed to the finances of the organizations.

FINANCES

A voluntary organization by definition raises its funds to a considerable extent, if not wholly, by voluntary effort. The organization may conduct its own campaign for funds, or be a member of a federated fund. Most of those studied also received public grants.

A few organizations which conduct their own campaigns try to raise as much money as possible, whether it is needed or not.¹ This can be rationalized on the basis that the effect on public opinion of not conducting a campaign with the usual vigour may break the public's habit of giving to a particular appeal. A nominal campaign might also affect the "public image" of the organization. One gets the impression that the aim is always to exceed the previous year's record and this aim is often accomplished, even if the income last year could not be spent.

A. OPERATING REVENUE

In 1961² the operating revenue of the voluntary health agencies studied totalled more than \$31,000,000. This calculation represents a minimum, and perhaps the actual figure is higher by another \$1,000,000.³

Seven of the largest national agencies which have provincial divisions or local units prepare consolidated financial statements which include figures of all levels of operation. These include the Canadian National Institute for the Blind, the Red Cross Society, the St. John Ambulance Association, the Canadian Mental Health Association, the Cancer Society, the Canadian Heart Foundation and the Victorian Order of Nurses. Their total operating revenue was, in round figures, \$25,000,000.

¹ Some committee members of one organization were reported to question the ethics of conducting the campaign when they were having difficulty in spending accumulated surpluses.

² The fiscal year ending in 1961 was used.

³ In these estimates institutions recognized as hospitals have been excluded.

The second group has one main administrative unit. It consists of the St. Elizabeth Visiting Nurses' Association of Canada, the Canadian Hearing Society, the Health League of Canada and the Canadian Mothercraft Society. The revenue of this group was \$200,000.

A third group of national patient-member organizations which includes the Cystic Fibrosis Foundation, the Musclar Dystrophy Association, the Multiple Sclerosis Society, the Diabetic Association and the Hemophilia Society have no record of the amount of local funds except those which are turned over to the national office. The national total was \$541,000 and the local funds are known to be small except in the Diabetic Association which, with a national revenue of under \$50,000, was estimated to have an additional \$100,000 locally.

The fourth group comprises organizations whose national body is a federation of provincial societies, and in two of these the provincial body is also a federation. The extent to which local figures are available through the provincial and national bodies varies considerably. In the Tuberculosis Association, the Societies for Crippled Children and the Foundation for Poliomyelitis, only the public campaign figures are available locally, and these provide the greater part of the funds. In the Association for Retarded Children no local figures are available. In the Paraplegic Association, the Ontario Division is the largest, and in its statement the figures for its Rehabilitation Centre cannot be completely separated.⁴ This group has a known total of \$4,500,000 but the available figures are incomplete.

The fifth group consist of 11 organizations with provincial or regional⁵ bodies in one or more provinces, and no national organization. The revenue of these was \$887,000.

In this calculation then, the major omissions are the local association for retarded children, and perhaps a dozen provincial organizations of relatively small size. Purely local organizations are also missing, except for those which have national incorporation, but health groups are more frequently organized at the provincial or national level than are welfare organizations.

In the calculation of the revenue, grants from one voluntary organization to another have been subtracted whenever they could be identified. Some duplication is still present, since some organizations list under patients' fees money paid on behalf of patients by another organization, public or private. In the total picture the duplication of voluntary funds is not considered to be very significant, except for fees paid by the Poliomyelitis Foundations. The amount of public funds included under "fees" is probably higher.

⁴ It has been impossible to separate completely the income of the hospital from that of the Ontario Division, for the services not paid for by the Hospital Plan, or patients' fees.

⁵ Regional is defined here as extending beyond one municipality but within one province.

The National Cancer Institute has been omitted, since its income except for government grants and interest, comes from the Cancer Society. The federal-provincial grants were \$234,137 in 1962.

Tables I and II give details for those organizations which individually had a total revenue over \$100,000 in 1961.

B. ASSETS

It was extremely difficult to make an analysis of assets, because of the various ways in which the financial statements were drawn up. Designated funds could not be separated into those in which the "designation" was made by the donor, and those which had been set aside by the organization and could be used for other purposes. Some organizations, for example, have building funds without any immediate plans for building, and if funds are needed elsewhere, they transfer the money from this fund. A few transfer a percentage of current revenue to the building fund each year to avoid a capital campaign at some later date. Some organizations show assets because the financial campaign has been conducted near the end of the fiscal year, although the sum is the operating fund for the next twelve months. Others appear to use designated funds as a way of removing from the financial statement released to the public the information about surplus funds.

Fixed assets are sometimes entered at a nominal value of \$1, while in other cases an actual value is given. Investments may be listed at cost or present value. Interest is sometimes added to the funds, without mention in the current revenue statement.

The need for reserve funds varies considerably within the different organizations. Although hospitals have not been considered in this study, one could question why one Sanatorium Board, financed fully by a tax on the municipalities and with its operating expenses covered in this way each year, needs a general reserve fund of \$549,000. The legislation provides that at the end of the year any surplus may be placed in the reserve fund with the Minister's permission, or it may be used to reduce the tax the following year. It is surprising that the governmental representatives on the Board have not asked for a tax reduction. Another such board, also with the hospital expenses completely covered, has a balance of over \$5,000,000 in a general capital account, and a general endowment fund of \$983,000. During the year \$214,000 was added to these funds.

An organization like the Canadian National Institute for the Blind with a great deal of property and business interests obviously requires a higher reserve than some other kinds of organization. An effort to calculate the apparent current assets (excluding fixed assets) gives a figure of \$5,847,000, more than twice its annual revenue. The consolidated statement gives the value of fixed assets as over \$9,000,000, more than two-thirds of which is held by the Ontario Division.

This Division has reserves in building and special funds of \$2,042,000, more than \$500,000 having been added during the year. In the plans for the new centre at Sudbury, with an estimated cost of \$495,000, the provincial government provided \$105,000 and the balance was being raised by voluntary contributions in that area. The Holiday Centre at Lake Joseph was calculated to cost \$400,000, to which the province gave a grant of \$50,000 and the balance was being raised through private donations and the Lions Club. The Institute noted that a capital campaign was thus avoided. It would be helpful to know why the existing building fund was not used for such projects without further help from government grants or special appeals.

Constitutionally the national organization is responsible for all funds and property, and yet extreme variation appears between the provinces, e.g., Ontario and Newfoundland. The latter received a \$20,000 loan from the national office, which it is in the process of repaying, and in its report, boasts proudly that the little group in Corner Brook has, through special projects, gradually built up a fund of \$10,000 as the nest egg for a building which "someday" it hopes may materialize.

The Red Cross Society appears to have reserves of \$5,288,000, not quite half its annual revenue. If the government grants for the blood transfusion service are subtracted from the revenue (since it can be assumed that these will continue while the service continues), the assets were close to the annual revenue. The capital fund was \$659,000.

The Priory of St. John, the constitution of which states that the organization may own property to the value of \$50,000, gives the value of the present property as \$750,000 carrying \$150,000 in mortgages. Legally however, the constitution could be interpreted as meaning the "annual value" and this was calculated at 5 per cent. The Priory is now considering asking for an amendment to the constitution to correct the legal position. This organization also has a capital fund of \$659,000, and current assets of more than one year's revenue.

The Canadian Mothercraft Society, with an annual revenue of \$98,000, including its hospital which is now covered by the Hospital Plan, has a reserve fund of \$123,678 and total apparent net assets of \$137,500. In 1961 it received its annual provincial grant of \$6,070 for the hospital and a special one of \$4,000 which was put into its building fund.⁶ It received \$14,000 from the United Appeal in Toronto.

The Canadian Tuberculosis Association reports provincial reserves of \$950,000 not including the independent National Sanitarium Association and the Halifax Association. The total revenue in 1961 was \$2,508,633. Ontario and

⁶ The building fund totals \$95,000 of which \$48,500 is listed as "provincial government grants". The endowment fund totals \$123,000.

British Columbia hold a large part of the reserves at the local level, and the provincial associations have been finding it difficult to persuade some of the local groups to part with the money for research or, in Ontario, to share with poorer organizations. Yet one provincial government has paid the major part of the executive's salary for 18 years, and in 1961 gave an additional grant of \$5,000.

The Ontario Society for Crippled Children showed a reserve of \$1,000,000 and a revenue of almost \$1,500,000. This reserve was probably held for the Rehabilitation Centre constructed the following year.

These illustrations came from a few of the larger, well-established organizations. Most of the others are living from hand-to-mouth with little or no current assets.

The reserve funds create problems for the federated appeals as well as for government. The general policy of financial federations is that an agency may become a member while it has reserves, but funds allocated by the Appeal must not be used to build up reserves. If the annual allocation is not used in full, as agreed upon in the budget, the surplus must be returned to the Fund, or held for the following year and deducted from that allocation. Reserves are not taken into consideration in making the allocation. Organizers of federated funds also insist that interest from reserves and investments must be counted as operating revenue, yet some of the national organizations which do not follow this practice are members of local funds. The funds do not allow for depreciation. Thus some of the national policies do not correspond to local fund policies. Yet the national organizations or their local units are frequently members of the federated funds.

The location of reserves also creates budgeting problems for federated funds. In the constitution of the Canadian National Institute for the Blind, financial power lies entirely with the national body. It has delegated the investment of the reserves to the provincial divisions, which must follow policies set by the national board. The reserves thus are not considered in any external budget review, at either the national or local level.

The same problem is potentially present in any organization in which the national (or provincial) organization has the constitutional control of the property, the reserve funds, and basically of all finances. For example, the Priory of St. John is a centralized organization, controlled from the central unit. The national consolidated report shows no differentiation in its financial statement between the activities of the Priory, the Ambulance Association and the Brigade, and no provincial breakdown. Yet the local groups of the Association belong to federated funds and obtain substantial amounts from them, and provincial groups obtain provincial grants.

These observations suggest some of these difficulties faced by federated funds in their efforts to establish policies and budgetary requirements which are reasonable and fair to both local and national agencies.

C. NATIONAL ASSESSMENT ON LOCAL FUNDS

Several of the national organizations are financed in part by an assessment on provincial or local groups, made in different ways. To provide most of the national funds, the Canadian Tuberculosis Association marks up by 27½ per cent the cost of the campaign supplies which it sells to the provincial associations. This method bases the provincial and local contributions upon the number of seals and supplies used, rather than on the money raised, so that the community which subscribes less per mailed letter pays the higher rate. Some of the provincial financial statements list the assessment as a separate item because the association wants to emphasize to its members that they contribute to the national office. Others deliberately do not do this, because the local groups would probably object to the payment. Some of the assessment pays the national administration costs of its campaign activity, the rest going to other national and international service. In addition to the "mark up", member organizations are asked to contribute one per cent of their revenue to the research fund.

The national office of the Canadian National Institute for the Blind receives 6 per cent of the revenue of its divisions, with the exception of Ontario which pays 12 per cent. This difference is based partly on the fact that Ontario has its offices in the national building, and that staff is shared to a considerable extent, but also on Ontario's ability to raise money. In addition each division pays \$25 for each blind person in its area who uses the national library.

The Victorian Order of Nurses asks for 2½ cents per visit as the contribution of the branches to the national services. It recognizes that this assessment produces only a small fraction of the cost. Since the proportion of time spent by staff in a branch on visiting varies with the amount of activity in school health services, well-baby clinics, etc.,⁷ it must be assumed that the consultation and supervision of the national office is largely directed to the home-nursing program. The national organization apparently considers that the modest levy is all the branches can afford. The rest of its funds comes from public grants and a "Five Year Appeal". This assessment means that the local charges for visits are not covering the total cost of the service.

D. SOURCES OF REVENUE

The voluntary organizations have three main sources of revenue - voluntary donations, grants from municipal, provincial and/or federal governments, and fees for service. Miscellaneous sources include income from sales, and grants from foundations. Tables I and II provide an analysis of the sources of the operating revenue of the largest organizations.

⁷ In one branch the proportion of "non-visiting" time is 44 per cent.

TABLE I
REVENUE BY SOURCE OF THE NATIONALLY INCORPORATED
VOLUNTARY HEALTH ORGANIZATIONS^a FOR THE FISCAL
YEAR ENDING IN 1961
 (thousands of dollars)

	Total Revenue	Public Grants		Total Voluntary Donations ^b	Other ^c	Voluntary Donations from Federated Funds
	\$	\$	%	\$	\$	\$
Canadian Red Cross Society	8,193 ^d	1,386	17	5,977	830	2,614
Canadn. Cancer Society	3,808	44 ^e	1	3,665	100 ^f	83
Victorian Order of Nurses	3,781	1,012(306) ^g	27	1,833	937(657) ^g	1,473
Canadn. Tuberculosis Assn.	2,561	100	4	2,383	78	2
Canadn. Natl. Institute for the Blind	2,461	359	15	2,101	5	1,697
Canadian Heart Foundation	1,360	— ^h	—	1,325	35	—
Can. Arthritis and Rheumatism Society	1,147	182	16	809	155(122) ^g	637
St. John Ambulance Assn.	901	69	8	589	243 ⁱ	371
Can. Mental Health Assn.	787	69	9	643	76	445
Muscular Dystrophy Assn.	390	—	—	370	20	119
Can. Paraplegic Assn.	177 ^j	42	24	131	—	4
Health League of Canada	159	24	15	87	48 ^k	78
St. Elizabeth Visiting Nurses' Association	120	23	19	81	15	81
Total	25,845	3,310	13	19,984	2,557	7,604

^a Organizations of which the revenue exceeded \$100,000.

^b Includes bequests listed under current revenue.

^c Includes interest, fees not identified as public money, sales, memberships, rentals, transfers from reserves for operating accounts.

^d Not including hospital revenue or \$1,033,000 received for designated funds. The latter includes \$368,000 raised by the Junior Red Cross.

^e Includes \$38,000 earmarked for transportation of needy patients.

^f Includes \$91,000 interest.

^g Patients' fees in brackets; are also included in total amount in column.

^h No figure in the financial statement. Public Accounts show \$252,436 which is disbursed by the Foundation but apparently does not pass through its books.

ⁱ Includes class fees \$133,00; interest \$38,000.

^j Excluding hospital revenue to the extent that it could be identified.

^k Sales \$41,000.

TABLE II
REVENUE BY SOURCE OF THE PROVINCIAL VOLUNTARY HEALTH ORGANIZATIONS^a
FOR THE FISCAL YEAR ENDING IN 1961
 (thousands of dollars)

	Total Revenue	Public Grants	Total Voluntary Donations	Other ^b	Voluntary Donations from Federated Funds
	\$	\$ %	\$	\$	\$
Alcoholism Foundation of Alberta	293	256 87	33	4	8
Societies for Crippled Children (and Adults)					
British Columbia	174	1 c	166	6(2)	—
Ontario	1,462	77 5	1,208	177(97)	—
Quebec (Easter Seals Society)	140	— —	111	29	—
Alberta	123	— —	123 ^d	—	—
Manitoba	629	245(14) ^e 39	285 ^f	99	—
Saskatchewan	289	39 13	169 ^f	81(18)	38
Foundation for Polio- myelitis and Rehab- ilitation					
British Columbia	259	— —	254	5	12
Ontario	615	— —	613	2	306
Quebec	166	28 17	136	2	—
Mental Hygiene Insti- tute Quebec	127	64 50	62	—	47
Total	4,277	710 17	3,160	406	411

^a Provincial organizations whose revenue is not included in the consolidated statements of national organizations, the revenue exceeding \$100,000.

^b Figures in brackets are fees for patients and are included in the first figure. Includes interest, sales, fees, etc.

^c Less than 1%.

^d Includes a grant of \$800 from the Foundation for Poliomyelitis.

^e Fees paid by Provincial Public Welfare Department; amount is included in the first figure.

^f Easter Seals and March of Dimes campaigns included.

(1) Voluntary Funds

Voluntary funds are obtained from financial campaigns aimed at the general public, "private campaigns" limited to friends, bequests and legacies, grants from charitable foundations or from other voluntary organizations, and a wide

range of money-raising projects — benefit concerts, hockey games, bazaars, teas, the sale of Christmas cards, etc. The main sources in Canada are the public campaigns, run by the organization or by the federated funds.

Of the total operating revenue of \$30,000,000 reported by the organizations whose revenue exceeded \$100,000 in 1961, \$23,100,000 or 77 per cent came from voluntary contributions. Of the latter sum, \$8,000,000 or 29 per cent was contributed through federated funds. Since "other donations" are sometimes combined with bequests and legacies, these items cannot be separated. Only bequests and legacies included in operating revenue are counted in these calculations.

Campaigns of Individual Agencies

CAMPAIGN METHODS

Most of the national agencies take an active part in the conduct of the national campaign — providing campaign material, developing a symbol, a campaign slogan, or a name by which the organization becomes nationally known, and arranging for national publicity. When the national organization has legally reserved the sole right to use the name, it allows the use of it to provincial or local associations on certain conditions, in an effort to ensure that the local use will not discredit the meaning of the symbol, and that the money collected is used for the purposes for which the national campaign was conducted. In the "Christmas Seals" campaign, the Canadian Tuberculosis Association has a written contract with the provincial bodies, and tries to ensure that the provincial associations have a similar contract with each local "Seals Committee". It has met with resistance in some areas, has not been able to enforce this policy fully, and considers that it can exert only limited pressure on voluntary groups.

The extent to which the national office can provide publicity and supplies is heavily dependent upon the degree to which the activities of the provincial associations are similar. The Canadian Poliomyelitis Foundation has found that national publicity is not possible, except in very general terms, because provincial associations have varied their activities since the need for funds for "polio" victims has been reduced. It prepared a film for use, but the associations found it unsuitable. By contrast, the Canadian Tuberculosis Association provides most of the publicity and, with years of experience and continual study of the results, has developed a detailed manual of procedures, which it maintains are the most effective in a mail campaign and will raise the most money at the lowest cost. The manual demands or suggests certain procedures — e.g., if possible, a bank manager should be made treasurer, and the bank be persuaded to handle all the letters received and to agree not to charge the exchange on out-of-town cheques; a part-time secretary should be employed at an honorarium even in the smallest area, but a volunteer should always be present when she opens the

letters, so that there will be no accusations regarding the pocketing of donations. This organization suggests the wording of the letters which are printed on the provincial letterhead, although variations to stress local activities are considered desirable.

Some of the Societies for Crippled Children started the "Easter Seals" campaign before there was a national organization, adopting it from its origin in Denmark, and later buying the seals from New York. As more societies used the seals, the Ontario Society took responsibility and sold its designs and campaign material to others. More recently, however, since some of the provincial societies include adults as well as children in their names and services, the national campaign material is not applicable, although uniform seals are used.

The amalgamation of the Society for Crippled Children with the Foundation for Poliomyelitis in some provinces means that the one body runs both campaigns, sometimes having the same campaign secretary but using different publicity and emphasis. All the revenue goes into the common fund, and no separate account is possible. Since both of these campaigns have been successful, one would judge that the combined societies do not want to give up either, and yet are probably afraid of public reaction to two campaigns a year run by the same body for a common fund.

The "Christmas Seals" campaigns in Manitoba and Saskatchewan are run by the Sanatoria Boards. The Saskatchewan Board, a public body set up by legislation, runs the campaign and receives other donations also, particularly through the efforts of the Association of Commercial Travellers. This revenue is designated the Preventive Fund. The deficit in this fund was paid in 1961 from the "Federal Health Grant Reserve Fund", which was reported to stand at over \$62,000 at the end of the year. This is difficult to understand, since the federal grants are supposed to be spent currently or else returned to the federal government. It also points to the lack of differentiation between the use made of voluntary and public money. The Manitoba Sanatoria Board, also set up by legislative act but with majority representation of the voluntary members, conducts the "Seals" campaign from the central office. This Board is increasingly responsible for the administration of federal and provincial institutions for patients other than the tuberculous, and its reports to the public do not make clear the use made of the voluntary funds.⁸ In both cases the financial statements show substantial reserves, and the validity of appeals to the public for voluntary funds is questioned, unless a clear differentiation in their use, as distinct from that of public funds, is made.

⁸ The Executive Director explained in a letter: "Funds from the Christmas Seal campaign are entirely spent on our tuberculosis preventive activities including tuberculin surveys, chest X-ray surveys, health education and rehabilitation services. Other donations or bequests are used either for specific projects or to fulfil special needs in our programs which are not met in other ways or from government funds Our total expenditures for preventive services and related accounts for the year 1961 were \$332,529.83 and we had an excess of income over expenditure in this department of \$6,140.86."

The Muscular Dystrophy Association runs its national campaign entirely from the national office. The local groups raise funds in other ways for local activities. Membership in the federated funds is sought by the national group, and it does not allow its locals to become members as this would confuse the local communities.⁹ This would seem to be a difficult arrangement for the local groups.

The national body of the Victorian Order of Nurses has adopted a different pattern. For its national expenses it runs an appeal every five years, responding to the complaints about multiple appeals in this way. It limits its approach so that it is not in competition with its own branches.

The Heart Foundation has an annual national campaign meeting and provides the supplies. The campaign is run in some areas by mail and in others by door-to-door canvassing. The Canadian Cancer Society leaves the campaign method to the provincial and local groups, selling the supplies to them. The groups use different methods and in many areas use other local organizations to raise the money.

In citizen-member organizations, the campaign is conducted with all the expert salesmanship which the organization can command. When an organization enlists high status businessmen for its Board, it may do it to give the public confidence in its respectability or to get the contacts for special names and corporations, but it also makes use of their business experience. The businessman uses his ability as a salesman on behalf of the organization. The publicity material, the planning of the campaign, the annual reports, even the forms of the financial statements are in different degrees designed to sell the agency to the public. They do not, in some cases, present a true picture of the activity of the agency.

The publication of books on how to run successful campaigns,¹⁰ and the development of professional fund-raisers¹¹ demonstrate the recognition of the necessity for expert salesmanship. Board and campaign staff unite to develop their 'sales argument'. The books contain such chapters as "An Annual Report Can Raise Funds Too"; "How Your Public Relations Programs Increase Support"; "Gaining Through Giving - Taxes".

The financial support which an organization obtains is probably more dependent upon the skill of the campaign 'salesmanship' than upon the appeal

⁹ Some local groups have continued membership in funds by which they had been accepted before this policy was established.

¹⁰ Examples of such books are Margaret M. Fellows and Stella A. Koenig, *Tested Methods of Raising Money*, N.Y., Harper and Bros., 1950, and, by the same authors, *How to Raise Funds by Mail*, N.Y., McGraw-Hill, 1950.

¹¹ Only one instance of the use of professional fund-raisers was discovered. This was the joint campaign of three organizations for the Blind in Montreal. Two of these have now joined the Combined Health Appeal.

of the particular 'cause'. The financial reports of the strong citizen-member organizations suggest that at least in part the public give to the successful organization, the public being not only the individual donor, but also the federated funds and the government.

CAMPAIGN COSTS

The Accounting Manual produced by the National Health Council states:¹²

In the case of business concerns or commercial enterprises, very seldom, if ever, are they evaluated on the size of their advertising and promotional expenses. In direct contrast, voluntary health agencies are frequently judged largely on the amount spent in raising or generating income. Although an agency's efficiency in this respect is certainly an important factor and should not be disregarded, it should not be the sole nor necessarily the principal factor in evaluating its merit for existing because, if limited to this, the picture can be thrown badly out of focus and, where one agency is compared with another, illogical conclusions formed. Nevertheless, regardless of how the information may be used or misused, the public is entitled to accurate and realistic fund-raising figures. With this as an objective, the objective, the following definition was framed to serve as a foundation for getting costs applicable thereto uniformly classified:

FUND RAISING represents activities conducted or materials distributed and/or used for the sole or principal purpose of getting the public to financially support the agency's cause *plus* any and all other expenses incurred in planning, directing, administering or participating in fund drives or other programs in which contributions are actively solicited.

The statements of campaign costs made by the health organizations are very misleading. National office costs are not always included, except for the cost of supplies bought by the provincial or local groups. The Canadian Tuberculosis Association marks up the price of campaign materials to include the assessment for the running of the national office, only part of which is campaign expenses. Some organizations count a percentage of permanent staff costs while others list only the temporary extra staff. The campaign expenses of local committees as in the Societies for Crippled Children are not always known. Where the costs are calculated as part of each dollar contributed, the calculation is sometimes made on the basis of total revenue, including allocations from federated funds from which the expenses have already been deducted. Some organizations charge as much as 40 per cent of the costs of material and supplies to "public education". It must be acknowledged that it would be difficult in some cases to determine accurate costs, or to agree on the items, such as overhead, which should be included, although the Manual quoted above tries to do so.

Some of the organizations justify their campaigns and their campaign costs as "public education". The Tuberculosis Associations seem sometimes to

¹² *Accounting and Financial Reporting Procedures for Voluntary Health Agencies*, N.Y., National Health Council, 1962.

suggest that the campaign is conducted to give them a captive group to educate. Some organizations have refused Fund membership on the grounds that much of the public education value would be lost. Some argue that mail campaigns are preferable because salesmanship pressure can not be used and hence the donation is truly voluntary.

Participation of Other Organizations

Most of the provincial and national campaigns which are not direct mailings from a central office raise their money by using other organizations, such as service clubs, fraternal orders, the Canadian Legion, the Fire Fighters Association, church groups, Women's Institutes, school children, in fact almost any group acceptable to the community. Some of these groups canvass for several organizations. The new Council for the Rehabilitation of the Disabled suggests that its two campaign committees might unite, since in many communities both the "Easter Seals" and the "March of Dimes" campaigns are undertaken by the same service clubs. A report mentions that one service club may raise money for four or five different organizations. The British Columbia Tuberculosis Association insisted in its constitution, until a recent revision, that only committees of accredited organizations (i.e., service clubs) would be accepted as "Seals Committees".

Although a particular group, locally or nationally, may "adopt" a particular organization – the Muscular Dystrophy Association is referred to as the "Fire Fighters' baby"¹³ and in two provinces the Poliomyelitis Foundation is associated with the Canadian Legion – one gets the impression that many other organizations which want to have activities of a socially acceptable nature to interest their own membership, use the raising of money for a charitable cause for this purpose. They want to have a concert or a bazaar and they can do this only if they have a good cause to which the money is to be given.

One suspects that while in one capacity, as members of Chambers of Commerce or Boards of Trade or corporations, businessmen raise their protests against the multiplicity of appeals, in their individual capacities as members of service clubs, fraternal organizations, etc., they may be extremely active in initiating several more campaigns or fund-raising projects in the same community. That the public makes a distinction between a campaign and the fund-raising activities of service clubs is assumed in the statement of the Canadian National Institute for the Blind when it announced that it had been able to avoid a capital campaign because the Lions Club had pledged the money.

It is argued here that much of the voluntary funds is given because it is socially acceptable and enjoyable to give, or because the organization has

¹³ By resolution of the international union of "Fire Fighters".

expert salesmanship techniques, rather than because a particular cause deserves support. If this is true, the policy of some federated funds and of some governments to give funds only to organizations which have demonstrated that the community supports them by the funds they have been able to raise is imminently unsound. In health organizations in which membership figures include the membership of organizations assisting in the campaign, or in which the membership is based upon a donation of one or two dollars, the real interest of the member in the objectives of the organizations is frequently uncertain.

Federated Campaigns

MEMBERSHIP

Community Chests and United Appeals contributed \$8,191,000 for the year 1961 to the national organizations included in this study. This figure is compiled from reports of 60 of the 110 federated funds in Canada and is estimated to represent 90 per cent of the money allocated to voluntary organizations through such funds.¹⁴ It does not include health organizations with no national body. In Tables I and II¹⁵ it was shown that the organizations with revenues over \$100,000 in 1961 reported receiving \$8,015,000. This figure includes some agencies not included in the \$8,191,000, but excludes others. It represents 38 per cent of the total voluntary donations received by the included agencies.

Federated funds have increased rapidly since 1945, both in the number of funds and in the extent of agency participation in them. Some of the organizations included in this study were not able to state precisely the number of their local units which are members of funds. Table III gives the position as accurately as it could be obtained for 1962. Table IV shows the increase in participation over a period of years, as reported by the funds.

It will be seen that all the organizations except the Canadian Hemophilia Society, the Canadian Hearing Society, the Canadian Mothercraft Society and the Canadian Cystic Fibrosis Foundation have membership in some of the funds. Three of the above groups have been refused membership, because of the incidence of the disease, duplication of service, or financial position. The national policy of two organizations, the Cancer Society and the Heart Foundation, is opposed to participation, but units which were previously members have continued in some cases and others have joined since the policy change. It is a policy of the Muscular Dystrophy Association that the national body but not the local chapters may join, but some chapters have continued. The national association withdrew from two of the larger funds in 1962. The Canadian National Institute for the

¹⁴ Canadian Welfare Council, *Allocations to National Organizations by Community Funds*, Ottawa (published annually)*.

¹⁵ See pp. 95-96.

TABLE III
NATIONAL ORGANIZATION PARTICIPATION IN
FEDERATED FUNDS, 1962

Organization	No. Fund Memberships	Remarks
Victorian Order of Nurses	68 ^a	Full participation
Canadian National Institute for the Blind	68	Full; in Montreal Combined Appeal
St. John Ambulance Association	59	Full; in Montreal Combined Appeal
Canadian Arthritis & Rheumatism Society	45	Full; in Montreal Combined Appeal; has been refused in at least 2 instances
Canadian Red Cross Society	44 ^b	Has joined as a "partner" in United Appeals, including Montreal Appeal
Canadian Mental Health Association	33	Both national and provincial in Toronto
Canadian Cancer Society	26 ^c	Policy est. 1956 against participation; small units previously members have continued. In B.C. joint appeal with Cancer Foundation. U.S. policy the same.
Multiple Sclerosis Society	23	Since 1959 has urged locals to join; has been refused by some Chests; in Combined Appeal in Montreal.
Foundation for Poliomyelitis and Rehabilitation	23	Provincial autonomy; some variation but mostly outside; has withdrawn from 2.
Canadian Heart Foundation	14	Policy against, as in U.S.A. Some local groups were previously members
Muscular Dystrophy Association	10	National prohibits locals to join & seeks membership of national; withdrew from Vancouver and Saskatchewan in 1962
Society for Crippled Children	10	Provincial autonomy; in small Chests; perhaps more
Canadian Association for Retarded Children	9	Mostly in small areas in B.C. & Sask.
Canadian Diabetic Association	1 ^c	No policy
Canadian Hemophilia Society	none	Has been refused in some instances
Canadian Hearing Society	none	Private campaign and Foundations
Canadian Mothercraft Society	none	Was in Toronto and membership was cancelled; Chest refused in Ottawa
Canadian Cystic Fibrosis Foundation	none	Has applied in some places.

^a Actual total 1962.

^b Includes joint appeals.

^c Actual total 1961.

Source: Canadian Welfare Council, *Allocations to National Organizations, 1962*; 76 funds reporting out of 116.

TABLE IV
PARTICIPATION OF VOLUNTARY HEALTH ORGANIZATIONS IN FEDERATED FUNDS:
SELECTED YEARS

Year	No. Chests Reporting ^a	CNIB	VON	Red Cross	St. John	CARS	CMHA	Retarded	Cancer	Heart	MS	MD	Polio	CP	Other
1944	24/?	21	19	7	4	—	—	—	—	—	—	—	—	—	—
1947	33/?	25	25	10	7	—	—	—	1	—	—	—	—	—	1
1949	27/?	24	27	9	11	—	—	—	—	—	—	—	—	—	1
1952	35/55	27	25	7	15	—	—	—	—	—	—	—	—	—	1
1954	48/63	40	33	14	23	9	1	—	9	—	1	—	3	1	5
1956	55/71	45	39	13	34	19	5	—	12	—	2	3	4	4	7
1958	56/82	40	41	21	36	20	11	9	11	2	4	6	8	4	7
1960	57/104	52	43	34	44	30	21	18	15	7	11	9	9	10	10
1961	70/110	62	53	44	54	37	31	25	14	9	17	10	16	11	11

^a The number of Chest and United Appeals reporting as a proportion of the total number organized in Canada. The latter number was not available in the first three years listed.

Source: Canadian Welfare Council, *Allocations to National Organizations*, op. cit.

Blind and the Victorian Order of Nurses have been members of almost all funds since 1944. The participation of the St. John Ambulance Association has increased steadily, but was levelling off in the last three years, suggesting that its local units are members in all communities in which they are organized. The Red Cross Society joined slowly in the earlier years, but has increasingly become a "partner" in United Appeals. The Canadian Arthritis and Rheumatism Society is a member in almost all the areas in which it has local activity.

Since one of the objectives of federated fund raising is the reduction of the number of appeals in the community, one might expect the general rule to be an "open door" regarding the acceptance of members, but there are variations.¹⁶ Where the fund is having difficulty in meeting its objective, it may not encourage new members. At the other extreme is a small Chest which advertised in a newspaper, inviting "worthy proven causes" to join. Some Chests assess the value of the work done by an applying organization and the public attitude to it. Most of those with an "open door policy" require some kind of local organization (a board or a committee), to be accountable for the budgeting, local service expenditure, although the provincial or national organization may not have an active local group. Three Chests require extensive support by the public before the organization is admitted. The Toronto manual of "Operating Policies" demands *inter alia*, that the agency be incorporated, that it "not unnecessarily duplicate a service available through some other agency, whether public or private" and "have the type of backing and community support which will lend strength to the United Community Fund and to the agency and which will provide workers for the United Appeal and a list of contributions to the campaign. The list of subscribers should show evidence of sufficient operating financial support in the community to bring into the United Appeal Campaign enough increases to support the operating budget at the time of admission and show evidence that this support will continue". It must "have supported itself for three years, or such other period as the United Community Fund may determine".

Eight of the 30 Chests reported that the Multiple Sclerosis Society had been refused admission because there was no local branch. One Chest, against the advice of a medical consultant who thought the incidence did not warrant the action, considered assisting the organization in forming a local group. The Arthritis and Rheumatism Society was refused by two Chests. By mutual agreement, the Canadian Hearing Society did not enter the Toronto Appeal because its desire to increase its revenue substantially could not be met through an allocation. The Canadian Mothercraft Society was a member in Toronto for a few years, but membership was discontinued when the Hospital Services Plan reduced the need for voluntary financing. Its branch in Ottawa was refused membership because it was considered to duplicate existing visiting nursing services. The Hemophilia Society, the Muscular Dystrophy Association, Cerebral Palsy Associations and the

¹⁶ For this study, federated funds were asked to supply information. Material received from 30 funds is used in this section.

Federation of the Blind have encountered refusals occasionally. The Damon Runyan Cancer Society, an American organization interested only in research, was refused admission in two Canadian communities because of the duplication of the work of the Canadian Cancer Society.

Some organizations have withdrawn from Chests on their own initiative. The Muscular Dystrophy Association was dissatisfied with its allocation. Local groups of the Heart Foundation and the Cancer Society have withdrawn when national policies against participation were established. The assumption by government of support of the school resulted in the withdrawal of a local Association for Retarded Children in British Columbia. The Foundation for Poliomyelitis has withdrawn from two major funds.

ALLOCATIONS

Table V shows the allocations of Community Chests and United Appeals to voluntary health agencies in selected years from 1944 to 1961. In the 17-year period, the total has increased from \$701,000 to \$8,191,000, the increase having commenced in 1954. Table VI is the calculation of the percentage these figures represent of the total Chest revenue. The receipts of the Chests increased from \$6,417,000 in 1944 to \$31,000,000 in 1961. The percentage allocated to the health organizations varied unevenly from 7.4 to 11.7 between 1944 and 1952, and then increased steadily to reach 26.4 per cent in 1961. Of this percentage, 19.6 was shared by four organizations, and 2.9 by the remainder. The Canadian National Institute for the Blind has varied only from 3.6 to 3.8 per cent since 1958. St. John Ambulance Association has maintained a constant 1.5 per cent during the same period. Canadian Arthritis and Rheumatism Society reached 2.3 per cent in 1956, fell to 1.9 in 1958, and then returned to the former proportion. The Victorian Order of Nurses reached a high of 6.1 per cent in 1956, fell to 4.9 in 1958, and rose to 5.2 in 1961. The organization which shows the greatest variation is the Red Cross Society. It was given a low of 1.5 per cent in 1956 and has climbed rapidly to 8.4 in 1961. A large part of the total increase is due to its more recent partnership in larger campaigns.

It must be pointed out that "allocations" are the amounts the Funds agree to pay but if, in a given year, the organization does not spend the full amount, the balance is returned to the Fund or debited against the allocation for the following year. The money received by the Fund is the total used in the calculations and this amount may not be the total allocated, since the Fund may hold some money as a reserve or, if the campaign has not been successful, may supplement the receipts from its reserve. The percentages and the amounts are thus not completely accurate, but the variations from these will generally be very small. The figures have been used in Figures 1 and 2.

TABLE V
ALLOCATIONS OF FEDERATED FUNDS TO VOLUNTARY HEALTH ORGANIZATIONS: SELECTED YEARS
(thousands of dollars)

Year	No. Chests Reporting ^a	CNIB	VON	Red Cross	St. John	CARS	CMHA	Retarded	Cancer	Heart	MS	MD	Polio	CP	Other	Total
1944	24/?	105	222	369	—	—	—	—	—	—	—	—	—	—	—	701
1947	33/?	128	339	318	10	—	26	—	—	—	—	—	—	—	40	861
1949	27/?	162	369	232	16	—	—	—	—	—	—	—	—	—	—	779
1952	35/55	198	410	229	22	—	—	—	—	—	—	—	—	—	—	859
1954	48/63	305	787	319	78	57	13	—	35	—	—	—	3	2	41	1,640
1956	55/71	380	992	269	196	405	96	—	43	—	10	11	18	26	79	2,527
1958	56/82	908	1,240	843	380	493	182	30	50	48	NG ^b	118	246	37	9	4,584
1960	57/104	1,057	1,394	2,140	428	646	289	246	NG ^b	95	25	128	293	57	196	6,994
1961 ^c	70/110	1,143	1,601	2,614	479	704	445	374	59	41	40	119	359	86	130	8,191

^a The number of Chests and United Appeals reporting as a proportion of the total number organized in Canada. The latter number was not available in the first three years listed.

^b Not given.

^c It should be noted that total agency figures for 1961 do not coincide with those in Table I because the sources of data are different and because of variations in agency fiscal years reflected in Table I.

Source: Canadian Welfare Council, *Allocations to National Organizations*, *op. cit.*

TABLE VI
ALLOCATIONS OF FEDERATED FUNDS TO VOLUNTARY HEALTH ORGANIZATIONS AS A PERCENTAGE
OF TOTAL FUND REVENUE: SELECTED YEARS

Year	Total Chest Receipts (\$'000)	Percentage Allocation														
		CNIB	VON	Red Cross	St. John	CARS	CMHA	Retarded	Cancer	Heart	MS	MD	Polio	CP	Other	Total
1944	6,417	1.6	3.5	5.8	—	—	—	—	—	—	—	—	—	—	—	10.9
1947	7,882	1.7	4.3	4.0	0.1	—	0.3	—	—	—	—	—	—	—	0.5	10.9
1949	9,378	1.7	3.9	2.5	0.2	—	—	—	—	—	—	—	—	—	—	8.3
1952	11,716	1.7	3.5	2.0	0.2	—	—	—	—	—	—	—	—	—	—	7.4
1954	14,011	2.2	5.6	2.3	0.6	0.4	0.1	—	0.2	—	—	—	a	a	0.3	11.7
1956	17,760	2.1	6.1	1.5	1.1	2.3	0.5	—	0.2	—	a	a	0.1	0.1	0.4	14.4
1958	25,504	3.6	4.9	3.3	1.5	1.9	0.7	0.1	0.2	0.2	NG	0.5	1.0	0.1	a	18.0
1960	28,000	3.8	5.0	7.6	1.5	2.3	1.0	0.9	NG	0.3	0.1	0.5	1.0	0.2	0.7	24.9
1961	31,000	3.7	5.2	8.4	1.5	2.3	1.4	1.2	0.2	0.1	0.1	0.4	1.2	0.3	0.4	26.4

a Less than 0.1%.

FIGURE — I

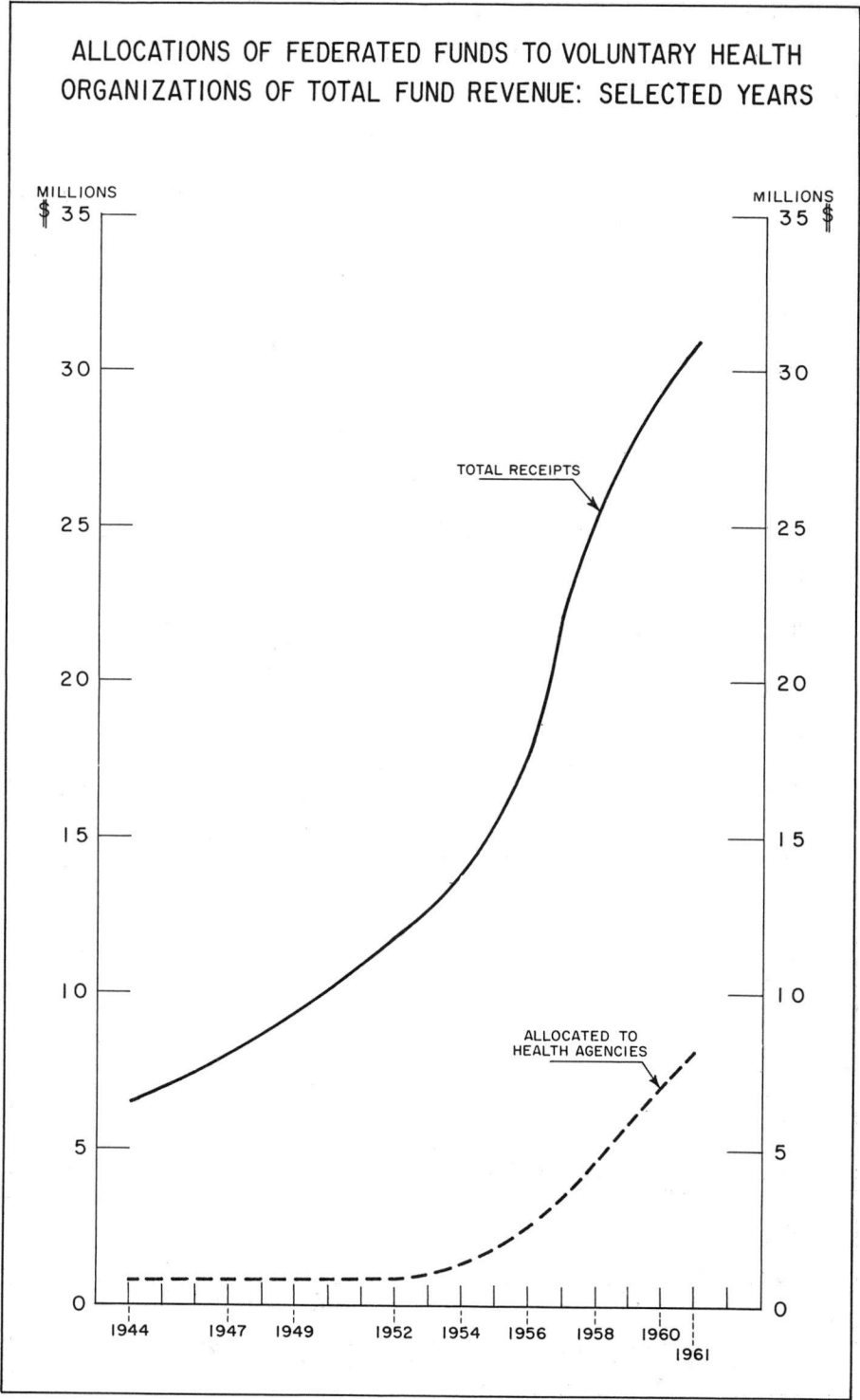


FIGURE - 2

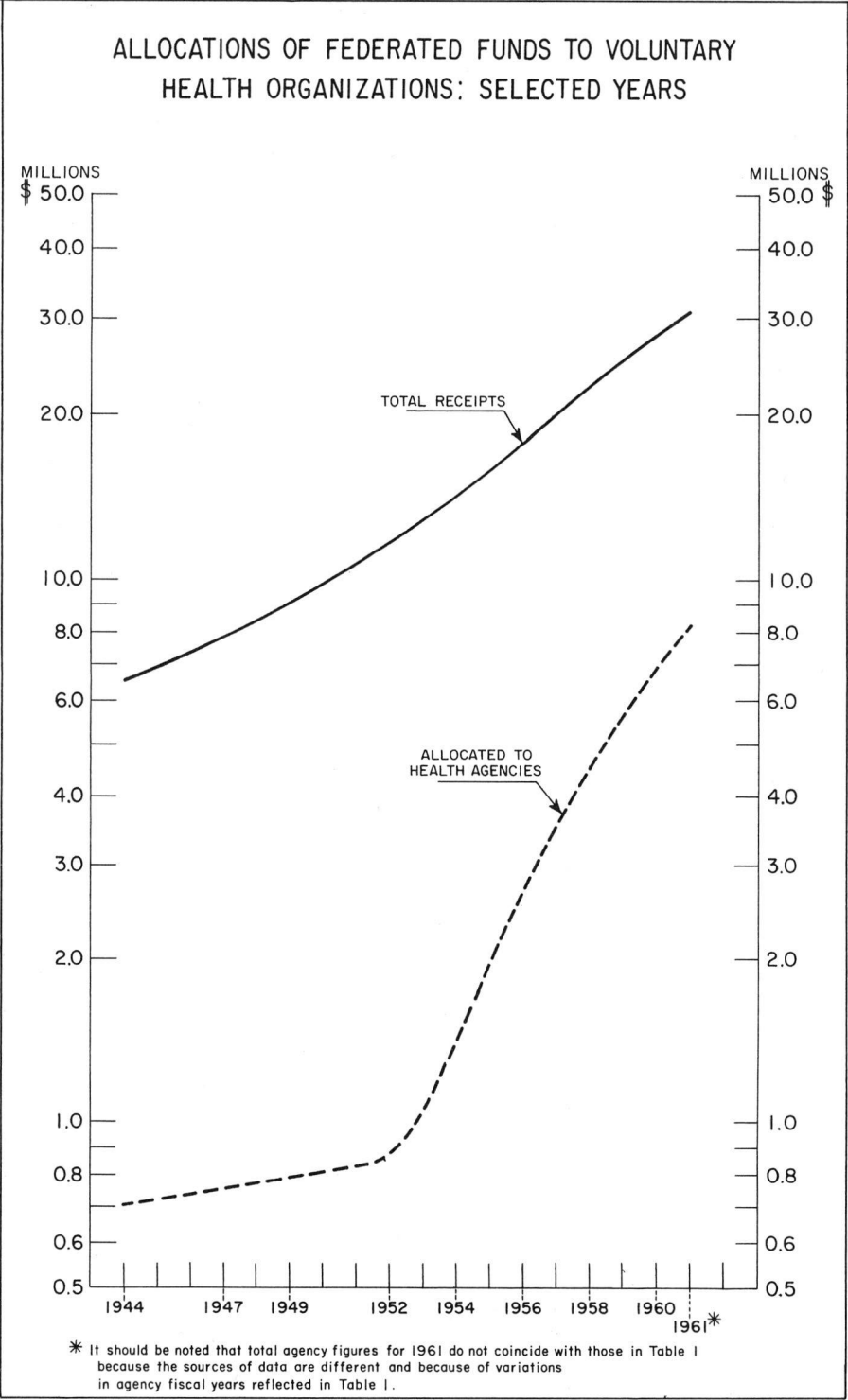


Fig. 1 compares in absolute terms the total receipts by the Chests and United Appeals with the allocations to the health organizations at the national level, and also at the provincial and local levels when these budgets are included in the national one. It demonstrates the rapid increase in federated fund raising, particularly since 1952. This increase is due to an increased number of funds as well as an increased number of participating agencies. Information is not available to provide a comparison with the voluntary funds raised independently. Fig. 2 uses the same data to show the relative rates of increase. Previous to 1952 the amount allocated to health organizations was relatively constant, although the total received by the funds rose steadily. Since that year, the proportion allocated to the health organizations has risen very sharply, but appears to have reached a plateau in 1961 although receipts still increased, but at a reduced rate.

It is claimed that those organizations which have less public appeal and less support – and particularly those devoted to diseases of limited incidence – are the ones which want to join the funds, since the stronger organizations can raise more money outside. The fact that some of the strong organizations are “inside” in Canada – e.g., the Canadian National Institute for the Blind and the Red Cross Society – suggests a slightly different picture, and it is known that in some areas the smaller ones have been refused admission. The “bargaining power” of the Red Cross Society is great, and there are suggestions that in some areas fear of its competition is such that it is given a “preferred” status within the Fund. The Combined Health Appeal in Montreal, for example, is a Combined Health and Red Cross Appeal, and the agreement is that the proceeds will be divided in proportion to the two budgets, so that if the goal is exceeded, the Red Cross will get its proportion of the additional amount, while the balance of the excess will be held in reserve and not distributed among the other agencies.

NATIONAL AGENCIES AS FUND MEMBERS

A number of Chests reported difficulty in budgeting, particularly with national agencies. Five of the small funds reported that priority was given to local operations of the groups, as contrasted with the national activity. Two larger ones reported that, where the objective of the campaign was not reached, the national agency allocations were the first to be reduced. One third of the Funds, both small and large, study the budget of an organization as a whole and do not discriminate against its national – as distinct from its local – requirements. Some of them apply the “fair share” formula recommended by the National Agency Review Committee.¹⁷

The Toronto Appeal classifies the agencies as local and national, the latter being those “whose provincial, national or international association exercises a

¹⁷ See p. 120.

fairly rigid control of policy, programme, and distribution of funds over the day-to-day operations of the local affiliates and whose programme of service is not entirely influenced by its service to the local community". For the national group, a separate committee is appointed to "carry responsibility for reviewing the annual financial requests of the national organization, negotiating with each organization... as to the amount of their participation within the total approved for national organizations in the goal". If the campaign goal is reached or exceeded, the aggregate amount is then divided among the national organizations "on the same percentage base as each was included in the goal"; if the goal is not reached, the amount available is distributed "on the basis of the previous year's appropriation or current request, whichever is lower, and national organizations may apply for a share of any surplus in the aggregate amount remaining for their group".

A considerable number of the Chests made no comment on "budget procedure", and 60 per cent of them failed to say what use they made of the reports of the National Agency Review Committee. Three of the smaller Chests make no use of these reports, and a few others reported limited use.

Under the leadership of the Trail Community Chest, a provincial review structure has been formed in British Columbia, and is regarded as beneficial to the local Chests. Even so, one volunteer reported from a British Columbia Chest, that:

As interesting as I find these reports, I am somewhat skeptical that any one or group of persons is sufficiently imbued with gray matter to be a judge of the rights and wrongs of the operation of so many complex groups. Glaring mismanagement has never been revealed in any reports I have read, but I have heard that there are unnamed groups which have excessive reserves. We read the reports, but as I have said, none that have come to my attention have recommended other than that the agency is deserving of continued support and I cannot see how on a local level we could assess the reports otherwise.

The general rule is that agencies in federated funds are restricted in the extent to which they may solicit funds outside the Chest or United Appeal. Some permit solicitation outside the city limits if service is available there. Some explicitly encourage the solicitation of nominal membership fees, which must not compete with the federated campaign. The ways usually allowed to supplement the revenue are through social events, bazaars, etc.

Capital campaigns are generally planned informally by the organizations in a community. Brantford, Ontario, is the only city known to have co-ordinated all capital campaigns of health, welfare, religious, and educational institutions. This scheme was initiated by the Chest and the local Board of Trade and its success depends on voluntary co-operation.

In some smaller cities where budgets are not high, health agencies seem to be able to raise their money without affecting the efforts of the Chests. The

majority of Chests and Appeals, however, report difficulty because of the health appeals. When campaign dates are set nationally, they sometimes coincide with those of the local Chest. Sometimes competition for canvassers is a problem. The "fear appeals" on behalf of cancer and heart are blamed generally for any harmful effects on Chest drives, and in both instances there is a strong national policy against branches becoming participants of the Funds. With the movement of such agencies into employee payroll deduction schemes (previously thought to be the preserve of Chests), competition for the small giver's dollar is expected to intensify. In contrast, one United Appeal executive suggests that because the aim of the unified appeal is to reduce the number of campaigns, the health campaigns may have suffered.¹⁸

The health organizations present another side of the picture. Some of the organizations have been under considerable pressure to join the United Appeals, and in two instances found it necessary to explain to the public through official "policy statements" why they refused. The British Columbia Foundation for Poliomyelitis and Rehabilitation did this when under pressure to join the Vancouver Appeal. The Fund would not permit capital grants, and the Foundation spent a considerable amount in that way. A campaign would still have to be conducted throughout the parts of the province in which there were no Funds. And only through their own campaign could they determine the extent of approval by the public of their programme. The development of a United Appeal in Edmonton caused greatest concern to the Council for Crippled Children and Adults, which claimed that the publicity informed citizens that they should not feel any obligation to any other appeal than its own. It seems to have resulted in greater effort, however, and the Council announced that within two years they overcame any ill effects. At the same time a local Cerebral Palsy Association in that Council reported that it had to join the Appeal for financial reasons.

The Muscular Dystrophy Association explained that it was not a charity since its purpose was not to help the indigent and hence it should not be a member of the Appeal. Its concept of itself as a temporary organization was another reason given. The Cancer Society regards the public education value of its campaign material as more important than the money raised, and sufficient reason for a separate campaign. Other organizations, such as the Association for Retarded Children, argue that a federated fund is not appropriate for an organization with a rapidly expanding programme, as the allocation would not reflect the increasing public support they can command independently. Some health organizations have withdrawn from funds because of the limited allocations.

Although the federated funds want to reduce the number of appeals, the conditions of membership are not always appropriate to local chapters of provincial or national agencies, or to provincial or national organizations. The policies

¹⁸ The health agencies in this area express great bitterness regarding the effect of the Appeal on them.

were developed for local agencies providing local services and assume considerable, if not absolute, local autonomy. Some of the health organizations have no local chapter or have local groups only for fund raising. The participation of the local group subject to national policies presents difficulties when a condition of membership is that the Chest must approve any change or expansion of programme, or a capital campaign, and when requirements regarding budgeting and audit differ from Chest to Chest.

LOCAL RESPONSIBILITY

The other major problem is the adjustment necessary in the traditional functioning of federated funds. The emphasis on "community" has strengthened the normal feeling in a local area of wishing to help one's neighbours (and oneself) and the concept that money raised locally should be spent locally. In the public sector of services, it is increasingly recognized that a local community is not an appropriate unit for financing its health and welfare services. To the extent that the services are based on financial need, or have as one purpose the raising of social standards (housing, education, health, etc.), the community requiring the most services is the community least able to afford them. The division of financial responsibility between two or three levels of government and the development of equalization grants is increasingly accepted as necessary. The private sector of health and welfare services has not moved as realistically in this area. Until recently, most health and welfare organizations have been local in their origin and activity. Those which have developed from the national level, with considerable national or provincial control, have to a large extent fitted into the existing pattern of local agencies -- the Victorian Order of Nurses will only establish a "branch" in a community which can support it financially; the Canadian National Institute for the Blind expects provincial (and to some degree local) self-sufficiency; the Red Cross, while somewhat more flexible, endeavours to have each provincial division spend amounts related at least roughly to the money raised in the area.

People who devote time and energy -- and their own money -- to the raising of funds, are given greater incentive if the funds are to be spent on a project in which they have a particular interest, and in which they can see at first hand the results of their work. The public, in subscribing to a campaign, is also influenced by appeals of which it can see the results. The crippled child next door is more "real" than the one living a thousand miles away.

Federated funds have capitalized in their publicity on the spirit of the "good neighbour". National and provincial organizations have in some cases struggled against it. Where they have insisted in the beginning that all funds collected must be turned over to the provincial or national group, they have sometimes had to limit this to funds collected in the public campaign and have allowed local groups

to raise additional funds through special projects, the proceeds of which may be spent on their own activities and, in some cases, not accounted for to the national body. When an organization like the Multiple Sclerosis Society demanded all funds, the resistance of its local groups forced it to allow them to keep a percentage, this being gradually increased under pressure. Where other organizations are used to collect funds, there is pressure to allow them to keep some of the money. In Ontario, where money raised by the local tuberculosis groups traditionally has been used for local activity, some groups are now finding it very difficult to spend the amounts they collect, and the provincial association has encouraged them to send surpluses to it, either to help a poorer local group or to support special projects. The local unit can earmark its contribution or leave the allocation to the discretion of the provincial association. But this seemingly logical plan is resisted by some local groups. In the Easter Seals organization, in which committees of service clubs are predominantly used to raise the funds, the practice has been to allow the local committee to retain 50 per cent of the proceeds, from which, after the deduction of its campaign expenses, local crippled children's activities are financed. Although the organization may demand in its "enfranchisement" of the group that this money must be kept as a special fund to be spent on the purposes for which it is raised, in most provinces it has no way of ensuring that this is done. In one province a complaint was made that the service clubs were not keeping this money separately from their other welfare funds.

Among the national agencies, the Heart Foundation requires 22½ per cent of the money raised by the provincial associations to be sent to the national office. The Cancer Society tries to enforce its policy that all money should be turned in to it, and local branches operate on an imprest account within an approved budget. The Muscular Dystrophy Association has had difficulty in ascertaining what funds the local units raise and hence what they keep for themselves. Local chapters were joining Chests for their local needs, and the national office, which wanted to do this for the national campaign, found itself asking for membership in a Fund of which, unknown to the national, its local group was already a member. It laid down a policy that local units must not join Funds (leaving the option to the national body to do so), but some who were previously members have not withdrawn. The St. John Ambulance Association is generally a member of the local Fund although, since constitutionally all the money belongs to the controlling national body, the Fund must be faced with difficulties in budgeting.

RESEARCH

When the money for research comes from the federated Funds this does not mean that the general public is supporting research, but only that the groups determining fund policies are convinced of its need. The allocation of the money is not determined by the donors, but by a small budgeting committee set up by each Fund to represent the public. In some cases the member organization may be

in the Fund because it does not think it can interest the public sufficiently in a campaign in which research is given heavy emphasis.

The question of campaign goals and budget allocations for research purposes is a difficult one, since the budgetary estimates must be based upon what an organization hopes to raise rather than on any realistic calculation of need, or even of ability to spend. When the organization conducts its own campaign, this is not a very serious problem. It sets out to raise all the money it can. But when the organization, or its provincial or local branches are members of Chests and United Appeals, the budgeting process becomes a major difficulty. How can a local budgeting committee – or the National Agency Review Committee – establish any reasonable method of weighing the request of a health or welfare organization for money to be given for research against the direct service needs of other – or the same – organization, in order to reach a decision regarding the request for the allocation of funds? A further complication is the need to make a judgment of what the local share in a national research fund should be.

Enquiry about the attitude of local Chests brought some comments on these points. One Chest felt there should be a local "fair share" formula for research needs. A number of others reviewed agency budgets as a whole, realizing that research requirements were usually financed through appropriations to the national agencies concerned. The dilemma facing Chests and United Appeals in responding to requests for research moneys, and perhaps especially those Chests with large budgets and heavy demands from the welfare field, may be noted in the following statements from Executive Directors:

I feel that United Funds and Chests must take a realistic view and include medical research in its financing programme. In the first place within such organizations as Cancer, Heart and Polio, the public has demonstrated its willingness and desire to provide voluntary funds for medical research. Secondly, there is within medical research the need in some instances for a base of voluntary support, as a result of which the organizations are in a position to attract government moneys to their cause. Thirdly, in the area of medical research, there is a need for some "risk" funds which are not available from government sources. At the same time, this is a field in which the need for some controls in directing voluntary money only into appropriate channels for its use is apparent. We feel that through Federation the donor has more expectation that his dollar will not be utilized for purposes which are more appropriately the responsibility of government.

It is our experience that the matter of research is viewed as being related to a Federal area of responsibility principally because of the long term duration of projects with possible non-positive results. Because of this the identity of the welfare dollar towards research cannot be fully comprehended by the "donor". The feeling is that whatever benefits accrue as a result of research programmes the whole population is affected and in terms of cost the population as a whole should bear the expense – not only citizens of cities and towns who have recognized the welfare needs of their own community and have established organizations to raise and administer the funds to meet such needs.

A policy statement on research prepared for the National Agency Review Committee by a special committee with outside consultants laid down guide lines for the use of local budget committees, review panels, and the agencies. The National Agency Review Committee, having approved the policy statement, finds justification for the inclusion in agency budgets of research funds which are estimated to be about one per cent of Chest and Fund disbursements. The policy of the Committee in reviewing the national agency budgets submitted to it is to give neither approval nor disapproval of the research estimates, but the committee asks for information about:

- a) the relation between the proposed expenditures and those in immediately preceding years, and a forecast for those in future;
- b) as much description as possible of the research to be undertaken, its relatedness to other projects, with its scope and duration;
- c) evidence of the adequacy and suitability of the research manpower and facilities to be employed.

In general terms, it would appear that such information would be readily forthcoming, yet the value of (b) and (c) for local budget committees appears dubious. The validity of projects would of necessity have to be taken for granted. As research requirements increase, more appropriate machinery would appear to be necessary and might include a statement on current research applications from the Medical Research Council. There is already consultation with the Council by those agencies which support research, and in some cases the Council membership overlaps with that of the agency medical advisory boards.

A further complication arises from the fact that some of the organizations are receiving substantial contributions through bequests, legacies and earmarked donations, and compete with each other in soliciting them.

Where an organization asks a Chest for an allocation for research for a particular project to be conducted or participated in by its own staff (e.g., to assess the value of a service, to study the needs of its clientele), there would seem to be minor difficulty for the federated Fund to determine the validity of this budget allocation. But where the organization wishes to give grants to projects of research workers, or capital grants to develop research facilities, the budgetary problem under federated procedures appears to be insoluble. There would appear to be no valid way of determining the relative need for research in the different areas, i.e., heart as compared with cancer, or of determining an equitable weighting of research funds and operating expenditure within or between organizations. The Funds which in some cases recognize the need for research and public interest in it have no criteria upon which to allocate "a fair share". Their present participation in research may easily create for them greatly increased problems when the welfare organizations decide to move into the field of "welfare research" which has been neglected seriously up to the present time.

In relation to some of the disease entities, so little is known of causation that the desirable focus of research cannot yet be identified, and the hope lies in basic research discovering some clue which can then be followed through in relation to the particular disease. For these diseases a common fund would seem to be preferable to separate funds for specific diseases. Hence there arises a conflict between the basis of appeal to the public which it is hoped will contribute and the rational allocation of the amount raised. There is also general acceptance of the fact that voluntary funds can only raise a small proportion of the money stated to be needed.

For the purposes of this study, Dr. R.F. Farquharson, Chairman of the Canadian Medical Research Council, was consulted. He expressed the opinion that one fund would be preferable to the present method of allocation by different organizations, although he recognized that there was considerable consultation between the medical advisory committees of the awarding bodies. He was in favour of the establishment of a separate fund, rather than the use of the Medical Research Council for this purpose. Inevitably any fund must be controlled by a small group of scientific men, who, also inevitably, have their particular ideas regarding the best use of the available money. To obtain a wider representation of interests and "prejudices", a second general fund might be desirable. This would enable the organizations, and particularly those concerned with diseases about the causes of which little is now known, to pool their resources for basic research and obtain a more effective method of distributing the money. The group controlling the distribution might include specialists interested in each of the diseases with which the organizations are concerned in order to safeguard their interests.

As noted above, the budgetary difficulties of the federated Funds seem to be insoluble, except by the rule of thumb method that a given percentage of all receipts be allocated to research, and that this amount be divided between all the interested organizations. This leaves unsettled the question of how this division should be made.

Federated Funds have already decided that capital campaigns cannot be included in federated financing, partly because of the unevenness of capital requirements among organizations in any year, partly because of the nature of capital expenditure. Research funds (as distinct from a particular research project) might be considered more like capital funds than operating expenditures, particularly with the growing realization that projects or persons must be financed on a continuing rather than an annual basis. It would therefore seem logical to exclude research funds from federated financing, and encourage organizations which have research as one of several objectives and which are members of Chests or United Appeals to conduct separate campaigns for research purposes. To avoid further community-wide appeals, local campaigns might be limited to individual donors and money-raising efforts. A considerable part of the money now raised by the local patient-member organizations comes from such projects. If a common Research Fund for some of the special interests were established, corporations

might be encouraged to give directly to this Fund. The likelihood is that in general their interest is in medical research rather than research regarding a particular disease. The organizations might also be encouraged to reserve all bequests and legacies for research purposes for the general fund, unless such donations were specifically given for other purposes. This would further reduce the competition.

BUDGETARY REVIEWS

As has been noted earlier there are differences within the national (and provincial) organizations in the relationship between the senior body and its units. This has implications for the budget review by federated Funds.

Where the local association is an autonomous body joined with other local groups in a provincial organization, and the provincial organizations then join in a national federation, the local group can be a member of a federated Fund in the same way as any other local agency, with the one difference that its budget will include an assessment to be paid to the provincial organization. The local budgeting problem is then only related to the "fair share" of the provincial and national budgets on which that assessment is made. But the local group is a unit of a provincial or national association; its budget may come from the parent body through an imprest account system, or approved by the parent body, or be the proportion of the money it has raised which the parent body permits it to retain. Here the national budget is the one which controls the organization at all levels. Sometimes the local chapter is expected to pass over all the funds it raises in the provincial or national campaign, and then to raise funds for its local activities as it sees fit (sometimes only with the approval of the method by the senior group). Here are two independent budgets, but only one Chest membership, unless the provincial or national organization is accepted as a separate member. The unit is unable to conform to the Fund's requirement of no other campaign, unless both levels of operation are included in the membership of the local Fund.

Local Funds assess local budgets, having in mind a number of points; the importance of the service to the community, generally reported on by the community planning council where one exists; the standards of administration and service; the budget submission, in relation to the services offered and to the submissions of other agencies; and the goals and eventually the achievements of the campaign. If the Fund is provided with an approval of the provincial or national budget by some body at that level, and is given a provincial or national guide to its "fair share", it can include this amount in its allocation. If a national budget is submitted, without a national or provincial budget review process, the local group must have difficulty in assessing both the total budget and the "fair share". If it does attempt a full budgeting process, it is repeating what is done in every other Fund to which the national group belongs. Obviously, a provincial and/or national budget review becomes very important.

In 1955 the National Agency Review Committee was organized in Canada to assist the national budgeting process. It is staffed by the Canadian Welfare Council, although it is not considered an activity of that organization. Most of its members represent the business community. In 1961, eight organizations submitted their budgets for review, including five of those covered in this study. A growing number of Funds are requiring such submission for an organization which wishes local membership, but the number of agencies participating is still small. The impression is gained from the reports and a comparison with the information obtained for this study that the Committee does not obtain full enough information to make reliable decisions. It may be that the Committee is still so anxious to persuade the national organizations to use it that it hesitates to be critical. It has not developed standards of agency administration, accounting, etc., as has its American counterpart. While the Committee approves of the inclusion of funds for research, it does not seem to have developed any criteria for the amount of which it will approve. The reports regarding the budget submission and recommendations about the formula used to determine a "fair share" for a local fund are circulated to the federated funds and to 180 national corporation presidents.

Some local Funds accept the recommendations of this Committee without further budget review. Small Funds feel particularly incompetent to make judgments on national budgets. Demand has arisen for review of provincial organizations' budgets and NARC has experimented with this in 1963 for the first time. British Columbia has started such a review independently.

The American developments are of interest here, to show the attempts being made to cope with a similar situation. The United Funds and Community Councils of America stress the difference between the national and the local budgeting process as one of support. Whereas the local Fund knows how much money it has and what the demands for that money are, and therefore has a reasonable hope of being fair within one community, the national organization must find its funds across the whole country, through the Funds in which it participates and through its own activities in areas where it conducts its own campaign. Hence the budget review organization must not only approve a budget, but also a plan of support, a method of dividing the request for contributions on a geographic basis. The communities from which the money will come differ not only in their potential contributing ability but in their response to the appeal of a particular organization.

The National Budget and Consultation Committee endeavours to demand standards of the national agencies the budgets of which it approves. The standards are related to the provision in the constitution for membership and democratic control, personnel policies and staff, needs, programme and goals, budget, support plan, co-operation with public and voluntary organizations, nation-local relationships, public education, fund raising and promotion publicity, accounting, public reporting, and periodical evaluation. Some of the organizations covered in the present study would probably not meet the American requirements.

Initiated by the United Funds and Councils of America, the United Health Foundation was launched in 1962 as a national organization prepared to accept funds for research from federated Funds, provided they commit themselves to give three per cent of their campaign returns at present, and to increase this to five per cent in the future. Estimates have been made of the proportion of the total budgets of national agencies which are devoted to research, and local Funds of which these agencies are members may count in their three per cent the appropriate part of their allocation to these agencies. It is argued that when the Fund makes this assessed contribution to research, it can inform the community contributors that they need make no further donations to independent appeals, as they have already paid their "fair share", and that through this process the money will be allocated to research related to "the whole man", be used more effectively and save heavy campaign and administrative costs of numerous organizations. In some parts of the United States, Health Funds of this pattern have already developed locally and regionally. The Foundation is also prepared to provide these bodies with consultation regarding research projects, and to undertake health education on a broad scale to lessen the fragmentation and duplication of effort. The percentage figures are based on the amount of voluntary money now going to research and the estimates of what it will be in 1970.

This move would seem to be an aggressive step to undermine the campaign possibilities of some of the national agencies, and "drive them out of business". In view of the relative lack of provision for research funds in the welfare field, the great need for it, and the present difficulties in providing for other needs, the amount to which funds would be committed for health research seems open to question.

The National Health Council has apparently struggled for life over a period of years, and has been given new impetus by the present criticisms of the multiplicity of health agencies. It has within its membership more than 20 of the national health organizations, a wide range of professional associations, and, as advisory members, various federal government departments. It has recently published a *Manual of Accounting Procedure*,¹⁹ on which it has been working since 1956, and, in co-operation with the National Social Welfare Assembly, and financed by several foundations for a three-year period, is launching a campaign to persuade both health and welfare organizations to adopt a uniform method which will provide the public with an honest and understandable account of their financial operations. This was one of the main recommendations of the "Hamlin Report".²⁰ The criticisms in that report, and the public controversy about it, have caused a great deal of concern in both of the national health and welfare co-ordinating councils, and emphasis upon accounting reform seems to have been given high priority, almost as a defensive measure. Professional accountants are involved in the joint effort,

¹⁹ *Accounting and Financial Reporting Procedures for Voluntary Health Agencies*, op. cit., p. 181.

²⁰ *Voluntary Health and Welfare Agencies in the United States*, N.Y.: The Schoolmasters' Press, 1961.

and consultation is offered to organizations to assist them in adopting the recommended procedures. It is recognized that, with experience, the Manual will need revision, and that adaptation of it for welfare organizations will be necessary.

Another American organization without a Canadian counterpart is the National Information Bureau in New York, established in 1918 as a non-profit institution "dedicated to maintaining and strengthening standards of philanthropy". It provides confidential evaluations of national and international organizations which solicit funds from the public, giving these only to its members in order to protect itself legally. It also provides a special consultative service to members, including the checking of contribution lists for those wishing to insure a wise distribution in their giving. It serves as "a national watchdog to help keep philanthropies in its field true to the ideals and standards that should characterize all charitable organizations". Its membership includes Foundations, Corporations, Chambers of Commerce, United Funds and individuals in about 1,500 communities, and it reports on more than 500 non-profit organizations. The reports include the background of the organization, its purpose, programme, personnel and finances and make an evaluation based on the standards the Bureau has developed. It claims that it "has not only exposed flagrant charity racketeers but also has not hesitated to question the unethical practices of some of the giants in the field".

The statement of basic standards in philanthropy²¹ which the Bureau has developed is as follows:

Philanthropic operations entail a high degree of responsibility because of the element of public trusteeship involved. Compliance with the following basic standards is considered essential for approval by the Bureau:

1. *Board* — An active and responsible governing body, serving without compensation, holding regular meetings, and with effective administrative control.
2. *Purpose* — A legitimate purpose with no avoidable duplication of the work of other sound organizations.
3. *Programme* — Reasonable efficiency in programme management, and reasonable adequacy of resources, both material and personnel.
4. *Co-operation* — Evidence of consultation and co-operation with established agencies in the same or related fields.
5. *Ethical Promotion* — Ethical methods of publicity, promotion and solicitation of funds.
6. *Fund-Raising Practices* —
 - a) No payment of commissions for fund raising.
 - b) No mailing of unordered tickets or merchandise with a request for money in return.
 - c) No general telephone solicitation of the public.
7. *Audit* — Annual audit, prepared by an independent certified public accountant or trust company, showing all income and disbursements, in reasonable detail. New

²¹ *Report: Safeguard We Must The Contributors Trust*, N.Y.: National Information Bureau, 1961.

organizations should provide a certified public accountant's statement that a proper financial system has been installed.

8. *Budget* — Detailed annual budget, translating programme plans into financial terms.

The national Better Business Bureau reports on a wide range of projects and organizations including national ones concerned with health and welfare. It provides information and is not considered to duplicate the work of the National Information Bureau.

These various national organizations are in different ways attempting to meet the present criticism regarding the multiplicity of appeals. To assess the adaptability of their methods to the Canadian situation, recognition must be given to factors which make Canada "different". While it is true that many of the Canadian movements received their incentive from the American counterparts, and are in close touch with them at the national level, they are not replicas of the American organizations. Differences, such as giving ability, population, Foundation funds and public grants, enforce different approaches.

Federated funds have developed under pressure of the business community, irritated by the multiplicity of appeals and frustrated by the problems of dividing the corporation contribution among them. This pressure can be extremely strong, and can be misused. The new Combined Health and Red Cross Appeal in Montreal illustrates the pressure which can be created.

This new organization is running its first campaign in March, 1963. As the health agencies are largely non-sectarian, few of them had been members of the four federated funds. The Board of Trade took the initiative in demanding a combined appeal to reduce the multiplicity of campaigns. It enlisted the support of La Chambre de Commerce, and provided the funds to establish an organization,²² lending its own offices in the first instance for the purpose. Various corporations loaned or donated staff, furniture and office equipment to launch the new body. Twenty-six health organizations were approached and 15 are participating, with the Red Cross Society joining as a partner rather than a member. Of those organizations which are not included, consultation with the Appeal resulted in agreement that participation was not desirable in four instances. The corporations have agreed to inform the others not included that they will give their usual donation in 1963, but not again. The City of Montreal is reported to have refused one such organization a permit to conduct its own campaign, on the grounds that it should have joined the combined effort. It remains to be seen how successful the campaign will be.

This is a current illustration of the exercise of power by the large givers among the corporations, to develop a particular form of fund raising (for very good reasons from their point of view).

²² Twenty-five firms gave \$1,000 each to start the new organization.

People who stress the point that freedom to organize and to promote one's "pet interest" is an essential and highly desirable feature of democracy seem to see no conflict between this philosophy and the efforts of another "democratically organized" body to use high-powered pressures to control the activities. Some who offer strong objections to government control advocate control by a local or national body — or even a small committee — which is not selected by democratic means. This use of control can stultify voluntary participation. Since the budgeting process and the allocation of money determine what an agency shall or shall not do, and since the tendency is to accept what has "always" been done and to question and "cut" in the areas of new development, the process also leads to conservatism, slowness in adapting to changing needs, and discouragement of the implementation of new ideas. It could be considered to some degree the antithesis of the philosophy of the function of voluntary agencies. The very fact that new agencies with expanding programmes do not want to become Fund members and sometimes withdraw from membership because the Fund is unable to meet the financial needs of a rapidly expanding programme illustrates this point.

(2) Public Grants

The definition of a voluntary health organization for this study was based on that used by the National Health Council in the United States, but one characteristic was modified. That definition states: "they are supported primarily by voluntary contributions from the public at large rather than from government sources or endowments".²³ Some of the organizations included in this study receive considerable proportions of their income from public funds. In the *Manual of Accounting Procedures*²⁴ which the National Health Council encourages agencies to use, public funds are entered under the miscellaneous category of sources of revenue. In most of the Canadian organizations they must be given a much more prominent place. Of the total revenue of the organizations of which the annual revenue in 1961 was over \$100,000, public grants amounted to about 13 per cent. This does not include hospitals or rehabilitation centres provided by some of the health organizations and financed for operating costs for in-patient services almost entirely by the Hospital Plans or, in the case of sanatoria, by provincial funds. Neither does it include capital grants.

The figures shown in Tables I and II as public grants are minimal figures. Some of the organizations do not distinguish under the item "fees for patients"

²³ The complete definition of national voluntary health agencies used by the National Health Council gives these distinguishing characteristics: "they are composed of individuals both lay and professional or of associations of both lay and professional individuals, voluntarily and democratically organized on a national basis, the primary or major purpose of which is health-related in that they are organized to combat a particular disease, disability, or group of diseases and disabilities, or to improve or protect the health of a particular group of people — they are supported primarily by voluntary contributions from the public at large rather than from governmental sources or endowments — they engage in programmes of research, education, and service to individuals and communities in their particular sphere of interest."

Voluntaryism and Health. National Health Council, New York, 1962, p. ii.

²⁴ *Op. cit.*

the sources of the payments. The Canadian National Institute for the Blind receives \$145 a year for service to each war-blinded veteran – 351 in 1961, but it omits this in its financial statement as the amount covers the complete cost. It also receives supplementary payments for residents – \$72,500 in Ontario – but the residence costs only appear in its statements as net expenditure. If local figures for the Associations for Retarded Children were available, a considerably larger total of grants would be shown. In Ontario, for example, \$880,000 was given to these associations in 1961.

Service is purchased by the Department of Veterans Affairs and Workmen's Compensation Boards from the Canadian National Institute for the Blind, the Canadian Paraplegic Association, Canadian Arthritis and Rheumatism Society, Victorian Order of Nurses and the Canadian Hearing Society; by the Indian Affairs Branch, mostly for hospital care; by the Civil Defence Service, Health Departments and Departments of Highways from the St. John Ambulance Association; and by provincial and municipal Public Welfare Departments for services to indigents, including children. Some of these payments do not pass through the books of the organization, but are made at the organization's request: e.g., payments for wheel-chairs, prosthetic appliances, home care equipment. The distinction between fees for service and grants is not always clear as the public grant may be considered to be payment for service to the indigent.

Most public grants are for the general work of the organization. Some are given for particular purposes, such as a building, equipment or a special service.

The amount of the grant is occasionally based on a formula. Grants from the provincial or local education authorities to schools for handicapped children may use the formula developed for the regular schools-pupil attendance, and a set sum for each certified teacher. Nova Scotia and New Brunswick base their grants to the branches of the Victorian Order of Nurses on set amounts for the first nurse, somewhat less for the second, and so on. Nova Scotia has worked out a detailed policy for the grants to local community mental health centres, which cover from 80 to 90 per cent of the operating expenses. Ontario has a formula for rehabilitation centres, a base grant of \$10,000 plus 10 per cent of the preceding year's cost of operation, reduced if there is considered to be an "unreasonable surplus". The Victorian Order of Nurses is paid for school health services on an estimate of the hourly cost. One province reported that it tried to relate its grants to the degree of support the public gave to the programme, as evidenced by the amount of voluntary funds it obtained.

The statement provided by British Columbia is the most comprehensive:

1. Basically, we require the presentation of a worthy programme, outlining specific services and/or objectives in a written constitution.
2. The programme must not be presently duplicated by any other similar agency.
3. Grants are given as assistance (not entire support).

4. Grants are to be used for direct services to patients (although some leniency is allowed where an agency has just commenced operations and its administrative costs are accordingly higher than normal).
5. Presentation of financial statements (hereunder) and annual progress reports.
 - (a) Budget — annually
 - (b) Revenue and Expenditures — monthly and annually (audited)
 - (c) Balance sheet — monthly and annually (audited).
6. The ultimate annual grant payment will be dependent on a formula sharing agreement. For example,

Total estimated cost of direct services:	\$10,000
Maximum allocated grant:	3,000
Total actual cost of direct services:	8,000
Total actual grant ($\frac{\$8,000}{\$10,000} \times \$3,000$)	2,400

Legislation is the basis of a few grants. For example, the Charitable Institutions Act in Ontario provides a definite amount per diem per resident. The federal-provincial health grants for capital construction are based on so much per square foot or per bed. Ontario is planning legislation of a similar nature for residences for retarded children. The Ontario Homemaker and Nursing Services Act provides for provincial-municipal payments for these services, setting maximum amounts. Each province has a policy regarding the supplementation of the amount paid from the Blind Persons Allowance for residential care.

A few organizations, particularly patient-member ones, make no approach to government for public grants except for schools.

Some financial statements record under revenue voluntary funds only, and deduct government grants from certain items of expenditure, so that only net expenditure is shown. The casual scanner of the statement would tend to get the impression that the organization received no public money. It is possible that this might be done with intent if the organization thought that by doing so the voluntary giver would be persuaded to be more generous.

Some organizations receive grants from a number of government departments. There is no indication that there is consultation between these departments, and since the Public Accounts are listed by department, the impression may be gained that the organization receives less money than it does. In some cases, the amounts given in the Public Accounts are greater than those which appear in the organization's own statement as "received", since the grant is for the government's fiscal year and a proportion is held in the reserve for the balance of the organization's year.

Where public grants are, in effect, a purchase of service for which the government has assumed responsibility, the actual cost of service is the logical formula. The Victorian Order of Nurses seems to have worked this out most

effectively. It charges on a time-unit basis when the service is given in a clinic, school or industrial firm, and on a cost-per-visit basis for service in the home, basing the calculation on a formula developed by the American League for Nursing. The unit costs are probably too low, since the division of responsibility and of finances between the national and the local offices complicates the calculation.

The provincial Departments of Health were asked to provide figures of their grants to voluntary health organizations as defined in this study. The information was secured from only five of them, but this is sufficient to demonstrate the trend. Table VII shows that from 1945 to 1960 the grants increased from \$87,684 to \$1,820,949 and that the number of organizations to which they were given increased from 11 to 62. Two provinces which showed the sources of grants included the federal health grants in these totals. Grants increased heavily in 1960 and again in 1961. The Heart Foundation received from Ontario (including federal grants) \$196,840 in 1955, \$239,858 in 1960, \$243,955 in 1961. British Columbia gave the Cancer Society \$432,971 in 1955 and \$590,056 in 1960. Nova Scotia gave this Society nothing in 1955, \$151,937 in 1960 and \$32,923 in 1961.

TABLE VII
GRANTS FROM PROVINCIAL DEPARTMENTS OF HEALTH
TO VOLUNTARY HEALTH ORGANIZATIONS, 1945-1961

	1945		1950		1955		1960		1961	
	No.		No.		No.		No.		No.	
	Amount	Org.	Amount	Org.	Amount	Org.	Amount	Org.	Amount	Org.
	\$		\$		\$		\$		\$	
British Columbia	12,000	1	317,720	4	686,877	4	961,959	6	Not available	
New Brunswick	35,000	2	16,300	4	42,800	5	34,433	7	54,440	7
Newfoundland	5,000	1	32,500	2	27,000	3	49,750	8	50,400	7
Nova Scotia ^a	16,200	3	38,080	8	34,892	9	328,371	18	282,570	23
Ontario	50,984	4	58,500	6	526,088	18	446,436	23	594,974	27
Total	87,684	11	463,100	24	1,317,657	39	1,820,949	62	Incomplete	

^a Includes grants from Health Departments and Provincial Treasurers.

In some instances, such as Red Cross hospitals, nominal grants of \$25 are given in order that they be 'officially recognized' as hospitals for such reasons as exemption from sales taxes.

The provincial Health Departments were also asked about the official relationship between their departments and the organizations. Nova Scotia reported representatives of eight of the voluntary organizations on the Advisory Committees on Health Grants. Officials of the Department are on the medical advisory committees of three of the organizations, and on the Executive or Board of 14 others. Eight of these are the local community mental health centres on each of which the Administrator of Mental Health Services sits ex-officio. Local directors of health

units are all members of the Medical Advisory Committee of the Tuberculosis Association, and ex-officio executive members of the local association. The nursing supervisors are also members of these local groups.

Although high-ranking official staff in Ontario are active in some of the organizations, they act as individuals and not as representatives of the government. It may be difficult for the organizations or the public to distinguish between the government positions of the officials and their private roles.

(3) Grants from Charitable Foundations

For the purposes of this study letters were sent to 71 Canadian foundations, public and private, asking for information regarding their support of health agencies. Replies were received from 45 of these. Some of them gave little or no information. Nine had given few or no grants, or none in the field of health. One replied that the compilation of the information would take too much time.

Seven foundations did not wish to provide information. One stated: "The Foundation does not publish information with regard to any of its grants or donations. This policy has been in effect since the formation of the Foundation and it is, therefore, impossible for us to complete the questionnaire". Another letter said that the accounts were not published and "The Foundation does not keep a record of the category to which a grant may be applied".

Twenty-four foundations supplied material as requested, and of these it was possible to compile comparable information from 19. About half of these requested that the material should not be identified. The details of the replies are given because they raise the question of the extent to which both private and public foundations should regard themselves as contributors to community planning, and therefore responsible to some degree to the community for the way in which their funds are used.

Fig. 3 provides an analysis of the reported grants, from 1945 to 1961, by five-year intervals. The total grants to all organizations increased steadily from \$67,000 in 1945 to \$2,174,000 in 1961. Grants to health organizations, including hospitals, declined in the period following 1955. As these were largely for capital construction, it is probable that the federal health grants affected the amount requested. Grants to voluntary health organizations, including some research grants paid direct to universities, increased in amount and fluctuated between 5 and 10 per cent of the total grants to all organizations. These figures do not include research grants paid to hospitals where this could be distinguished. This item was \$15,500 in 1960 and 1961.

Research grants have been a favoured designation of foundation awards to health organizations. Fig. 4 shows that the rapid increase took place after 1955, reaching \$124,000 in 1961. Most of these awards went to medical schools, some

of them to the United States. The grants for capital construction in 1961 were \$76,000 less than the 1955 total, but these grants were relatively small, and one of \$50,000 to the Canadian National Institute for the Blind in the earlier year affected that figure.

FIGURE - 3

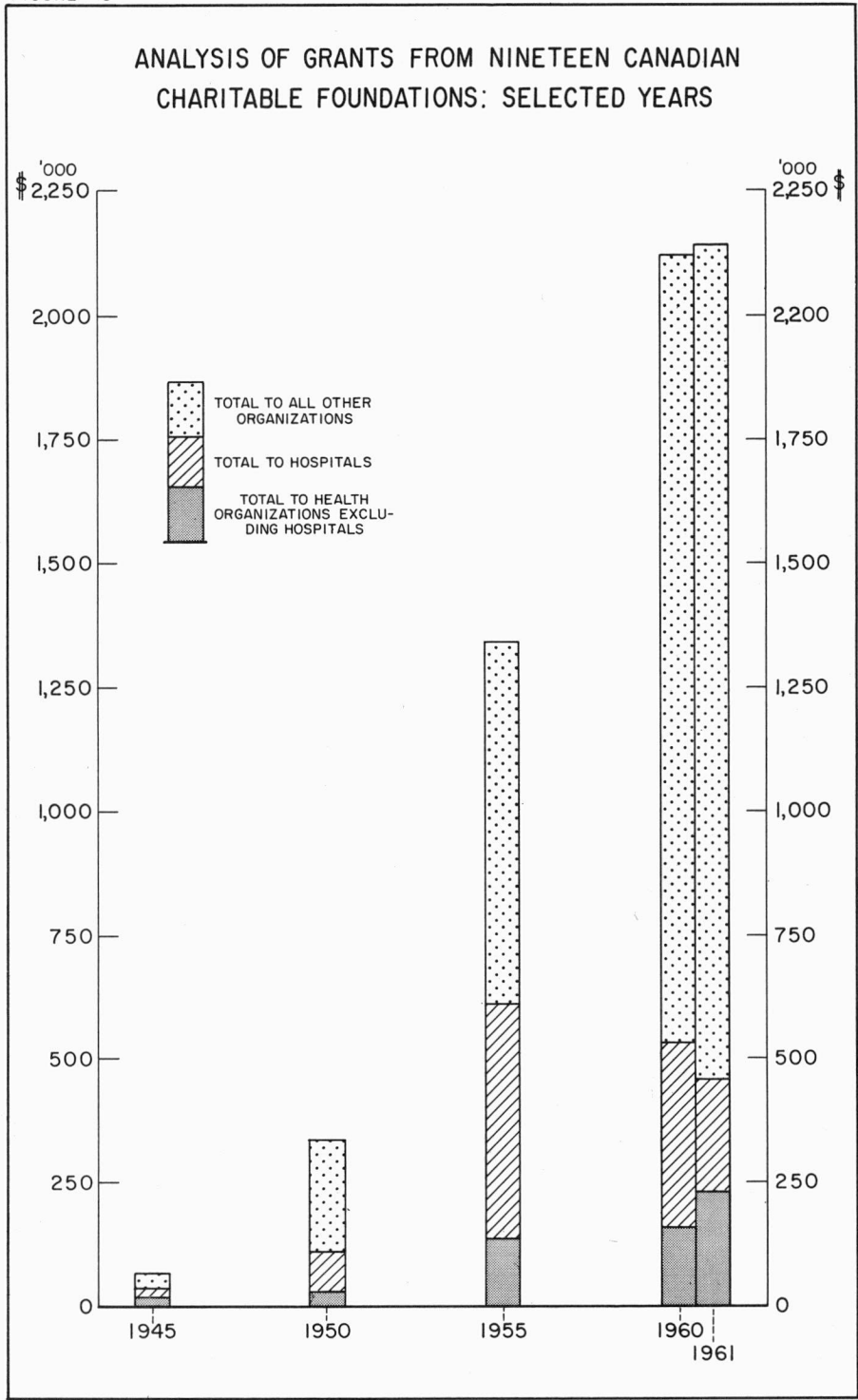


FIGURE -4

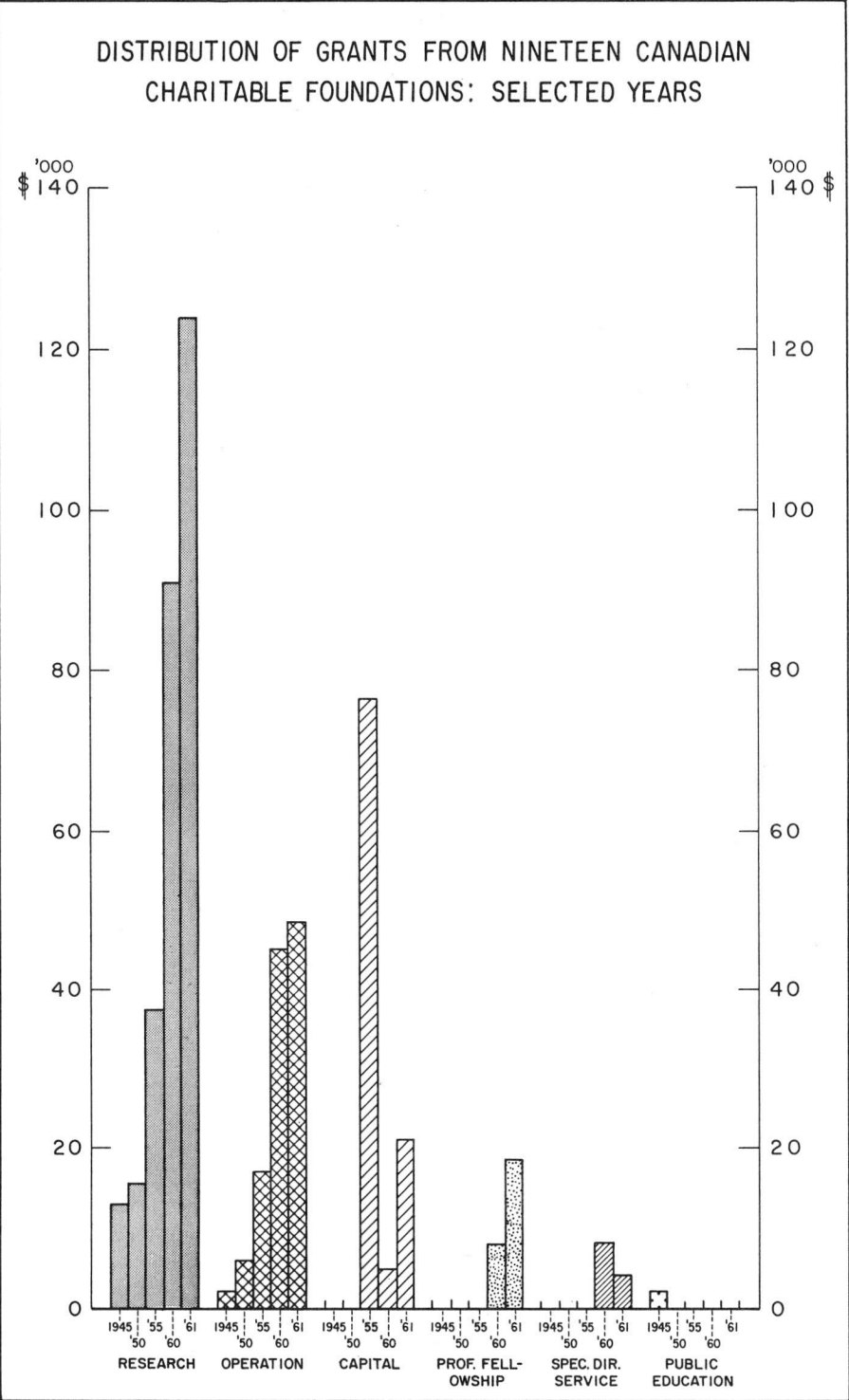
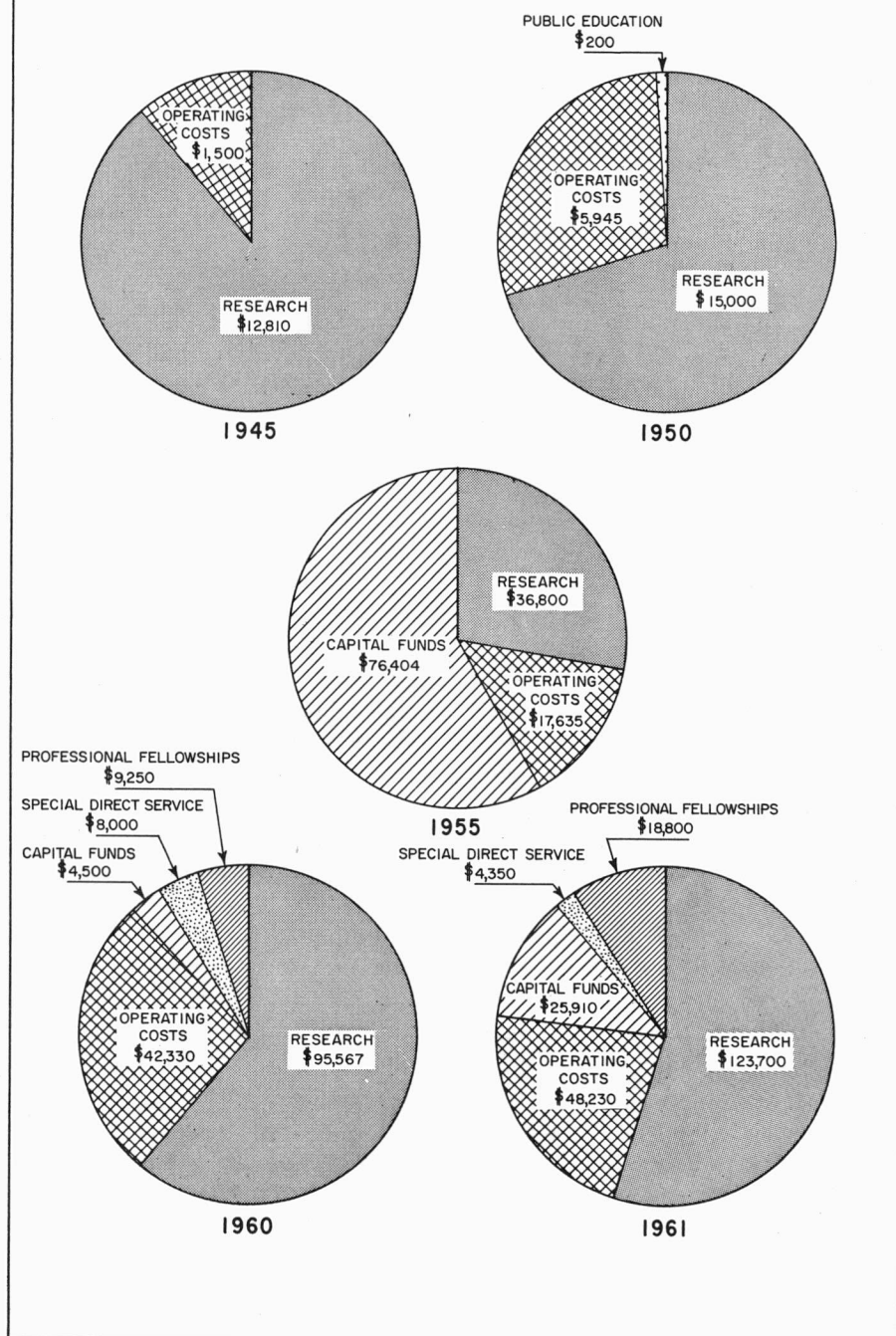


FIGURE — 5

DISTRIBUTION OF GRANTS FROM NINETEEN CANADIAN CHARITABLE FOUNDATIONS: SELECTED YEARS



Professional fellowships and training grants are relatively new for these foundations — \$9,000 in 1960 and \$19,000 in 1961. It is known that another foundation, not included in these figures, gives a considerable amount for this purpose each year. The Victorian Order of Nurses bursary fund is a major beneficiary in this category.

Direct service projects have received little and public education has received virtually no support from foundations.

Fig. 5 presents graphically the fluctuations in grants for each of these purposes over the period. The dominant interest in research is evident. These figures represent only a small proportion of the foundations in Canada, and they cannot be taken as representative.

When charitable foundations apply for incorporation at the federal level and are identified with an individual or family, their objectives are limited to aiding and assisting charitable activities. If they engage directly in operating a charity, "we demand very full information respecting the type of activity to be undertaken, the need thereof, and information regarding the ability and experience of the applicants to implement these objects. Almost invariably we find that the applicants do not intend to operate a charity as such but really seek incorporation for matters that are related to taxation". In reply to a question regarding the foundations' legal right to refuse to discuss information of their activities, "they are really private organizations and apart from the tax implications not directly accountable to anyone".²⁵

Although no study was made of provincial incorporation, it is known that such legal recognition places restrictions upon the expenditure of the money outside the province in which the foundation is incorporated, probably because of the problems regarding succession duties, etc. This makes it difficult for such foundations to make grants to national organizations. The Ontario legislation is concerned with insuring that the income is spent and not added to the reserves.

The increase in both private and community foundations has been considerable in the last 20 years, and there is suspicion that some at least of the private ones are created for taxation purposes. Although the funds could make a very useful contribution to community health (and other interests), the trustees of many of the private funds seem to regard their operations as a personal matter and do not develop policies regarding their grants. Some of the large public foundations distribute annual reports to the public and regard themselves as being in a position to inform the community and to use the money to develop community interest and activity. One such Foundation, for example, gives a grant to an organization which does not really need it, because a condition of the grant is the submission of the

²⁵ Letter dated November 27, 1962, signed by R.E. Curran, Legal Advisor, Department of National Health and Welfare, Ottawa.

annual financial statement. Thus, it argues, a community group can keep an eye on the organization's activities. This Foundation also has used its power to give money as a method of persuading other groups, such as the government, to give financial support on a matching basis. It sees its function as an important influence in sound community planning.

Although foundations in Canada play a very small part as compared with those in the United States, they could be more influential if they recognized a responsibility to use their influence to support wise community planning. For this, an attitude to the public different from that displayed by the majority would be necessary. The Community Foundation movement in the United States seems to be developing such an attitude, but at this point it appears in Canada only in two or three notable exceptions.

(4) Indirect Donations to Campaigns

Deductions from Taxable Income

The provision in the personal and corporate income tax regulations that charitable donations up to a maximum percentage of taxable income may be deducted gives public encouragement to charitable giving and what may be called an indirect subsidy to the voluntary agencies. Because the individual taxpayer can choose between a flat rate deduction of \$100 including medical expenditures and requiring no receipts, and the detailed enumeration for higher claims, statistics on total charitable giving can not be obtained. Some federated funds use the regulations regarding the deduction to try to obtain larger donations – the “loss” to the giver is less than the amount given, because of the reduction in the taxable income and hence in the tax. In the United States the expressed concern that proposed tax changes may affect the “incentive” to give, implies that charitable donations are made, in part, to deprive the government of some taxes.

The Department of National Revenue has provided the following details regarding the way in which these regulations work.²⁶

The term “charitable” or “charitable organization” is not defined in the Income Tax Act. It is therefore necessary to look to the general law regarding the meaning of “charitable” and “charity”. Generally speaking the meaning to be attributed to “charitable” is, that the activity must aim at

- a) the relief of poverty,
- b) the advancement of religion,
- c) the advancement of education,
- d) other purposes beneficial to the community as a whole and analogous to the three other purposes stated.

A charitable organization is thus an organized body created for the promotion of some object of a charitable nature within any of the four general categories established as common law and set out above, and actually functioning as such

²⁶ Information obtained from a letter dated January 18, 1963, signed by D.R. Pook, Chief Technical Officer, Assessments Branch, Taxation Division, Department of National Revenue, Ottawa.

In order that a charitable organization — incorporated or not — may be entitled to exemption from income tax, and further, in order that gifts to that organization may be recognized as deductions from income, two requirements must be met by the organization:

- a) All its resources must be devoted to charitable activities which the organization carries on itself, and
- b) No part of the income must be payable to or otherwise available for the personal benefit of any proprietor, member or shareholder of the organization.

The Act does not require that an organization apply to be recognized as a charitable organization, but many do. They are then asked to complete a form listing details regarding officers, the purposes for which the funds are to be raised, the time of the campaign, the amount expected to be raised, a breakdown of the costs of collection and the names, addresses and occupations of "each person who will hold the money collected and the name in which the property or assets will be registered". On the basis of this information,

if we agree that the organization is a charitable organization, then our District Offices are notified accordingly. There is no set procedure for reviewing the actual operations of a charitable organization after it has been approved. In the case of any charitable organization, however, that on review is found not to be functioning as such, action will be taken. Donations made to 'non-profit corporations' or 'charitable trusts' are deductible in the same way. Approval of charitable foundations follows the same procedure as outlined above.

Information Bulletin No. 17,²⁷ issued by the Department for the guidance of charitable organizations states that:

Qualification as a charitable organization is a matter of law and in doubtful cases the Taxation Division is prepared to offer its opinion on application.... Receipts should be signed by a duly authorized officer of the organization and, in order to properly control their issuance, should preferably be serially numbered. ...Charitable organizations which issue receipts for tax purposes should have available for inspection sufficient records to permit the verification of the authenticity of the receipts and of the nature of the donation.

It is apparent that many of the voluntary health organizations discussed here would not qualify as "charitable organizations" under the strict application of the definition, except as "other purposes beneficial to the community". Some of them insist they are not charitable organizations and give this as the reason that they are not in federated funds. Many would not seem to qualify either under the requirement that "all its resources must be devoted to charitable activities which the organization carries on itself", since they give grants to other organizations and to research. Some would not seem to qualify under the second requirement, since the Executive Director in the Health League, for example, and the Commissioners in the Priory of St. John, are members of the controlling Boards.

²⁷ Information Bulletin No. 17, "Charitable Donations", Taxation Division, Department of National Revenue, 14th December, 1962.

Either this official statement of policy is not being implemented or the Department does not have sufficient information to judge.

Some of the organizations expressed concern regarding fulfilling the requirements about receipts, since it appeared very important to them that their donors should qualify for tax deductions. Thus the Multiple Sclerosis Society only issues permanent receipts from the national office, and the Muscular Dystrophy Association centralizes the issuance of receipt books, which have to be returned to the national office for the filing of the duplicate.

These comments are not made to suggest that deductions should not be permitted, but rather that the definitions and the method of approval are inappropriate in 1963. "Charity" is no longer limited to "the relief of poverty", and many of the health and welfare organizations, including those in federated funds, would not qualify under this definition. A Taxation Division is not competent to determine whether an organization fulfils the requirements stated. It is suggested that a revision of the definitions, the requirements, and the means of assessing them is overdue.

Publicity through Mass Media

Campaigns are given immeasurable assistance by radio, television and newspapers. The Board of Broadcast Governors has no policy regarding public service broadcasting and each station or network makes its own decisions. The only regulation is one forbidding any station or network operator to broadcast "any appeal for donations or subscriptions in money or kind on behalf of any person or organization other than...a recognized charitable institution or organization",²⁸ except with the consent in writing of a representative of the Board. The Board considers that "stations are in a better position to recognize public service needs in their own community than is this Board, from a centralized position, able to lay down rules for public service broadcasting."²⁹

The Supervisor of Institutional Broadcasts for the Canadian Broadcasting Corporation in Toronto reported that decisions regarding such broadcasts were made internally, with some consultation with federal and provincial departmental officials when this was thought desirable. No formal policy or procedure has been established, but the work being done by an organization in the community and its plans for spending the money raised are taken into account. Assistance to the voluntary organizations is considered part of the Corporation's function, and although no reliable estimate can be given of the value of the time (because it is not known how many private stations use the network broadcasts), it would be several million dollars a year.³⁰ Some private stations give local agencies receipted invoices to enable them to make an estimate.

²⁸ Radio (AM) Broadcasting and Radio (TV) Broadcasting Regulations, Section 5(1) (h).

²⁹ Information from a letter dated November 7, 1962, signed by W.D. Mills, Secretary, Board of Broadcasting Governors.

³⁰ This includes a wide range of voluntary organizations and not only those concerned with health.

Some organizations which want coverage for their campaigns invite the officials of the corporation to their planning meetings, and a decision is made regarding the most effective and appropriate use of television and radio in relation to the particular campaign. While some publicity may be given around the year, emphasis is placed on a particular organization during the month of its campaign. Material is prepared for national, regional and local use, and the amount of time is determined roughly by "the importance of the agency". Thus the Society for Crippled Children has the "Easter Parade" programme while the Muscular Dystrophy Association is "mentioned" in spot announcements.

Private stations appear to give a great deal of publicity to organizations providing local service. The Ontario Association for Retarded Children had a Telethon programme for 18 consecutive hours on one station, and raised the sum of \$190,000 in this way.

The question of free newspaper coverage was raised with the three leading dailies in the Toronto area. One of them³¹ reported as follows:

The Globe and Mail has always felt that it has a responsibility to the community to record the efforts and accomplishments of voluntary health organizations which are doing worthwhile work in Canada. We do not look upon such coverage as publicity. Really worthwhile organizations make news. They do make news when they raise funds and they make news when they spend those funds. We are never very receptive to ideas involving out and out plugs on behalf of any organization, no matter how good its intentions may be. On the other hand, groups such as the Cancer Society often make available to newspapers human interest stories and educational material which have a genuine value for our readers.

If someone comes to us and says "How about some free publicity?" we invariably say "No". If they come to us with a legitimate piece of news, we will give it the space and the display which it merits. What we might offer in the way of opinion in our editorial column on Page 6 would result from the impression made upon our editors by the news reports we have carried in other parts of the paper.

There is no relationship at the Globe and Mail between editorial and advertising policy.

The policy of the Toronto Star³² is:

to publicize worthy causes, ... by means of news stories or features. In particularly worthy causes there might also be an editorial. The paper, of course, takes steps to make sure the cause is worthwhile and the amount of publicity is decided by the editorial director or the executive news editor.

The same policy was reported by the Telegram.

One paper stated in addition that a director might have a personal interest in a particular organization and ask it to be given special support. The most

³¹ Quoted from a letter signed by R.J. Doyle, Managing Editor, The Globe and Mail, February 6, 1963.

³² Quoted from a letter signed by J.V. Kingsbury, Executive Editor, Toronto Star, dated February 12, 1963.

effective support, in addition to news items, was considered to be mention over a period of time by columnists who were read regularly by the readers. In this way readers interested in other matters had their attention drawn to the organization and its campaign.

Advertising follows the same policy in all three papers. It is a business matter and no free publicity is given. If an advertiser wishes to use his space to support an organization, he can do so at the regular rate. One paper reported that "Before accepting advertising from non-profit organizations with whom we are not familiar, it is our policy to check with the Toronto Better Business Bureau. In matters where health is concerned, we would also check with our local M.O.H. or the Minister of Health and Welfare".

The National Information Bureau³³ in New York, which provides an evaluation of national agencies to its members, has within its membership the Advertising Council. It reports that national periodicals, the New York Times and broadcasting systems use its services to determine whether publicity should be given to a national health or welfare organization. Canada has no such organization.

E. EXPENDITURE

(1) Statements of Disbursements

Because of the variety of the organizations' activities and the different ways in which the expenditure statements are drawn up, it is impossible to make any detailed comments on this matter. Some statements itemize disbursements under such headings as salaries, travel, etc., while others divide them by services, e.g., "rehabilitation" including salaries and all other expenses attributable to this activity. The only area in which expenditure on one item could be ascertained was "research and fellowships."³⁴

The national and provincial organizations which prepare consolidated statements or approve local budgets devise forms for the use of all units. The Cancer Society has a detailed accounting manual for the use of its branches, giving instructions regarding the pro-rating of such costs as travel between the functions of education, welfare, campaign and overhead. The percentage distributions appear to be arbitrary but the general pattern is devised to produce uniform records for a reliable national statement.

In some expenditure statements – corresponding to the practice in their revenue statements – gross expenditure is listed with a deduction of revenue for a particular item, and only the net figure carried into the totals. The revenue

³³ See also p. 122.

³⁴ See p. 75 ff.

deducted may be government grants, patients' fees, sale of goods, etc. The totals thus give a misleading picture of the amount of the organization's business and, correspondingly, of the sources of their revenue.

Some statements enter under operating revenue depreciation charges without a corresponding receipt entry in the assets statement, or enter transfers of surpluses to reserves without providing a balance sheet. Where this is done before the totalling of the expenditure and the subtraction of this total from the receipts, it gives the appearance of a considerably reduced surplus, or in some cases, records a deficit which is very misleading to the layman who glances over the balances.

(2) Reduction in Costs through Tax Exemption

The costs to the agencies are sometimes reduced by exemption from certain taxes. At the federal level, exemption from sales tax is provided for "articles and materials for the sole use of any *bona fide* public hospital certified to be such by the Department of National Health and Welfare, when purchased in good faith for use exclusively by the said hospital and not for resale."³⁵ This exemption

has been extended to drugs supplied by a *bona fide* hospital to patients, including patients attending the Dispensary or Out-Patient Department, in cases where the charge made by the hospital to the patient does not exceed the purchase price of the drugs by the hospital, plus 10%. Where, however, the charge made to the patient for drugs and medicines supplied exceeds by more than 10% the hospital's purchase price, the sales tax may be accounted for on the basis of 11/111ths of the charge made unless the tax is charged separately, in which case the amount of tax charged should be remitted to the Department.

An institution certified by the federal Department of National Health and Welfare as "a *bona fide* public institution whose principal purpose is to provide shelter and care for children or aged, infirm or incapacitated persons who reside in the institution", and which is in receipt of aid annually from the federal or a provincial government for the maintenance of the inmates, may claim a reimbursement of the sales tax paid on purchases of goods for its own use and not for resale.³⁶ "There is no exemption provided for charitable organizations providing medical equipment to persons remaining in their own homes."

Free entry is given to any importer under the tariff regulations for a variety of drugs, prosthetic devices and equipment required by disabled persons, including items used by or given to patients by many of the health organizations – vaccines, insulin, etc.; artificial limbs and braces; hearing aids; specially constructed boots; wheelchairs and crutches. The list also includes containers used in the Blood

³⁵ Information quoted throughout this section was provided in a letter dated January 8, 1963, signed by P.P. Last, A/General Executive Assistant, Department of National Revenue, Ottawa.

³⁶ This provision is met in one province by the government giving \$25 to organizations to enable them to qualify.

Transfusion Services. Articles for training the mentally retarded are free when imported by a school, association or institution for the training of this group.

All articles specially designed for the use of the blind, whether for educational, recreational, industrial, personal or other purposes, when for blind persons and imported by, or on the order of or certificate of, the Canadian National Institute for the Blind, or other *bona fide* institution or association for the blind are exempt.

This is the only clause mentioning a specific organization. These articles and some others are "unconditionally exempted from sales tax under the Excise Tax Act".

It is obvious that articles which can be imported without duty are those essential for the care and comfort of the handicapped or ill person, and they do not constitute an indirect subsidy to the health organizations. The exemption from sales tax of drugs provided by out-patient departments of hospitals also benefits the patient. It was probably instituted at a time when out-patient departments were the main source of medical care for indigent persons. As patients are increasingly provided with medical care by private practitioners, as is now the situation in many provinces, consideration should be given to the manner in which the same relief regarding the costs of drugs might be provided under other systems of indigent care.

F. ACCOUNTABILITY TO THE PUBLIC

A basic principle accepted by reputable organizations is that the expenditure of money solicited from the public should be accounted for to the donors. To some extent this principle is enforced by government in its efforts to protect the citizen's interests. Federated funds account to their public for the disbursement of the money they have raised.

(1) Public Control of Incorporation

When an organization applies for incorporation under the federal Companies Act as a non-profit organization and is related to any aspect of health or welfare, the application is referred by Cabinet directive to the Department of National Health and Welfare.³⁷ Unless a favourable report is made, Letters Patent are not granted. The Department has developed certain "policy principles" to guide its assessment. It secures information on the applicants, the need for a new organization, and the extent to which the programme has been developed. It might recommend deferring the issue of Letters Patent until an assessment can be made on the basis of demonstrated experience. "If we are of the opinion that a field sought is substantially occupied by one or more responsible organizations, we might very well recommend against the issue of Letters Patent until such time as the need

³⁷ Information in this section is taken from a letter dated November 27, 1962, signed by R.E. Curran, Legal Advisor, Department of National Health and Welfare, Ottawa.

for an additional agency had been established." The policy is developed by the Department and not by legislation, since "the issue of Letters Patent is largely an exercise of the royal prerogative and not directly a matter of legal right. ...Before the institution of this policy of prior review of applications for Letters Patent of Incorporation where the objects dealt with matters of health or welfare, situations afterwards sometimes came to light where the objects authorized by the Letters Patent were inconsistent with the best interests of the public of Canada. ...Once Letters Patent have been issued, there is no further check or supervision."

The corporation must file an annual statement containing information regarding the names and addresses of the directors and officers and the location of the head office, but no financial statement is required, nor is an audit demanded. "In the public interest, action could be taken to revoke the incorporation." The federal government is not involved in any way with organizations which are not incorporated federally, except in income tax deductions. The only occasion in which it has exercised control over national appeals was under the War Charities Act, which has since been repealed. No federal legislation requires an accounting to the public for funds raised.

(2) Public Control of Financial Campaigns

Some of the provincial legislation exercises a degree of control over incorporated organizations. Thus the Societies Acts in British Columbia³⁸ and Saskatchewan³⁹ require that organizations file an annual financial statement, and give the Registrar power to refuse to grant incorporation if he is not satisfied, and to revoke and cancel it at his discretion. These Acts make provision for appeal regarding the decision. The Public Contributions Act in Alberta⁴⁰ applying to both incorporated and unincorporated groups prohibits campaigning without a permit, and holds the organization accountable for the donations received. That the Minister may order the publication of information relating to the organization or the campaign if he deems this to be in the public interest. The Charities Accounting Act in Ontario,⁴¹ applying to incorporated charitable organizations and to trustees administering bequests, but excluding religious and fraternal bodies, gives to the county or district court the authority to empower the Public Trustee to make an investigation and to report to it and to the Attorney General, on the complaint of any person regarding the collection or disposition of funds solicited from the public.

³⁸ R.S.B.C. 1960, c. 363.

³⁹ R.S.S. 1959, c. 30.

⁴⁰ R.S.A. 1955, c. 253.

⁴¹ R.S.O. 1960, c.52.

Manitoba's approach is rather different. The Charities Endorsement Act⁴² prohibits canvassing for charitable purposes (with certain exceptions), unless authority is obtained from the Provincial Secretary, the Civic Charities Endorsement Bureau of the City of Winnipeg, or the mayor or reeve of any other municipality.

In some other provinces municipalities have passed by-laws requiring organizations to obtain permits for public campaigns. This is often merely a way of distributing appeals over the year, allocating dates for tag days, etc., and may involve no actual control. In some municipalities, such as Montreal and Winnipeg, a degree of control is exercised.

By Montreal's by-law,⁴³ "every charitable, benevolent, religious or national institution, society or association whatsoever which intends to solicit or gather gifts or alms in money or in kind" must file a declaration at the Municipal Assistance Division giving details of its objects, office, officers and administrators, and of the persons appointed to solicit "and the conditions of their engagement". Each institution must make an annual sworn report showing the work it has done in the past year, and is prohibited from soliciting unless it is issued a permit. "The permit...shall be granted only upon delivery of a copy of a written agreement with the beneficiary charitable organization or organizations, which shall receive a minimum of 75 per cent of the gross receipts realized." The percentage may, however, be reduced to 50 per cent if artists are paid. A sworn report of receipts and expenditure and of the receipt by the organization of the amount paid to it must be submitted within 30 days. A penalty of a fine of a maximum of \$40 or of imprisonment up to 60 days is provided.

An annual report of the permits issued, the dollar objective of each campaign, the form of the money-raising project, gross receipts, expenses, net receipts and the percentage of the expenses is prepared by the City. The "Gazette" on September 22, 1962, published all these details for 104 subscription campaigns, including those of the four federations. The total of the objectives was \$24,400,000 and almost \$16,000,000 was raised. The average per cent of expenses was 7.47, 15 organizations reported more than 25 per cent, and 9 more than 50 per cent. In 1961, 959 permits were given and 26 refused. Probably the publication of these results is more effective as a control than any other procedure would be. The Report⁴⁴ advises the public: "Be sure that the object is meritorious. Be careful not to be taken in. *BEFORE* subscribing, obtain information....Do not fail to notify our office of any collector who cannot prove his good faith by showing the regular municipal permit, issued by the Social Welfare

⁴² R.S.M. 1956, c.5.

⁴³ City of Montreal, by-law concerning tag-days and other collections for charitable purposes and mendicancy, No. 1447 (adopted 18th August 1937).

⁴⁴ City of Montreal, Department of Social Welfare, Municipal By-Law 1447: Statistics Year 1961. (Mimeo.)

Department of the City. ...Give GENEROUSLY but give WISELY." Each month the newspapers are provided with the lists of organizations which have received permits to canvas during that period. An organization wishing to conduct a campaign through Greater Montreal must obtain a separate permit from each municipality.

Some American county or municipal solicitation committees have refused to approve appeals which are independent of federated financing. This does not prevent the organization from conducting the appeal, but would certainly affect the public response to it.

(3) Voluntary Control

Some Chests and United Appeals publish in the daily press summaries of the financial statements of their member agencies. In Winnipeg, a recent policy decision has admitted the press to the budget review sessions, and full publicity in the papers has been the result. This is applying to the private sector of agency financing a principle which has long been recognized in democratic government — that the people who provide the money should know how it is spent in order to exercise ultimate control.

Some of the organizations recognize this principle in their constitutions (e.g., the Priory of St. John requires reporting to the donors of the way in which their money has been spent). In contrast, one organization has a clause limiting access to the books to Board members, except by special resolution of the Board.

The discussion in this chapter suggests that, even when the principle is accepted in theory, most of the organizations present their financial statements in forms which do not give contributors the opportunity to determine the validity of the expenditure. Some of the annual reports give no financial statements, and one organization commented that it was useless to do so, as the public could not understand. Some give a nominal statement, so summarized that its value is lost. Occasionally this consists only of a graphic representation of the division of the contributed dollar, together with the total expenditure. Many of the organizations, providing an income and expenditure statement, give no balance sheet and no treasurer's report. Some of those which do not publish a full statement offer to provide one for any interested person. A few organizations hesitated to provide their material for the present study, and in one case the Executive Director insisted that financial reporting to its national Board was only verbal and no statement existed. In very many instances, the publized financial statements require further explanation before they can be understood. When an explanation was requested in one instance, an executive seemed to be insulted, and replied hotly that the statement had been audited. An auditor's function is not to ensure that the statement can be interpreted by the public. Although some organizations say publicly that they "operate in a shop window", the window does not always provide the necessary light.

Accountability includes the requirement that the money be spent for the purposes for which it is given. It has been noted that, while some national organizations, like the Canadian Tuberculosis Association, are very conscious of this, they have difficulty in enforcing it on local associations. The pooling of funds of two campaigns by Societies for Crippled Children and Adults renders this form of accounting impossible.⁴⁵ The failure of the Sanatorium Boards in Saskatchewan and Manitoba to distinguish clearly in their financial statements the expenditure of the voluntary funds raises the same criticism. In some organizations with a surplus of funds, the efforts to spend the money raises questions as to whether the disbursements fall within the objects of the societies.

The Canadian situation is open to the same criticism levied at the American organizations:

Voluntary agencies derive their support primarily from the public, and have a duty to disclose fully those activities that do not involve confidential relationships with clients. Failure to give accurate and complete information is a breach of the agency's fiduciary responsibility to its supporting public. The public as the investor in an agency has the *right* to know the facts. The agency as the recipient of public funds has the *duty* to disclose fully to those who invest in its activities.

This duty of full disclosure has not been carried out by some agencies. A few have even unjustifiably denied this obligation. Others have provided misleading information.

The Ad Hoc Committee believes the public should withhold support from any agency that fails or refuses to disclose information or that misleads by the material it provides. Such an agency is not fulfilling its public responsibility.⁴⁶

As noted above, American national co-ordinating bodies are engaged in concentrated action to try to remedy this situation. If Canada undertook to do likewise, it would have the benefit of the accounting manual already published.

The principle of accountability is, of course, not limited to finances. It demands also that accountability be applied to all forms of agency reporting and to its publicity material. While some of the material seen for this study is definitely misleading and even contradictory,⁴⁷ it could not be called untruthful. The

⁴⁵ As noted earlier, the Canadian Foundation provides a breakdown although the provincial Societies for Crippled Children and Adults say the funds are pooled.

⁴⁶ *Voluntary Health and Welfare Agencies*, op. cit., pp. 12-13.

⁴⁷ One organization, concerned with a disease of which the incidence is unknown, uses three different figures for its estimate in publicity material: the highest is three times the lowest.

effect of the "salesmanship" component is to emphasize what will motivate the public to give, to underemphasize other matters, and to word material ambiguously so that it cannot be classified as "false". A salesman must always have the "customer" in mind and his effort is to sell his product in the best light. In the conflict between the principle of accountability and the goal of raising the money, the principle should be given priority.

The material related to public grants also raises questions of the application of the principle by some of the public bodies. Whether the money is given as a lump sum or on a "fee for service" basis, the public authority should demand an accounting of its use, to fulfil its own responsibility. In some instances this is undoubtedly required. In others, there is no indication that this is the case. Sometimes the support by government of the activities of an organization seems to be disguised in the public accounts. Where grants are given by different departments of government, and hence appear separately in the accounts, considerable work is necessary to ascertain the total contribution a government makes. Where the organization also presents its statements in a way which appears to minimize the public contribution, the taxpayer is again misled.

In the course of this study, a comment was received to the effect that the public assumes that governmental officials and politicians sometimes try to use public money for unauthorized or unethical purposes, and it assumes, in contrast, that people devoting time and energy to a non-profit organization are universally ethical in their handling of its affairs. Hence the public does not demand an accounting or look too closely at the operations of private organizations. Such an assumption is naive. It ignores the "salesmanship" factor, the conviction of some leaders that the "end justifies the means", and the realistic fact that some of the leaders find in the "manipulation" of agency business, the outlet for their cravings for power. It must also be recognized that many people make donations to the canvassers with little or no knowledge of the organization to which they are entrusting their charitable gifts.

If the principle of accountability is accepted, the difficult question lies in the decision as to its method of enforcement.

INTERRELATIONSHIPS

The purposes, structure, activities and finances of the voluntary organizations have been discussed up to this point in general terms, using particular agencies to illustrate the material but emphasizing the whole complex rather than its discrete units. Comments have been made regarding this general picture. It is necessary now to look more specifically at the interrelationship of these organizations. Most of the questions relate to overlapping or duplication of services, adjustment to changing conditions and co-ordination.

ORGANIZATIONS WITH BROAD OBJECTIVES

Three national organizations define their objectives so broadly in relation to "health" and "suffering" that they could in fact cover all conditions of health and disease. A fourth has the same broad terms related to the field of mental health. The World Health Organization's definition of health does not distinguish between physical and mental health, and there is increasing recognition of overlapping or interrelated areas.

Of the three Organizations concerned with "health", the Health League of Canada is recognized as the "Canadian Citizens' Committee of the World Health Organization" and it must be assumed that it accepts the above definition in the implementation of its basic objective – "to undertake such measures as it may consider desirable to promote personal and community health and the control and elimination of communicable diseases". Its reports do not give its activity in regard to the international body, except for the organization of a "committee" of members of the Federal Parliament which meets infrequently to receive information about WHO. Sometimes international developments are a topic at the annual conference. Its very broad public education programme certainly overlaps with that of other organizations, but this may not be undesirable, since there are varying points of view on many questions and the material is directed to a variety of readers. Since the League operates from Toronto with a relatively small Quebec Division, and is controlled largely by the medical profession, one wonders about its representativeness as the "Citizens' Committee". Its voluntary funds come almost

entirely from the United Appeal in Toronto, which suggests local rather than national community support.

The Canadian Red Cross Society defines its purposes, in addition to its direct war-time and disaster services, thus: "In time of peace or war to carry on and assist in work for the improvement of health, the prevention of disease and the mitigation of suffering throughout the world" — again an all inclusive definition which has led it into activities which overlap with the objectives of, and sometimes appear to duplicate services given by, other organizations. It has contributed financially to many of the other organizations, particularly those developing in the early years when the Society had surplus funds following World War I. Some of its activities have been demonstration projects which it has endeavoured to pass over to governmental or other groups at a later stage. At the present time this applies, for example, to the outpost hospitals and nursing stations, the dental cars, and the Red Cross Centre for handicapped children in Windsor, Ontario. The demonstrations may be progressive and desirable, but when the Society considers the need is demonstrated, considerable pressure may be used to have them taken over. It is possible that a group might choose to "demonstrate", and hence face government with a difficult problem of having "priorities" determined for it.¹

Reports of competition and duplication revolve chiefly around sickroom loan cupboards, training courses in home nursing and first aid, and water safety. Although formal agreement has been reached with the St. John Ambulance Association, the latter organization seems to feel unfair competition. The Royal Life Saving Society was not included in this study and its point of view on water safety was not determined. Since the loan of sickroom supplies has a three-month time limit, this service does not duplicate the provision made on a more permanent basis by several other organizations, but the validity of having several sources of supply with the distribution based on either time or disease is questioned.¹ The Junior Red Cross funds are given to a considerable extent to pay for medical prescriptions for children known to other organizations.

The St. John Ambulance Association defines its purpose as "the relief of suffering", a very broad purpose. Its efforts are concentrated upon training courses in home nursing and first aid, including in the latter artificial respiration. Through the Brigade it organizes first-aid posts and services on highways, ski-runs and public occasions. In some areas it had developed a blood transfusion service, but later agreed to leave this field to the Red Cross Society, lending its support to the activities of the latter. In its relationship with the schools, it would appear to be in competition with the Junior Red Cross.

No comments have been received regarding overlapping or competitive services within hospitals. The Red Cross Society, the Canadian Mental Health

¹ This may be particularly difficult when the "demonstration" has involved considerable capital expenditure, as in hospitals.

Association, and the Hospital Auxiliaries are all interested in building up support of volunteers and, partly for this purpose, they develop volunteer services in hospitals. Disease-focused organizations, such as the Cancer Society and the Diabetic Association, are also undertaking hospital visiting in some areas. Hospitals may have difficulty in avoiding competition and confusion in the various volunteer services.

The Canadian Mental Health Association includes mental deficiency in its objects and hence, although not to a noticeable extent in its present practice, overlaps with the Canadian Association for Retarded Children. The Saskatchewan Division of the Mental Health Association has made grants to a total of \$18,000 to assist the newer patient-member group. Since the national organizations for the retarded is relatively new, (as are some of the provincial ones), difficulties are not yet revealed. The organizations for emotionally disturbed children, now limited in number and basically local in their activity, will present the same problem of overlapping objectives. Some formal understanding between the citizen-member organization and the two patient-member ones in this field would seem to be desirable and should be mutually beneficial. Since their activities are related to health, education and welfare – all matters of provincial jurisdiction – liaison at the provincial level, with consultation at the national, would be appropriate.

ORGANIZATIONS FOR SPECIFIC DISABILITIES

Organizations concerned with specific disabilities are likely to overlap with those with more inclusive objectives or providing specific services. Since the organizations of disabled people are active in many communities in regard to social action, employment and recreation, the relationship between the patient-member and citizen-member groups is important.

The activities of the Canadian Hearing Society are based in Toronto. local groups are organized in other communities, some of them consisting of the parents of handicapped children seeking to obtain needed services. While Junior Red Cross funds are used in some areas to provide hearing aids for needy children, the costs are heavy – as is inevitable when an appliance requires changing as a child grows up – and in some areas it is difficult for a child to obtain what he needs. Since the nationally incorporated organization is not national in scope, and since its activities are relatively limited even within the immediate area, close collaboration between it and the groups across the country could not be effective. Some Societies for Crippled Children have included children with hearing defects in their services.

The Canadian National Institute for the Blind provides all inclusive services, except education. It has a semi-official arrangement with the government, giving the specialist examination necessary to determine eligibility for the Blind

Allowance,² and providing placement services which for most handicapped persons are provided by the National Employment Service. It has pre-empted the field, so that public services are minimal. Its services vary, since its policy is that a Division should be self-supporting. In some areas it is able to provide "luxury" services which place the blind in a preferred position among the handicapped in comparison, for example, with the paraplegics. Some of the services are designed to reduce the cost of living for the blind, whose handicap creates additional expenditures. It has also been able to obtain for the blind a preferred position among handicapped groups in federal legislation, through the additional "allowable income" in means test provisions. Since the federal government purchases service from the Institute for the war-blinded, and the Workmen's Compensation Boards for industrial casualties, there is no overlapping or duplication of services.

The Institute finances and acts as consultant to the Blind Clubs, at local, provincial and federal levels. The latter provide social activities for their members, a "union" for the members employed by the Institute and a social action group. The Federation of the Blind appears to be a rival, dissenting group.

The questions raised by the Canadian National Institute for the Blind are not related to overlapping or duplicating services, but to the preferred position of the blind in comparison with other seriously handicapped persons, because of the very successful operation of the organization. Although questions have been raised regarding this organization in the course of this study, the major consideration is whether government policy should be reviewed with regard to grants, concessions, etc., through which it supports the "preferred position", and should consider whether persons suffering from other disabilities should be given more equal provision. This could be achieved in some areas by public services and in others through the voluntary agencies.

The Canadian Paraplegic Association, established to assist the war-injured, continues to work closely with the Department of Veterans Affairs, using the facilities of the latter in some cases and in others, its own Rehabilitation Centre in Toronto or a community one, as in Vancouver. Workmen's Compensation Boards purchase service for industrial accident victims. There appears to be no duplication of services. Like the Institute for the Blind, this organization employs persons suffering from the disability wherever possible. In Manitoba, the Association is related to the Society for Crippled Children and Adults.

Paraplegia is a condition for which continuing medical care is essential. It has been reported by the Association that the regular check-up in hospital is not always accepted under present Hospital Services Plans. Any extension of a national health care programme to include such items as home nursing, drugs,

² In some instances it has refused to register as blind, within its definition, persons to whom Blind Allowances are given. It is reported to be extremely difficult to assess the degree of sight in borderline cases.

physiotherapy and wheelchairs will be of great assistance to the sufferers and will reduce the services now financed by the Association.

ORGANIZATIONS AFFECTED BY CHANGING NEEDS

Three organizations have encountered particular difficulty in defining their activities because of changes which have taken place since they were established — changes in medical knowledge and in public assumption of responsibility.

The original movement of the Tuberculosis Association had rapid success, and as the government took over the financial responsibility for treatment (a goal of the Association since the beginning), the voluntary groups directed their attention to prevention, including early diagnosis, health education and the eradication of the disease. Government has given increasing attention to case finding, mass surveys and the follow up of discharged patients, so that the role of the Association now appears to be inseparable from that of the government. In different provinces, Associations provide mobile units staffed by government officials, nurses assigned to work under the public officials and clinics in which the government doctor works.

In Newfoundland the 'M.V. Christmas Seal' is used for mass surveys staffed for the most part by public health personnel, with the films read by the Department's doctors or the Grenfell Mission. The boat has also been used for the government's Sabin Vaccine Program, the registration of the disabled for the government's rehabilitation programme, case finding for the Diabetic Association with provincial financial assistance, and general health education. The Provincial Co-ordinator of Rehabilitation was for several years also the Executive Director of the Association. In Nova Scotia for a number of years the Association provided the Rehabilitation Supervisor, under whom the province's rehabilitation officers worked. In Prince Edward Island, the provincial Director of Tuberculosis Control, who is also the Superintendent of the Sanatorium, serves without salary as the Executive Director of the Association, and uses his office for the purpose. The only employee of the Association is a stenographer. When the Ontario organization was started, the medical doctor from the Department who chaired the organization meeting was elected secretary. Within a short time one of his staff became the Executive Secretary and has remained in the position for eighteen years, although he is still a civil servant receiving a full salary from the province³. In St. John, the provincial doctor is also Medical Director of the Association's clinic. Its nurses, who go into the schools for case finding, are accompanied by the school nurse.

In a number of provinces the Association employs a "survey organizer". When the Department decides to undertake a mass survey in the area, this organizer is responsible for enlisting the help of local organizations to canvass the

³ Until 1962 the Association's reports gave no indication of the hidden subsidy.

community to be tested and for arranging for some volunteer help when the testing team arrives. The assumption seems to be that only a voluntary organization can enlist community help of this sort. Yet, as one doctor explained, when the organizer goes into the community he attends a meeting called by the Department's district nurse, who introduces him so that the goodwill of the community towards her will be extended to him.

In most instances the official report of the provincial Director of Tuberculosis Control is published in the annual report of the Association, and in one case the report of the Association is published in the annual report of the Health Department. In Manitoba, reports of the federal officer for Indian Health Services and of the municipal Medical Officer of Health are included in the organization's report.

It is obvious that there is no clear line of demarcation between the responsibilities assumed by the official and the voluntary organizations. There is more than a suggestion in some reports that the formal activity of the Association is partly designed to encourage contributions to the annual financial campaign. In one annual report, in which the doctor recommends that surveys be limited to higher infection rate areas, he adds: "There are problems in curtailing surveys as there is a strong public demand for them, they are of health educational value, they X-ray 1,200 ex-patients a year, and their widespread coverage has no doubt been an important factor in maintaining the response of the public to the Christmas Seal appeal for preventive funds." In some provinces, the public services have developed to the point where the Association has great difficulty in spending the money it raises.

The change in treatment for tuberculosis has resulted in less need for accommodation in sanatoria. Where the sanatoria are under the administration of "voluntary organizations" – Saskatchewan, Manitoba, Ontario, and partly in Quebec – the Boards are really the equivalent of boards of "Public Hospitals", sometimes with a number of varied institutions under their administration. In the first two provinces named, the Association Boards are set up by legislation, which specifies the membership and provides complete financing by public funds.

Yet the Saskatchewan Anti-Tuberculosis League is a member of the Tuberculosis Association, runs the Seals Campaign and receives other voluntary donations for its preventive work. The deficit in the "Preventive Fund" in 1961 was met out of the "Federal Health Grant Fund" accumulated over several years.

In Manitoba, where the annual report highlights "A Voluntary Non-Profit Organization",⁴ the Board administers the federal hospital for Indian tuberculous

⁴ By legislation, the Board consists of 26 members of which 18 are elected, five appointed by the provincial Department of Health, two by the Union of Municipalities, and one by the City of Winnipeg.

patients, and has recently been entrusted with the administration of the new provincial Rehabilitation Hospital. It has transferred one hospital to chronic care, and runs an Indian-Metis social adjustment centre for physically disabled. It also runs the Christmas Seals Campaign but the specific use of these funds is difficult to discover in its report. Additional contributions are obtained from the Association of Commercial Travellers.

In Ontario, the Ottawa Sanatorium Board has recently given accommodation to, and then taken over the administration of, a Mental Health Clinic previously under the provincial government and financed by federal-provincial grants. This move is supported by the Canadian Mental Health Association as the first Ontario community mental health clinic. The Hamilton Health Association has developed a series of hospitals, some from unused accommodation for tuberculous patients, some newly built, and serving a variety of types of patients. The National Sanitarium Association in Toronto has sold one unneeded hospital to the province for about \$900,000⁵ and transferred a wing in another to chronic patients. All the Ontario Boards participate in the Seals Campaign, and are given additional assistance (except the National Sanitarium Association) from county tuberculosis associations in their neighbourhoods.

Thus the institutions have tried to adjust to the changes in the medical treatment. If they are to continue to appeal to the public as voluntary associations in need of funds for tuberculosis work, some further adjustment is desirable. The Canadian Tuberculosis Association has tried to adjust to this changing position. In 1957 it enlarged its objectives by adding to its basic interest in tuberculosis "related, contributing and similar diseases". It also, for the first time, established a Research Fund, hoping to utilize the surplus money held by some of the organizations. It has been placing increasing emphasis upon the need to contribute to international activity.

Reports of the medical personnel stress the need of a strong continuing public movement to counteract the apathy of the public who seem to regard tuberculosis as no longer serious. Some doctors are concerned with the failure of patients to continue to take the necessary drugs in their own homes, and are dissatisfied with the low priorities some public health doctors now give to the disease. They hope that through the efforts of the associations, eradication may eventually be achieved. This suggests the continuing need for voluntary activity, but activity of a kind rather different from that which has achieved the present degree of success.

The interest of the Cystic Fibrosis Foundation might be considered to fall within the broadened objects of the Tuberculosis Associations. As far as is

⁵ Although there has not been an opportunity to check, it is to be assumed that considerable provincial grants were given over the years for capital expenditure on this building. The receipts from the sale have become the Muskoka Hospital Memorial Research Fund.

known, no approach has been made by the Association to assist this group, which, in its financial difficulty, has turned to the Council for Crippled Children and Adults at the national level. Cystic fibrosis is a disease which until recently has been fatal in the first three years of life. It could only be included by those societies in which the definition of "crippled" has been interpreted to mean practically all handicapping conditions, and by those which do not limit their attention to children whose disabling conditions require remedial service. Another organization affected by a change in medical knowledge is the Foundation for Poliomyelitis. The Foundation, the sister organization of the Foundation for Infantile Paralysis in the United States,⁶ started when serious epidemics of a disease of unknown cause struck certain areas and left dead or disabled children and adults in its wake. The public fear of the disease was probably out of proportion to the number of casualties. Some governments stepped in and bore the costs of treatment, which in serious cases was long and expensive. Then a vaccine was discovered and the whole situation changed. While the Foundation continued to carry responsibility for "polio" victims, some of whom need long-term care, the public appeal for the victims of a disease which no longer appeared to be a menace was undermined, and the Foundation looked around for other "causes" to support.

Each provincial organization is autonomous, and the changed picture has resulted in different adjustments in different areas. The Foundation has not provided direct services, except a limited amount of counselling in some provinces, but has paid the cost of service obtained elsewhere. This payment may be in the form of fees for service to patients or grants to other organizations the services of which seem to the Foundation to come within its terms of reference. This means that its objectives must include those of other organizations. In Nova Scotia and Alberta the Foundation has continued to limit itself to polio victims,⁷ and consequently is able to be generous in its support. In Ontario, to distinguish it from the Society for Crippled Children, it has assumed responsibility for persons 19 years of age and over, who suffer from any disease or disability and who are not considered to be the responsibility of another organization. In British Columbia it has branched into special activities such as Poison Control and a Speech and Hearing Clinic and has defined its functions in "catch-all" terms. In Quebec it embarked on influenza immunization in industrial companies but discontinued this when the Legion complained that voluntary funds should not be used for this purpose.

It is questionable whether any organization should be permitted to incorporate for purposes defined negatively, i.e., to do what no one else is doing. It is

⁶ See Richard Carter, *The Gentle Legions*, New York Doubleday Doran, 1961.

⁷ When the victims are children, there is overlapping with Societies for Crippled Children, to which the Foundation has sometimes made grants.

also questionable whether one organization should raise money largely to distribute as grants, or to pay for services given by other voluntary organizations.⁸

Official agencies are now taking responsibility for public health services provided by voluntary organizations. In some cases there is duplication, in others an agreement that the voluntary organization should continue. This has already been discussed with regard to the Victorian Order of Nurses⁹ and the "T.B. Nurses". It also occurs with some local organizations such as the Child Health Association in Montreal, which provides both medical and nursing service in Child Health Centres in certain areas, and emergency home medical care for indigents. Obviously local situations differ and no sweeping recommendation can be made that all these services should be provided by the official agency. Each situation should, however, be studied to determine whether the present arrangement is the result of tradition and vested interests, or is in the best interests of the person receiving service. Where public responsibility has been assumed and the government uses a voluntary organization as its agent, the official agency should be responsible for assuring the public that the standards are satisfactory, that the costs are paid in full by public funds, and that the present arrangement is economic and administratively efficient.

ORGANIZATIONS FOR CRIPPLING CONDITIONS

The Societies for Crippled Children have enlarged their scope, not because of changes in medical or social treatment but (apparently) because of unmet needs and the availability of money. The development is partly due to the difficulty the Foundation for Poliomyelitis was having in spending its money or in developing a new base for its appeal to the public, and its willingness to align itself with the Society.

Some Societies still limit themselves to the assistance of children with musculo-skeletal defects. Some, while doing this officially, make their services open to any handicapped group – e.g., in British Columbia transportation provided primarily for the "crippled" was extended to the cerebral palsied, the retarded, etc. Some have broadened their sphere of activity to include any child suffering from a physical disability, so that children with defects of eyes, ears, speech, heart, etc., are included. Ontario has a clause allowing the Medical Director to accept

⁸ The Canadian Foundation for Poliomyelitis and Rehabilitation provided no written material for this study. The new Canadian Council for the Rehabilitation of the Disabled reported that it had not been given copies of annual reports, etc. The previous Executive Director of the Canadian Council for Crippled Children and Adults became the executive officer of the new organization. The Executive Director of the Foundation had been president of the Quebec Chapter for thirteen years and when his services were no longer needed by the national Foundation, he became its executive secretary at the same salary.

The Department of National Health and Welfare has supplied mimeographed statements of the campaign, revenue and expenditure of all provincial associations in 1960.

⁹ See p. 43.

for service in special cases any child who he considers will profit from treatment. The impression is that the Societies are basically concerned with those "crippling" conditions which can be improved by treatment, and occasionally this is specifically stated.

While Societies which limit their definition to musculo-skeletal handicaps do not conflict with patient-member organizations, those in which the definition is widened to include almost all handicapped children are in the same areas of service as some of the patient-member organizations. The organizations particularly affected are those focused on cerebral palsy, cystic fibrosis, muscular dystrophy, diabetes, epilepsy, hemophilia, cleft palate, hearing handicaps, and myasthenia gravis. Of these the Cystic Fibrosis Foundation is the only one limited to child-patients (due to early fatality). And while some of the organizations have concentrated their activity on children (e.g., cerebral palsy), others (e.g., epilepsy) have concentrated on adults. Where the original focus has been the child, the tendency is to move into services for the young adult as soon as money and effort can be mobilized.

The Societies for Crippled Children thus overlap on an age basis with all these organizations. Where the Society for Crippled Children and Adults serves all ages, there is duplication of the patient-member effort for the adult groups. It must be borne in mind, however, that many of the patient-member organizations seek to obtain services for their members, not to provide them.

The Ontario Society has developed a policy of trying to take over from patient-member organizations the provision of direct services. It reports that such organizations provide equipment such as wheelchairs, without medical prescriptions, in cases in which the doctor would not recommend this equipment. Sometime the lack of technical advice results in the provision of a chair unsuitable for the condition of the particular patient. Some of the interviews conducted during this study revealed the activity of these groups in providing services without adequate consultation with the patient's doctor. The organization may be more concerned about relieving the parent of responsibility and effort than about helping the patient to follow medical advice. It sometimes considers that with its intimate experience with the disease, it can assess the need. It is so identified with the suffering of the patient and his family that it has difficulty in refusing a request for help. Generally it does not have the advantage of professional staff, and a strong argument can be made that, unless it has, it should not become directly involved in providing medical prescriptions. Reports have also been received that frequently the prostheses supplied such as braces, glasses and hearing aids, are not used.

Many of the patient-member organizations are interested in obtaining community provision of the necessary services, rather than in providing them, and this seems desirable. It has led to a close association between the Societies and the patient-member organizations in some instances. This affiliation, however, may lead to

the elimination of the patient-member group and more thought should be given by the citizen-member organizations to the means of preserving the other group to enable it to give to its members, through constructive activity, the mutual support they need.

In its Brief to the Royal Commission on Health Services the Canadian Council for Crippled Children and Adults states:

It is the hope of the Council, however, that the goals that the Canadian Rehabilitation Council for the Disabled will achieve will include:

- (a) The establishment of a common meeting ground and provide leadership for all Provincial and National voluntary agencies interested in the rehabilitation of the disabled.
- (b) The co-ordination of the appeals to the public for the financial support of voluntary health agencies.
- (c) Where feasible, the provision of administrative services to agencies interested in specific disease problems, thus leaving maximum of funds available for service, research and education.
- (d) The stimulation of the efforts of local citizens groups across Canada towards improving the health services in their own community.
- (e) Encouraging the common use of existing facilities and personnel where the interest of two or more organizations can be best served in this way.
- (f) Through the development of a better understanding of the role of the voluntary agency in our Canadian way of life, a more effective partnership relation with Government.
- (g) The development of high standards of services on the part of voluntary agencies and to encourage the effective use of the volunteer.
- (h) In co-operation with Government, planning the development of new services.

It is evident that this new Council wished to assume leadership and, to some extent control of all the voluntary agencies interested in the rehabilitation of the disabled, although it says elsewhere in Brief that "co-ordination cannot be imposed on the voluntary agency either by government or by a more powerful voluntary agency". It recognizes that "rehabilitation is initially a health problem", with "psychological, emotional, educational and vocational aspects". It is very doubtful that an organization of the nature proposed can accomplish the objectives it enumerates.

A report¹⁰ of the situation in New Brunswick shows the thinking of the Canadian Council on the desirable relationship between the Society for Crippled Children and the Foundation for Poliomyelitis and Rehabilitation. In this province, a Co-ordinating Council for the Handicapped was organized in 1956 under the auspices of the Department of Health for the specific purpose of making the optimum use of funds available for the handicapped. Some fifty local groups showed interest,

¹⁰ This material is taken from a report of the Canadian Rehabilitation Council for the Disabled to the Board of the New Brunswick Co-ordinating Council, dated November 8, 1962.

but the most active were the Society for Crippled Children, the Poliomyelitis Foundation, and the Junior Red Cross. The Council was reorganized in 1960 to provide one administrative office which conducts both the Easter Seals and the March of Dimes campaigns.

As the federal and provincial governments assumed increasing financial responsibility, the procedure developed in which the public health nurse identified a sick or disabled person needing assistance then referred the case to the Department, which in turn referred it to the Council if public funds were not available. At present it is stated that for adults, the Council's function is minor, supplementing government provision when it is requested to do so. For children, the government makes provision of a "sliding means test basis", depending upon the availability of public funds. The children referred to the Council are stated to be those requiring types of health care, such as tonsillectomies, which are not within the objects of the organizations for handicapped children. "Local community organizations find themselves competing with the Government for cases." The Council's major projects have been a mass inoculation programme of Salk vaccine, payment for certain prostheses, transportation and, on request, supplementation of government provision.

The Council is considering a recommendation that, instead of paying for services, it should provide casework and transportation to individuals, offer services to the Cerebral Palsy Association, the Cystic Fibrosis Foundation and the Paraplegic Association, develop a Camp for Crippled Children and investigate the need for sheltered employment. It suggested that where the Council's help is requested, the Department should be asked to refer the family to the Council. "This policy is suggested partly to clarify in the minds of all concerned who is taking responsibility for providing assistance. This is important if the Council expects the citizens of New Brunswick to support their appeals."

The Report recommends "that the possibility be investigated of using the Easter Seal and the March of Dimes Campaign to meet the needs for voluntary funds of all voluntary agencies working with disabled persons". The income from these campaigns in the last year was \$55,000. "With a wider appeal and a very specific programme to offer, there should be no difficulty in doubling this amount."

To achieve this objective, it was recommended that a full-time staff person responsible for fund-raising and year-round publicity be appointed and that specific areas of responsibility be designated for the two campaigns. "As at present the Co-ordinating Council would be designated as the administrator of the funds but not itself a fund-raising organization ... In both cases the present March of Dimes Chapter and the New Brunswick Society for Crippled Children would in effect become fund-raising sections of the Co-ordinating Council." It was further recommended that the Council appoint a number of committees, among them a "March of Dimes: consisting of the present New Brunswick March of Dimes Chapter, and

responsible for the supervision of the March of Dimes Campaign", and "Easter Seals: consisting of membership from the New Brunswick Society for Crippled Children, and responsible for the supervision of the Easter Seal Campaign."

This detail is given to emphasize that when a campaign is successful, the organization wishes to increase its activity and, in this case, assumes that the other organizations will accept its help and control (since the provision of the funds assumes some control). The organization seems to be set up in a way planned to hide from the public the fact that two annual campaigns are being run by one organization for the same purpose.

OTHER PATIENT-MEMBER ORGANIZATIONS

The patient-member organizations define the disease entities with which they are concerned so specifically that overlapping does not arise, with the possible exception of the groups serving the retarded and those serving other children, particularly those with cerebral palsy, who may also be retarded.¹¹ Most schools for the retarded specify that the child must be toilet-trained, some that he must be capable of self-care. These are reasonable requirements to enable the staff to conduct a school programme. If the cerebral palsy child can meet them, but is sufficiently handicapped to be excluded from the public school, he may be able to profit by individual instruction in a special school even if he is not seriously retarded mentally. In a number of places the retarded and the cerebral palsied are enrolled in one school organized originally by one or other of the associations.

Since the school does not meet the needs of all children, the two associations may continue to function. Thus in Winnipeg, when the Association for the Retarded agreed to accept cerebral palsied children in its school, the Cerebral Palsy Parents Association disbanded, later reorganizing when it felt the need for additional services for its children.

SPECIAL PROBLEMS

Equipment

Since the same services may be needed by patients suffering from different diseases or disabilities, duplicate services are established to serve different groups of patients in the same community. Sick-room equipment is provided for a maximum of three months by the Red Cross and is used by other organizations, such as the Cancer Society, for that length of time, to be followed by provision from the Society's own more permanent "loan cupboard" if the article is still needed. Societies for Crippled Children and Adults have supplies of crutches,

¹¹ The person with multiple handicaps finds it difficult to obtain services when most organizations serve those with a specific handicap or disease.

wheelchairs, walkers, etc. The Paraplegic Association sells chairs or finds sponsors to pay for them. Many of the patient-member societies obtain equipment for their members, through service clubs and other organizations. When it is no longer needed by the patient for whom it was obtained, the article is passed on to another patient, since it remains the property of the organization. The Cystic Fibrosis Foundation purchases inhalation therapy tents which remain its property, although they may be paid for in full or in part by the family or the sponsor. These are returned and "loaned" to someone else if the child dies. Multiple sclerosis and muscular dystrophy patients may need wheelchairs and home-care equipment.

If this equipment is to be passed around, it must be located at strategic points where it is accessible to patients. Sometimes it is handled by the hospital and is supplied by the Society. More frequently the local group or the groups in a region maintain the store. Service clubs must be continually receiving strong appeals. Nurses and social workers complain of hours spent in trying to obtain equipment, attempting to locate the appropriate source, or to find a sponsor for the patient who does not seem to "fit in" to a category.

Home-care equipment, wheelchairs and crutches seem to be the greatest problems, since they are needed by so many types of patients. The confusion will remain as long as the organizations base their services on particular diseases, with each group trying to supply the needs of its own patients. The supplies are not so great that storage is a problem — for most organizations, a new request means finding a donor.

Some of this equipment is bought by the organizations, and some is supplied by the service clubs directly. The national organizations do not have figures for the expenditure of the local groups, and it is impossible to estimate the amount of voluntary funds used for this purpose. The figures available suggest that the total must be quite high. For example, the British Columbia Foundation for Poliomyelitis spent \$24,820 on equipment and appliances in 1961 and the similar organization in Ontario \$48,970. The Winnipeg Home Care Program, in the first full year of its operation (1959) reported that 32 out of the 73 cases served required equipment to enable medical treatment to be given at home. This was obtained from The Red Cross Society whenever possible but \$1,292 was spent from the project's own funds, and more was needed. In 1961 the Cystic Fibrosis Foundation disbursed \$17,827 on equipment and medical supplies. In Vancouver the G.F. Strong Rehabilitation Centre's expenditure on its brace shop was \$26,872.

Since almost all appliances and equipment should be supplied only on medical recommendation, the control of the supply should be located in the Department of Health. Voluntary organizations should serve as referral agents only.

The Province of Quebec

Quebec must be recognized as having its own pattern of services in the health field, as it has in that of welfare. This is particularly true of local agencies in the Montreal area, in which the division on the basis of both language and religion is very pronounced. Although the health organizations, including the hospitals and rehabilitation centres, are distinct when grouped by the auspices under which they operate, their services are available to patients of both language groups and are frequently used by both. National organizations that wish to establish provincial or local chapters are looked on as emanating from English-speaking Canada – “via Toronto”, according to one French correspondent – and although they may be successful in getting some French representation on their boards, they have difficulty in establishing strong organizations within the province. The Canadian Mental Health Association is apparently an exception. Thus there are separate and distinct organizations for bedside nursing, the blind, the deaf, crippled children and patients with cancer and tuberculosis. In some cases there is a degree of collaboration – e.g., the Cancer Aid League helps support the National Cancer Institute but is not a member of the Cancer Society. The Quebec Easter Seals Committee runs the campaign and, while giving some direct service to meet the costs of crippled children not otherwise cared for, disburses most of the proceeds to a considerable number of different organizations. The Montreal Council of Social Agencies has a very active Health Section, with current committees on alcoholism, the chronically ill, referral practice, recreation for the handicapped, the needs of mentally retarded children, the rehabilitation of seizure patients, and the education of the handicapped child, but although it has interested English and Jewish organizations and two City Departments, the participation of the French organizations has been extremely limited. Le Conseil des Oeuvres, in the same city, has been less active in the health field, and appears to be only concerned with the French community.

During the last year the Board of Trade and La Chambre du Commerce have united in supporting a Combined Health Appeal, with which the Red Cross Society has also associated itself. With the three separate federated Funds, the national agencies have had difficulty with their appeals. In 1963 the first Combined Appeal which will cut across language and religious groupings will be made. Some of its supporters hope that if it is successful, it may be the first step in a more co-ordinated approach to health and welfare fund-raising and community planning.

CO-ORDINATING COUNCILS

The federal leadership in rehabilitation has urged the development of provincial and local co-ordinating councils, because of the variety of services under different auspices which must in some cases be brought to the aid of one handicapped person. Provinces developed interdepartmental committees to plan their programmes

in the early years. Later the provincial rehabilitation co-ordinators promoted independent provincial and community councils in which both official and voluntary agencies participate. These are also used to advise the government. Sometimes, as already noted, the Society for Crippled Children has tried to link other organizations with it for joint activity.

For example, the Nova Scotia Rehabilitation Council has a membership of more than 20 organizations concerned with handicapped people. It seems to have developed into a community planning council in this field. It identified some gaps in the community, and has established three facilities which have become incorporated "autonomous" bodies – the Rehabilitation Centre now recognized as a hospital, the Brace Shop and a small sheltered workshop, New Leaf Enterprises. The Boards of all three are appointed by the Council itself, which seems to make them subsidiary enterprises. This creates the situation of one body holding several incorporations, and shows the problems which arise when certain services are required for the patients served by several disease-focused organizations. Since the Council includes senior staff members of other health organizations the boards of the subsidiary companies also include them. For example, the Chairman of the New Leaf Enterprises was the Executive Secretary of the Poliomyelitis Foundation. This is not an effective way of getting citizen participation in a voluntary organization.

In New Brunswick, the Rehabilitation Council is located in Fredericton and has been responsible for the development of a Rehabilitation Centre there. In Vancouver, an independent Council was formed which later became a division of the Community Council. The Saskatchewan Council, established in 1960, seems to have assumed a role in planning with government.

In Ontario the Rehabilitation Committee of the Medical Society organized a conference in 1962 from the deliberations of which the Committee developed recommendations that the Medical Society should urge the provincial Health Department to establish a provincial co-ordinating council. It decided that it was not an appropriate activity to be undertaken by the Medical Society, particularly because of the financial support needed. The provincial Health Department had already been urging the development of local or county councils and had helped to establish two or three, but reports suggest that these have not become effective bodies. The situation is confused by the fact that the Department of Public Welfare has the responsibility for vocational rehabilitation services under the federal-provincial agreement.

The only provincial community welfare council is in Ontario. It works on a project basis and has undertaken several projects in the areas in which the health organizations are interested, including homemaker and institutional services and facilities for the mentally defective. At the local level there are some 46 community welfare councils in Canada, of which only about 20 employ staff. Generally speaking such councils are concerned with health, welfare and recreation. Some

have "sections" for the members interested in health matters. Others – and this is the trend – work on "projects" by appointing *ad hoc* committees to consider matters of current interest. For this study the councils were asked to report on the participation of the voluntary health organizations.

Committees were working on a wide variety of subjects – rehabilitation, home care programmes, facilities in the community for particular groups, cooperation between hospitals, etc. In general, they reported more active participation from those health organizations with relatively autonomous local units than from those in which the power rested either at the provincial or national level. Some of them stated that organizations were very willing to work together on any project which the Council initiated and that any degree of inactivity was due to the council's lack of staff and hence of ability to initiate projects which would interest some of the groups.

Official and voluntary organizations were reported to work well together on individual cases, but official agencies hesitated to be involved in community planning or policy questions.

In a few local communities in Ontario, a local rehabilitation organization has developed to give some direct service and to co-ordinate services for patients. An illustration of this comes from Windsor, where the Institute of Physical Medicine and Rehabilitation was organized in 1955 as a "pilot project" with encouragement from the provincial government. It includes not only those organizations working with the handicapped but hospitals, municipal departments, service clubs, labour unions, etc., a total of more than 40 organizations. The provincial government asks for its recommendations for federal-provincial rehabilitation grants. The purpose is to co-ordinate the rehabilitation services and to act as a referral agent, although the number of persons going to it for this service was only 48 in the last year. Its reports do not suggest that it has accomplished a great deal in the way of co-ordination or the rationalization of the multiplicity of organizations in that area, although it is presently studying the possibility of a new building to bring many of them under one roof. Financed by the Poliomyelitis Foundation and the Community Chest, it operates on a budget of \$9,300. One question whether it has accomplished anything which the active Community Welfare Council could not have appropriately undertaken.

In Hamilton the Rehabilitation Institute has a full-time medical director and other part-time medical staff who seem to act as an assessment team, but the services are given to a considerable extent by other organizations operating in some cases in the same building. This situation seems to have resulted in difficulties in accounting to the public regarding its distinct contribution.

The Canadian Welfare Council, with a sectional programme, has not had a "Health Division" in its organization. It initiated a loose organization of national

health and welfare organizations, out of which, in part, the National Agency Review Committee developed. It also has had a number of special projects in which matters related to health and rehabilitation have been the subject of study.

These examples are given to illustrate the efforts at co-ordination which have now taken place. The need for co-ordination in rehabilitation has been widely recognized, but the effective way of accomplishing this does not appear to have been found. A Toronto report¹² states that "Unless there is greater co-ordination and integration of effort in the prevention and control of crippling diseases and in the provision of services for victims of specific diseases, the uneven provision of services will continue".

This chapter has discussed the relationships between the voluntary organizations and each other, and between them and government. It has concentrated upon problem areas rather than upon the many instances of constructive, cooperative effort.

In some cases, the problems can be solved by the good will of the organizations concerned. In others, the problems seem fundamental.

Increasing public responsibility in the health field emphasizes the necessity of full governmental participation in co-ordinating and planning. The changed division of responsibility for the provision of the services and for the payment of them, as well as the effects upon health needs of developing medical knowledge, demand a continuing evaluation of the organized activities. In areas in which public responsibility has been recognized, the leadership role of government in planning is particularly important.

¹² Social Planning Council of Metropolitan Toronto, "The Prevalence of Selected Conditions for which Preventive or Therapeutic Services are Required", Toronto, July 28, 1961.

CHAPTER 8

THE VOLUNTARY HEALTH ORGANIZATIONS AND THE FUTURE

In the preceding chapters, the rapid growth of voluntary health organizations in Canada has been outlined and a picture of the present position drawn. The objectives and the structure through which the organizations endeavour to pursue them have been discussed. The great variety of their activities has been portrayed. Consideration has been given to the sources of their financial support, and to their accountability to the community. Questions of overlapping and duplication of effort have been raised and the efforts at co-ordination discussed. Major attention has been given to those organizations with national or provincial scope, although local ones have not been ignored. Since health organizations – in contrast with those in the field of welfare – are predominately national and provincial, it is thought that the picture is not distorted.

The present chapter comments on the material previously presented and ventures to offer some suggestions regarding their future place in the health field.

THE FUNCTION OF VOLUNTARY ORGANIZATIONS

The traditional function of voluntary health and welfare organizations has changed radically in the last quarter century. The rapid increase in the number of organizations, the criticisms raised regarding numerous appeals to the public for donations, and the seeming competition between the organizations for community support, have led to concern on the part of both the organizations and the public in Canada, as in the United States of America. In the latter, they have been responsible for a re-assessment of the situation and efforts are being made to re-define their functions and rationalize their activities.

For many decades it was assumed that social services could only be carried properly under voluntary auspices; they had greater flexibility of program, greater personal understanding and interest from agency boards and staffs, greater opportunity for experimentation and adjustment of programs to new and changing problems and needs; the government was looked to for programs of major magnitude, beyond the capacity of voluntary philanthropy, but only as a last resort; the government programs

were considered to be restricted by binding legislation, and to be administered by soulless bureaucrats. This attitude still prevails in large sections of the community, although there has been a drastic change in the quality, the volume and the range of health and welfare services under governmental auspices. Even in pioneering and research, the government dollar investment far exceeds that available from voluntary sources. "Neat" categories on the respective roles of government and voluntary effort have been discarded, as needs have been identified of a magnitude only amenable to public concern and support, and as public performance has demonstrated validity in quality.¹

Voluntary organizations have traditionally been associated in the mind of their organizers and of the public with "charity" – service to a deprived group. When such an organization undertakes to provide a service – a rehabilitation centre or a Braille library – the concept of community service predominates, and the question of the ability of the user to pay takes second place. When an organization is concerned primarily with persons lacking the ability to pay for the service, the concept of "charity" is emphasized.² "Charitable" organizations have been associated with class structure, the provision of service by one group of citizens to another, "the less fortunate" – to whom a stigma of weakness or incompetence may be attached by sections of the community. In the field of welfare this tradition lingers. In the field of health it breaks down more readily through recognition that disease and disability are human hazards that cut across all class boundaries. Any person in the community may become a victim, and the fact that he does is valid explanation for his difficulty in paying the costs. Here the need for the service is the primary concern of the public and the question of payment is secondary.

The voluntary health organization can still be the "privileged" status group organizing a service or paying its costs. It can also be an organization of persons with direct experience of ill-health or disability, united in their common suffering to work for "the cause". It is suggested that this new "community of interest" which cuts across class lines is part of the explanation for the rapid development of the health organizations. The persons assisted by the citizen-member health organizations do not seem to be affected by the "stigma" of charity, which is sometimes attached to the recipients of "welfare services". The public does not attach blame to the patient for becoming ill. The patient-member organizations do not consider their work "charitable" but as a fight against an enemy.

The changing concept of the role of the voluntary organization is related also to the concept of the role of government. Hence in this discussion the assumptions regarding the voluntary role become important. In the Brief presented to the

¹ *The Role of Voluntary Social Welfare Agencies*, N. Y., National Social Welfare Assembly, 1962, p. 7, (mimeo.).

² Charity is an important part of our social values and it is to be regretted that it is commonly thought to attach a stigma to the recipient.

Royal Commission by the Canadian Council for Crippled Children and Adults a strong plea is made for the –

vital role of voluntary effort in our democratic life ... In the judgment of the Council, the organization of people into associations whose aims and objectives are focused around specific areas of interest is an essential part of Canadian life. The development of the voluntary health agency as a part of the Canadian way of life should be maintained and encouraged A voluntary agency is concerned with a specific health problem; it tries to establish community-wide services to meet the problem, and to encourage research to eventually eliminate the cause... The policies of most voluntary health agencies are determined by a Board of Directors consisting of citizens who donate their time and energies to the achievement of the purpose for which the agency was established. A high level of personnel and of the community interest is maintained in most instances under good professional leadership. This results in sound emotional reactions of the public towards those who are sick or disabled. Because the voluntary health agency is more restricted in its field of interest than government, it can be more flexible in its approach to individual need. It is in a position to concentrate both time, money and personnel on the more unusual and difficult situations. It has been more successful than government in molding the resources of health, welfare, education and vocational opportunities in the interests of the individual.³

This point of view seems to advocate that a service needed on a community-wide basis can be provided by a voluntary organization and through voluntary funds more adequately than by government, and that this method has intrinsic values and advantages which government provision lacks.

The Canadian Red Cross Society takes a different position in its Brief.

The function of the voluntary agency is defined by this organization as:

- (a) To be thoroughly familiar at all times with existing official and private services available in the health field; to stimulate and maintain interest in public health work and thus create the right climate of public opinion in order that necessary and desirable legislation may be enacted.
- (b) To recognize the primary responsibility of government and establish a close relationship so that programmes can be operated in co-operation with the statutory authority or on its behalf when such is considered to be the most efficient and economical method.
- (c) To ensure that its projects fill gaps in the public health services and do not overlap activities already carried out by governmental or other voluntary agencies, so as to avoid duplication.
- (d) To plan and conduct well-balanced programmes which could be continued within the framework of existing public health services.
- (e) To experiment with new ideas and methods; initiate pilot programmes and demonstrate their value, and to turn over to the official health services if and when this is appropriate.
- (f) To ensure that all its programmes are conducted at such a high professional and technical level that they will serve as models and will deserve the endorsement of the statutory authority and the support of the public.⁴

³ Canadian Council for Crippled Children and Adults, brief to the Royal Commission on Health Services, Toronto, May 1962, paras. 34–36.

⁴ Canadian Red Cross Society, *The Role of One Voluntary Organization in Canada's Health Services*, 1962, p. iv.

These two quotations exemplify two points of view which appear, with modifications, in statements made by different health organizations. The first argues that the voluntary organization can provide a "better" service than can government. Sometimes this includes the idea that it can do this more cheaply, and that government should provide the money – or more money – to enable it to do this on government's behalf. In the reports published by some of the voluntary organizations, this point of view is supported by some of the Ministers of both the federal and provincial levels, and by Deputy-Ministers or divisional heads in government departments who may be members of the board. Sometimes the statements in the reports seem to suggest lack of confidence on the part of government leaders in the ability of their own departments to provide an effective service. Probably they reflect a philosophy which would limit the direct function of government to those activities which cannot be pursued by any other organization in the community.

The second point of view places with government the primary responsibility for providing health services, and sees the function of the private organization as complementary, fitting in with the basic pattern established by government, but maintaining also the right to influence public opinion through education or demonstration in favour of action which the government has not yet undertaken.

The point of view held by the writer of the present study is that government is the instrument through which the citizens choose to provide services to meet those needs which can best be provided by the corporate action of the citizens, that government is capable of providing any service through its own organization if it chooses to do so, and that such provision can be made, if the citizens so demand, as efficiently, economically and flexibly by government as by any other type of organization. When government, as representative of the people, assumes responsibility for the provision of a particular service, it should be obliged to provide it directly, or to ensure that it be provided through other organizations. When it uses public money to support the provision of a service, it should be held accountable for the service provided.

THE STRUCTURE OF THE VOLUNTARY ORGANIZATIONS

It seems desirable now to review the general picture of the voluntary organizations in the health field. They have been categorized as "citizen-member" and "patient-member", and for some of the disabilities and disease entities, organizations of both types have developed. Most of the organizations have the support of members of the medical profession and some were initiated by it. Some are affiliated with the Canadian Medical Association, although the by-laws of that organization state that affiliation does not imply approval of their activities.

Citizen-member Organizations

The citizen-member organization is the type with which the community is most familiar. It has a long tradition of service to others and is thought, on this

continent, to be essential to "the democratic way of life". It includes people whose motivation is based upon their intimate knowledge of the suffering caused by the particular disease, either personally or through relatives or close friends. Comments have been received that some of the board members and substantial donors are "emotionally involved" and find it difficult to act objectively. In the organizations concerned with heart and cancer particularly, there is fear and anxiety aroused by the fact that these are the major "killer" diseases of which anyone can become a victim.

Most of the agencies have very limited membership. The freedom which allows them to organize may be democratic, but they represent small minorities and, within the structure of the organization, the general membership often has very nominal control. Some of them do not pretend to be democratic in their organization.

The board members are not necessarily "members" and a few of the constitutions state they do not need to be, or waive for them the payment of membership fees. The arrangements for annual or general meetings of members are formal, and the quorums stated – with a figure as low as six for a national association⁵ – demonstrate that such meetings are indeed a formality to meet the requirements of their constitutions and the conditions required for incorporation. In some cases the official constitutions do not seem to be observed. A government department is, at least in theory, responsible to the public; a voluntary organization is not, in theory or in practice. It represents a minority group and it is responsible to its membership rather than to its "public supporters". With the development of public services approved by the majority of citizens, the function of voluntary agencies is to represent minority opinion.

Some of the organizations have started under medical auspices to accomplish purposes of the medical profession which required lay participation; those concerned with tuberculosis, mental health, and heart are examples. Some appear to be dominated by the medical personnel, although they speak of a partnership between the lay and professional groups. Two have been affected by the changing medical picture, but, having developed "vested interests", including effective ways of raising money, are unwilling to curtail their activities.

When a voluntary agency becomes a member of a federated fund, it ceases to need a broad basis of membership for its financial support. Instead it needs board members whose position in the power structure of the community is such that their approval and presentation of the budget and the organization's plans to the budget committee of the fund, carry weight with the power groups within the fund. The support of such people on the board is necessary for the support by the "community" of the fund itself, since the support of the "big givers" and the corporations

⁵ The by-laws of one provincial association permit the board to alter the quorum provided the minimum of three is maintained.

provides the firm basis on which any fund stands, and since the funds themselves have developed under pressure from these groups. Similarly the presence on the board of representatives of power groups is considered to be necessary also to obtain from governments grants which are not based on legislative provision.

In many instances, the citizen-member organization has not adjusted to the changing role of the voluntary agency. And the organizations which the community has developed to support it financially and make its contribution more effective — the federated funds and the community planning bodies — have had effects upon it to which it has not found a solution. While the citizen-member organization used to have an active constituency in the community on whom it was dependent for its moral and financial support, it often cannot claim this when it is a member of a federated fund. Where it continues to raise its own funds, or its activities are dependent upon a large group of volunteers, it is in a different position.

Organizations which are not in federated financing, or which conduct their own campaigns in those areas in which there are no federated funds, do not generally raise the money through the direct efforts of their own members but use a wide variety of organizations existing for other purposes. These organizations have various reasons for giving their support. In some cases, an organization which is basically one of social fellowship wants to justify its activities to the public through its community service. A member, highly motivated to support a particular crusade, gains the support of his organization for it — it is a "good cause". And because of the interest of this member, the club's weight is thrown behind this cause rather than another. In some cases, the same organization supports and campaigns for several different causes.

It is hypothesized that in some instances, and possibly in many, the "cause" is not important to these supporting organizations as long as it is socially acceptable.

The particular health organization which these outside groups support is probably incidental to the basic motivation of binding their own membership together in a common effort. The association wants to have a bazaar or a concert, so it must have an acceptable recipient for the funds it raises. It wants to have a social occasion and yet justify this expenditure of time in a money-oriented world. These organizations have hidden motivation in the support they give. Like the patient-member organizations, they must find activities and outlets to enable them to provide for the needs of their members for social activity and the satisfaction of their leaders from successful leadership.

The amount of support that the health organization gets is based on its ability to enlist the support of the strongest organizations. This is not to question the very active interest an organization may develop in the cause it supports.

Patient-member Organizations

The patient-member organizations are developed by patients, or the parents of child-patients. To varying extents they enlist families and friends. Most of them are focused upon diseases of which the incidence is small,⁶ and have been organized because the community, the medical profession and those engaged in medical research were thought to be insufficiently interested, either to provide adequate services, or to seek the cause and hence the cure.

In such associations a strong motive of the membership is mutual aid. This means obtaining the services needed by the sufferers, less through their own financial contribution than through approaches to government, voluntary welfare organizations, service clubs and similar groups. It means social action to present the case for services to the public and, in some cases, to gain greater public acceptance of the patients. It means an emphasis on research, if not to help present sufferers, at least to help future generations. It means a basic need to associate with others who are familiar with the anxieties, fears, frustrations and suffering which the disease entails, both for the patient and the family. The person with a disease which is progressive and fatal faces complete frustration. He and his family must accept it with a spirit of fatalism, or find some way to fight it. In the process of fighting as one of a group, the patient no longer feels isolated and different from his fellows. He can share with them his anxieties, and gain from them and from the activities they engage in together, support in facing the present and the future, and companionship in his tragic position.

In some of the clinics for these diseases, the medical specialist has initiated group discussions among parents, to help them understand the diagnosis and its implications. Some of these groups have been the nuclei from which parents' associations have grown. The parents, experiencing mutual support, want to do something constructive in the situation. They form an organization and proceed to develop a school, a day centre, etc. The children themselves, depending upon the progressive character of the disease, may be able to develop sufficient self-confidence within this "like group" to move out of its protection into social relationships with those unlike themselves. The adult patients or disabled persons, particularly those whose conditions are stabilized, are encouraged to do likewise. Parents whose interest becomes extended beyond their own child to other children with the same disease may continue their membership in the patient organization after the child dies or moves into institutional care, or is able to function relatively normally in the community. Some parents and some adult patients, when they reach the stage of no longer needing the support of the "in-group" for themselves, may move away from it. And since they are probably the people who, strong in themselves, are the strongest leaders, the "in-group" is weakened. When the patient dies, the

⁶ The two exceptions to this are the Diabetic Association and the Association for Retarded Children. In both of these cases the incidence is relatively high.

parents, relatives or friends may withdraw rather than face constantly the reminder of the suffering.

Where the patient is a child, the parents are faced not only with anxiety, but with increased responsibilities for care, supervision and financial expenditure. Where the patient is the adult, his own illness or disability may be one which limits, physically and emotionally, his participation in the association. Several organizations reported that chapters died out or were re-organized frequently, because the people who were the leaders became ill or were hospitalized as the disease progressed. They have urged the inclusion of non-patients because of this, but it is probable that such an inclusion might reduce the amount of support which the "in-group" provides its members.

To get the mutual support and to reduce transportation difficulties, it is necessary for chapters to be small and intimate. The members need activity to bring and keep them together. They are very personally concerned, and most of the questions of policy are likely to be considered subjectively, rather than objectively. Because of the self-selection of membership, the motivation and the need for activity to release anxiety, the participants often do not have the skills or the social and political status essential for large-scale fund raising. They do not think of themselves as fund raisers, and most of their money is raised through local projects. Each patient is an individual to the group. His life must be made as pleasant as possible. He must be given what he needs to ease his physical condition.

The patient-member health organizations, through their own members' activities, are providing services which in the welfare field have become "professionalized". They do not always provide wisely, or with adequate medical advice. They act with strong identification with the patient, and their appeal to other organizations and individuals is an emotional one. They do not always know what services are available, so that some of their work duplicates that of other organizations. They gain from their work a tremendous amount of satisfaction, as do the non-patient members who associate themselves with them. To some extent, the latter group may be those who are excluded from volunteer work with welfare clients, through the professionalization of the welfare services.

These interests also create some conflict between the major interest of some of the national organizations and that of the local chapters. The national group sometimes stresses research and the local, direct service and mutual support. Some of the organizations have difficulty in persuading their chapters to make the contribution to research which they would like, because the local unit wants to spend the limited funds on direct services or on local research in which its members feel a personal interest. At the same time the small chapters and membership may not impress the federated fund, which is sometimes reported to have said it would not be justified in including a chapter since the incidence of the disease is low and the general public would not be interested in giving to the cause.

This situation creates organizational and financial difficulties. Some of the organizations, because of financial needs, have sought affiliation with a citizen-member organization, in spite of the fact that this affiliation may create problems when the chapter is a unit of another national association. One provincial Society for Crippled Children has a policy that it should try to take over the direct services from the parents' groups because of their emotional involvement. Yet the parents' groups fulfil a function of mutual support which is very important to them and hence to their children.

For example, concern had been expressed because many of the Cerebral Palsy Associations had become inactive when their services were absorbed by Societies for Crippled Children. At that time there were 51 local groups in Canada, 28 of them composed of parents only. From a study of questionnaires sent to parents⁷ and a workshop of professional staff, it was recommended that professional services should be the function of the citizen-member organization and integrated with services to other child-patients, and that this organization should provide the professional consultation to the parents' organization to enable the members to obtain from it the mutual support they needed by means of constructive activity. The functions of the latter organization were thought to be the moulding of public opinion to persuade it to initiate and support adequate programmes, to provide information to the community, to provide mutual support, and possibly to raise funds. In our opinion, there is also a valid function of volunteer direct service – e.g., co-operative day-care of a preschool group to relieve parents.

Most professional social workers are not at ease working with patient-member organizations, probably because professional objectivity is challenged by the highly charged personal involvement of the boards and the volunteers. Since the patients or their parents are the people needing help with their personal illness-related problems, the function of the staff social worker who tries to help them can become extremely difficult. The social worker in a consultative or advisory capacity probably has more possibility of being effective. Individual or group therapy sessions may also be needed, but they should probably be distinct from the activities which the patient organization provides.

National and Provincial Organizations

Both the citizen-member and the patient-member organizations appear at the local, provincial and national levels. The increase of national organizations during the post-war period has been particularly dramatic, and has created in part the present problems. Some of the organizations have centralized control, maintaining an authoritative relationship with provincial or regional divisions and local chapters or units. Others have started locally, later co-ordinating their activities at the provincial level, and eventually at the national level.

⁷ Armstrong, Keith S., (ed.), *The Parent of the Cerebral Palsied and the Community*, Canadian Council for Crippled Children and Adults, 1961.

Most of the earlier organizations in the fields of health, welfare and recreation were local, with the community planning and federated funds organized on that assumption. The rapid growth of parent bodies and of federations at the provincial and national levels, which has brought with it the development of national policies and national campaigns, has produced changes to which the former co-ordinating organizations have not adjusted.

The geographic area of Canada and the relatively scattered population inevitably creates difficulties for the democratic operation of a national organization. Membership meetings are few and ill-attended. Most organizations and particularly the patient-member ones are unable to finance the costs of travel. The effective management of the affairs of the organization are generally in the hands of a local nucleus of individual members, who do not represent the varied constituency. In a few cases the central body tries to control the situation through a constitution which is undemocratic – e.g., exercising control through the appointment of all senior staff. In two cases it also appoints all local boards. Since health and welfare matters are under provincial jurisdiction, centrally controlled national organizations must still be able to develop variations of programme and policy.

THE ACTIVITIES OF THE VOLUNTARY ORGANIZATIONS

The direct services to patients provided by the voluntary health organizations are, generally speaking, those which are not available through other public or voluntary organizations. They must therefore be taken to represent the points in community services in which citizen-member and patient-member organizations are aware that obtaining service presents difficulties to the patient.

The voluntary health organizations are at present engaged in the following activities, examples of which are given:

1. The organization of direct services related to medical and health care, which in some parts of the country and even in the same community are also provided by government – rehabilitation centres, bedside nursing, school health services.
2. The organization and provision of services as auxiliary to ones which the government is providing – lodges for out-patients attending hospitals, transportation.
3. The payment of the costs of services for all patients, or for patients on the basis of need, which in some places the government undertakes – schools for the retarded, prosthetic appliances, transportation.
4. The provision of services for groups of patients for whom the government has assumed responsibility, with government paying full cost, or sometimes a grant, for the services provided – services to the war-blinded, to the indigent.
5. The administration of institutions at the request of government, with all, or practically all, costs borne by government – outpost hospitals, sanatoria.
6. Demonstrations of services for which government has not yet assumed responsibility, with the objective that the public will be convinced that government should – Red Cross dental cars, schools for the retarded.

7. The provision of services supplementary to those of government through the provision of money or of volunteer activity — equipment for government hospitals, White Cross activities in mental hospitals.
8. The organization of pressure upon government to provide or improve certain services — Briefs to the Royal Commission on Health Services.
9. Education of the public on health questions which require action on the part of the individual — nutrition, immunization, mass tuberculosis surveys.
10. Education of the public in attitudes to illness and disability, to provide greater opportunities for the sufferers and to encourage early diagnosis — mental health, epilepsy.
11. Pressure and education of the medical profession to enlist their interest in and increase their knowledge of specific diseases, or to obtain specialized services — arthritis, hemophilia.
12. Provision of bursaries, fellowships and training centres for the increase or improvement in personnel in certain professions — public health nursing, physiotherapy, medical specialties.
13. The development of high standards of professional service through demonstration and training courses — visiting nurses, mental health.
14. The provision of money for and the participation in research both basic and clinical — heart, cancer.

This type of listing shows that the Canadian voluntary organizations are today providing services in some communities which are performed by government in others (and sometimes in the same community). The difference in function is only evident in the areas in which the organization is endeavouring to build up public opinion in favour of government action, or to bring direct pressure on government for this purpose. In some instances the organizations have undertaken, at the request and with the financial support of government, services for which the latter has assumed responsibility. They are also providing programmes for the total community, where the programme does not require the expenditure of money beyond their means. In some cases voluntary funds are being used to pay for services and facilities for which government has acknowledged responsibility.

In practice then, the functions of the voluntary organizations and government in the health field are intermingled to such an extent that little differentiation in function can be discerned. People act through the voluntary group in one instance, and act through government in another. Tradition, history, the availability of money, the emergence of leaders and the concept of the function of government all play their part in determining the present pattern.

Through these activities, the voluntary health organizations are providing or paying for the cost of a wide range of medical and related services.

The services are listed as follows:

1. Provision of specialized diagnostic and treatment clinics, either stationary or travelling and including casefinding surveys

2. Provision of medical specialists for treatment, including surgery
3. Fees for out-patient care in Rehabilitation Centres
4. "Halfway homes" for discharged patients
5. Payment of insurance for medical care
6. Dental care, including orthodontia
7. Transportation to medical centres for diagnosis and treatment by public facilities and ambulances, for patients and their escorts where necessary
8. Local transportation for frequent attendance at clinics, rehabilitation centres or schools for handicapped or seriously ill patients
9. Accommodation for patients and escorts at the medical centre, while receiving service as out-patients, awaiting admission, or, on discharge, pending transportation home
10. Accommodation for relatives in lodges during critical illnesses
11. Blood transfusion service and the Eye Bank
12. Surgical dressings, particularly for cancer
13. Drugs, including pain-killers
14. Milk, cod liver oil, etc., for children
15. Prosthetic appliances of all kinds
16. Equipment needed by the sick or handicapped — wheelchairs, crutches, colostomy bags, hoists, hospital beds, insulin injection and testing equipment, inhalation tents
17. Home nursing — both professional and practical
18. Homemakers, housekeepers, and home helps
19. Physiotherapy and occupational therapy at centre or at home
20. Social work
21. Dietary counselling
22. Speech therapy
23. Construction costs of hospitals and community health centres
24. Nursing stations in remote areas
25. Education and training
26. Vocational assessment
27. Workshops for work adjustment, vocational training and terminal employment
28. Placement in employment, and education of employers
29. Work for the homebound, including sales outlets
30. Housing
31. Residential care for particular groups — the blind, the mentally retarded, the crippled
32. Equipment designed for particular handicapped groups, such as the blind and paraplegic
33. Social adjustment activities, including group activities, day centres, camps
34. Recreation

Most of these services are available in some areas through government sources. Under the voluntary organizations they are provided in some communities and not in others, partly because of government provision, but also because of limited

finances and the unequal distribution of the agencies across the country. All these services are necessary to ease human suffering, to return the sick or disabled person to as normal health as possible, and to provide for his optimum rehabilitation.

It was impossible in this study to ascertain the extent to which the services are provided in any community, the unmet needs, or the costs to the organization. Each local unit conducts activities which, depending upon its autonomy, may be selected by itself, or may follow in general a national pattern. Its leadership, finances and standards of operation will differ from those of other units. Some local activities are conducted entirely by volunteers, with no paid staff. Any attempt to provide an "average" picture would be completely misleading, since the important question is what services are available to, or lacking for, a person in a particular community. Voluntary organizations are not the appropriate instruments to provide total service to any patient. Probably the agency which provides the most complete service across Canada is the Canadian National Institute for the Blind, and even in this organization there is a vast difference between the provinces.

Many of the local groups expressed their financial inability to provide for the recognized needs of the patients. Even such essential equipment as inhalation tents for cystic fibrosis patients was insufficient. Most groups do not attempt to assist with drugs because of the cost.

None of the services listed is a luxury, and most are necessities for adequate medical care for specific patients.

THE RELATIONSHIP BETWEEN GOVERNMENT AND VOLUNTARY ORGANIZATIONS

The Provision of Services

In the development of any extended government plan for medical care, the question immediately arises as to what, if any, use will be made of the voluntary organizations now providing or paying for these services. It is assumed that, when services are included in a public health plan, government has a responsibility to ensure that they are available to the citizens. The provision therefore cannot be left to the initiative of voluntary agencies. This, however, does not preclude the use by government of services and facilities which these organizations give or may be encouraged to develop. Any service which requires an organizational structure at least theoretically could be provided by government or by a voluntary organization.

Government is concerned with both the availability of needed services and the payment for their use. When the provision of a service is assumed as a public responsibility, the government should pay the entire cost, whether the assumption

of responsibility is on behalf of all citizens needing the service, or of a particular group, such as the indigent. When a service is paid for by government or is a benefit of an insurance or prepayment plan, its provision should not be subsidized by voluntary funds. Government should assure itself that the service is of the standard for which it is paying.

Where a voluntary organization is able to provide the service, government can purchase it from the organization. If no service exists, it can encourage a voluntary agency to provide it. Or government can choose to provide the service itself. All of these alternatives are illustrated in the existing pattern.

The choice of method will depend upon the pattern of services in a given community, the degree of necessary co-ordination with other services, and the extent to which the particular service represents the major activity of the voluntary organization. The voluntary organization, where used, must accept a degree of supervision and control from the public authority, since the government must be held accountable for the standard, efficiency and economy of the service for which it is paying.

Patient-member organizations should not be recognized as suitable for the provision of professional services.

When the total activities of a voluntary organization are those for which government assumes responsibility, the continuation of the voluntary organization, except in administering a public hospital, is open to question.

Some voluntary organizations try to justify their existence by arguing that they can provide the service "better" than government — that they do it more economically, can be more flexible, and more "personal". These organizations are often pleased to have government finance the service, but they want to retain administrative control. Somewhere in Canada government is providing almost every service provided by the voluntary organizations.

If government assumes responsibility for any service, there is no valid reason why it should not administer it. This makes it directly responsible to the citizens and accountable to them. Where it uses another organization, it must still observe its accountability, through some degree of supervision or control over the organization it uses as agent. This introduces a serious complication into its responsibility to account to the citizen.

The services which have generally been recognized as a public responsibility and are now provided in some parts of Canada by voluntary organizations are: public health services, including maternal and neo-natal care, well-baby clinics, child health conferences, immunization, school health services and public health education, mass surveys and case finding, employment services for the handicapped, and schools for educable handicapped children.

For many of these services, the government now pays the voluntary agencies. Sometimes, the government department provides the same service in different areas within the same governmental jurisdiction. It is suggested that government assume direct responsibility for all such services, strengthening its own provision to make this possible. Where, for justifiable reasons, the voluntary organization is encouraged to continue, the payment made by the government should cover the cost of the service, and be conditional upon a degree of governmental control of standards. In some instances such as case finding, the government should enlist the help of community organizations with or without the intermediary of a voluntary organization and its staff.

Some of the voluntary organizations are providing or administering hospitals and rehabilitation centres, under private Boards and financed almost entirely from public funds or hospital insurance benefits. These institutions are part of the "public hospital" system. They should be treated as hospitals, and a clear distinction made between these and the other activities of the same organizations (as is required for the National Hospital Services Plan but not for institutions supported by provincial funds).

The voluntary organization must be able to account to the donors for the voluntary funds. The importance of including in the national plan out-patient treatment centres, including rehabilitation centres, "travelling clinics" and "nursing stations" in areas not otherwise served by adequate medical facilities is strongly urged. Out-patient treatment is highly desirable when it is medically recommended, and its exclusion from the present plan means that patients who would otherwise remain in their homes are admitted to hospitals because of the coverage. Travelling clinics are necessary to take diagnostic and treatment services to unserved areas.

The personal services necessary for a patient to receive medical care in his own home, in preference to a hospital or nursing home, include bedside nursing and homemaker services. These are now provided almost exclusively by voluntary organizations,⁸ although the fact that such organizations function almost entirely in urban communities has resulted in a few public health departments making provision in rural areas. The patients are under medical supervision and the services must be related to the medical services. The cost of these services is sometimes paid by government for patients who are unable to pay, and in other instances by voluntary organizations or by the patients themselves. Payment by government for the indigent is increasing and generally comes from the welfare department. It should include payment for the medically indigent and not only those receiving public assistance.

These services should be available to all persons requiring them. It is medically desirable that certain patients be treated at home, and the cost is less

⁸ St. John's, Newfoundland, is an exception.

than other forms of care. Part-time and short-term nursing service can only be provided by an organization, and it is in the interests of the whole community that it should be available when needed. Hence its availability can not be left solely to the initiative of voluntary organizations.

In large communities in which there is a demand for considerable service and in which there are several hospitals, voluntary organizations large enough to provide economical and efficient service might continue, subject to the necessary degree of public control. In other communities, these services could be provided by the public health department.⁹ Under existing provisions for medical care, the payment for services is made by patients (or by government for the indigent) and would require the authorization of the departments to collect fees. If an extended health care plan included payment of such medical costs, these benefits would be paid to the health department (or reimbursed to the patient) since the source of payment is unlikely to be the same as the source of funds supporting the department. Probably the eventual goal should be public provision, rather than provision by a voluntary organization, on the principle previously stated that an organization in fact ceases to be voluntary when its major activity is financed by public funds.

Home care also requires the equipment necessary for home nursing. The organization providing the bedside nursing service would appear to be the logical one to provide the equipment.

Treatment by paramedical professions, such as physiotherapy, occupational therapy, speech therapy and social work should be provided in the home only when the patient cannot travel to a hospital centre. Travelling clinics will be necessary for more remote areas, and a team approach, related to the needs of all patients and not only those suffering from a particular disease, is essential. Since the team would provide for the patients of private practitioners as well as of hospitals, it might be located suitably within either the public health department or the hospital.

Prosthetic appliances – including braces, limbs, surgical boots, corsets, dentures, artificial eyes, glasses, hearing aids, etc. – have been provided free to all patients or free to needy patients by a wide variety of voluntary organizations. This is an area in which government has made little provision except for veterans and victims of industrial accidents. The recent federal Vocational Services Act provides for the sharing of the costs if the provinces make full use of it. Some public welfare departments make limited provision for the indigent, including children. Although figures can not be obtained, it appears likely that a very heavy part of the cost up to the present has fallen on the voluntary organizations. Wheelchairs, crutches, and similar equipment are provided by the same groups.

⁹ Homemakers are also essential services for families deprived temporarily or permanently of the mother, to maintain the family as a unit. Since these situations arise from social as well as health problems, the service should be available for both types of need and should be under social work direction. A choice must therefore be made as to its location in the health or welfare department, and in either case close co-ordination with the other department is essential.

These items are costly, particularly for children for whom the fitting must be changed as the child grows. They are essential to provide the maximum degree of physical independence for the patient and, without proper provision, the condition may become aggravated. The appliances and equipment are medically prescribed and part of medical treatment. They should be available to all who need them, paid for by public funds when the patient is unable to pay under our present system of medical care, or as a benefit under any insurance or prepayment plan. Since they are supplied only on medical prescription, the source of provision must be co-ordinated with the sources of medical care, and hence should be the hospital or the public health department. If their production is in the hands of commercial companies, profits should be controlled and exemption from sales taxes provided.

Drugs are provided by voluntary organizations only to a limited extent, except by those providing hospital or clinical services. This is said to be due to the heavy cost. Some organizations have been able to persuade individual suppliers to give discount prices to their members. The size of the discounts suggest that heavy profits are being made on the sale of drugs that are necessities to the buyers. Limited provision is made by public welfare services for patients receiving public assistance, but the lack of ability to obtain drugs may result in the progression of an illness which not only increases physical suffering and shortens life, but may reduce the person unnecessarily to permanent economic dependency.

This is an area in which public provision is essential for many reasons, including the fact that the cost is too great to be assumed by a voluntary organization.

Surgical dressings are similar to drugs, in that the commercial costs are reported to be exorbitant. The making of the cancer dressings by volunteers is an effective way of reducing the cost for the organization which provides free supplies. This volunteer service could be continued by the departments of health if this was thought to be the most effective way of reducing the costs of this service.

The blood and eye banks are highly organized services under two of the voluntary organizations, the former subsidized heavily by government. The question arises as to whether a public organization could enlist voluntary donors and clinical helpers to the extent now done by the Red Cross Society. Until a tradition of volunteer service within government is developed, it seems unlikely that this could be achieved.

Transportation to the medical centre and the provision of accommodation near it are services frequently undertaken by voluntary organizations, sometimes subsidized by public grants. The provision of medical care under any plan is meaningless to those who do not have access to the medical services because of their geographic location. When specialists are concentrated in larger urban areas, patients must be able to come to the centres for diagnosis and sometimes for out-patient treatment. If transportation but not accommodation is provided, they may

became in-patients unnecessarily and at greater cost. The person is often handicapped by his sickness in making arrangements and providing for himself during the time at the medical centre. Often he requires an escort. In urban centres, too, where handicapped or sick persons are required to attend clinics or rehabilitation centres frequently, and public facilities are inappropriate, transportation has become a major responsibility of the voluntary organizations.

Provision for transportation to and accommodation near the medical centre should be co-ordinated closely with the administration of the medical centre although the actual work might be undertaken by volunteers. Provision should be made for any patients needing the service coming to the particular centre. It would seem to be a logical activity for a hospital auxiliary, with the costs paid, on the basis of need, by the health or welfare department.

Provision of transportation of handicapped children to schools should follow the pattern of the regular school transportation services.

For some time to come there will be some items in the above list of services provided by the voluntary organizations for which government will not take direct responsibility. These services are not now provided in all the geographic areas in which they are needed and are inadequate in others. Thus the voluntary organizations will still be necessary in the provision of direct services, and the partnership between the citizen-member organization and the government will continue. Their major activity may be transferred at a later time from the provision of medical care and closely related services to concentration upon the provision of social and vocational rehabilitation.

The previous suggestions would give to government the responsibility for organizing and in part financing many of the services now provided unevenly throughout the country by the voluntary health organizations. Their implementation would result in the disappearance of some of the organizations, and would change the emphasis of the activities of others. It is to be hoped that it would result in the active participation of more volunteers, with a larger part of voluntary funds used for the administration of service and less for their provision or payment which would become a public responsibility.

The present activities of the voluntary organizations which unquestionably must remain as voluntary activity include:

- (a) The development of public opinion to take action in an area in which public action is thought to be desirable.
- (b) The organization of social action regarding the activities of government, or new activities which it is thought government should undertake, or the protection of the interests of minority groups.
- (c) "Watch dog" activities to hold government accountable to the citizens regarding its actions and to ensure both quality and economy in the services provided.

- (d) The provision of "extra" services to supplement those for which government has assumed responsibility.
- (e) The demonstration of needs in areas in which government has not assumed responsibility, or of methods other than those used by government.
- (f) Public education, research, and the provision of fellowships and bursaries – activities which provide sufficient scope for both public and voluntary activity.
- (g) The provision of opportunity for people to give service to their fellows, through voluntary activity and often directly in partnership with government.
- (h) The provision of mutual support to patient-members.

Legal Control of the Voluntary Organizations

The voluntary organizations to a large extent are controlled and directed by small groups of people and, in some instances, rely very heavily upon staff rather than board direction. The national organizations are forced, by the size of the country and by limited funds, to use small local or regional groups to conduct most of their affairs. Provincial organizations face the same problem within their areas. The ability of an organization to raise money is heavily dependent upon its "salesmanship" and the money it receives is not a valid assessment of the support of the community for the particular "cause". When active membership is very limited and funds are obtained through public campaigns, the total population becomes "the constituency" of the organization. This constituency provides no real control of the organization's activities.

The organizations for the most part do not provide in their financial and other reports the means whereby the public can assess their financial operations or administration. Some of the reports could be interpreted as a planned effort to mislead the public – to "sell" the agency, rather than to give a responsible account. With the complexity of the activities of many of these organizations, clear, understandable statements are very difficult to achieve, and the contributing public is a rather nebulous body to which to account. In the face of these facts, the public is unable to hold the organizations "accountable" for the money it gives them, and some of the organizations appear to take advantage of this.

It is suggested that government on behalf of the public should demand and enforce a greater degree of accountability, and provide the "policing" function which cannot otherwise be effectively performed. Incorporation under a Societies or Companies Act as a non-profit organization does not provide the safeguards necessary to protect the public which invests its money in these organizations. The local control of campaigns is also ineffective, particularly when the campaign is not that of a local organization.

It is suggested that federal and provincial governments should, where they have not already done so, pass specific legislation for the incorporation of charitable organizations and the control of public campaigns, and that municipal

permits to conduct campaigns be issued to national and provincial organizations only when they are thus incorporated. Exceptions could be made for small local organizations whose activities are so limited that incorporation is not considered necessary.

Incorporation of a national organization or of an organization of which the name implies activity in more than one province, should only be possible under federal legislation, and the relationship between federal and provincial incorporation of the units of one organization with different levels of activity should be clarified.

The laws providing for incorporation should require a constitution appropriate to the type of organization, whose objectives are clear and specific, and for the implementation of which authority to raise funds is given. It should endeavour to ensure the degree of membership control which is feasible in the constituency, in the provisions for election of the board, amendments to the constitution, and accountability to the membership. It should require and enforce conformity to the constitution and approval of changes in by-laws. It should require the annual submission of financial statements, preferably in a standard form, and audited by a chartered accountant not otherwise associated with the organization. It should provide that government approval of such reports be a requirement of continuing incorporation, that the government have the right to see the books, to initiate such inquiries as it considers necessary, and to investigate any complaints made by the public. It should make the reports available to the public. The law should make it possible for the government, on behalf of the public, to provide assurance that the financial transactions of the organization are satisfactory and according to the declared purposes for which the money was raised. Truthfulness in advertising and publicity should also be required. Some method should be devised to control the continuing incorporation of an organization which has ceased to be an independent body carrying out its proclaimed objectives, but which the organization seems now to maintain in some instances to justify the launching of a separate campaign, to preserve the right to a name, or to receive government grants.

Study should be made of the practice of some incorporated non-profit organizations engaged in profit-making business enterprises, either as part of their regular activities, or as "subsidiary companies" with separate incorporation. This includes the manufacture of prosthetic appliances, and businesses designed to provide employment for disabled persons. The question is raised as to whether such activities should not be regarded as commercial, perhaps coming under legislation modified from that applying to normal commercial ventures.

The legislation which now controls charitable foundations includes some of the provisions suggested above. This legislation is presumably based upon the concept that government has a responsibility to ensure that money provided through endowments or bequests should be spent for the purposes for which it is given,

and that the law is the instrument through which this should be safeguarded. The suggestions here merely involve the application of the same principle to money raised from the public at large.

Charitable donations deductible for income tax purposes should be defined more specifically. If the suggestions regarding incorporation are implemented, the requirement of the Department of Internal Revenue might be that the organization to which the donation was given should be incorporated under these laws.

Government is not the appropriate body to determine whether a voluntary organization is "needed" in the community, particularly as such an organization is a minority effort. Its function should be limited to a general judgment that the purposes promote the "common good" and its methods of operation are in conformity with its objectives, and the law. Community planning organizations, in which the public and private sectors of the community meet, must carry the responsibility for determining the desirability of duplication, overlapping, or experimental services and of setting standards of practice. Competition between voluntary organizations, or between them and government may be as desirable as it is assumed to be in industry, as a method of setting standards or of resolving conflicting opinions.

Public Grants to Voluntary Organizations

Most national organizations are receiving public money, sometimes from all levels of government. Government support is also given through the loan of staff, the provision of accommodation, the provision of drugs and other services. In a few instances, but in appreciable amounts, voluntary organizations are giving their funds to assist in the construction of government buildings, in the provision of essential equipment for government institutions, or in supplying staff for the public services.

Government money is paid to voluntary organizations to purchase services for groups of people for whom the government has assumed responsibility. Examples are veterans, the victims of industrial accidents, and the indigent. Or government pays for professional services which elsewhere are provided by its own departments – school health services, schools for handicapped children. Its decision to purchase services rather than provide its own, in instances in which its responsibility is clear, should be based on sound planning. In some instances it does so when the service overlaps with its own, perhaps because the activity of the voluntary organization preceded the public service, perhaps because the "vested interests" of the voluntary group create resistance to change. When the organization is providing an acceptable standard of service for a much larger group than the people for which government assumes responsibility – for example, the war-blinded, the decision to purchase may be sound.

When the government purchases service, it should be assured that it is receiving full value for its money and that it is paying the full cost.¹⁰ Voluntary funds should not be expected to subsidize a service for which government has assumed responsibility. In one major organization, it appears that the payment is insufficient, although proof is lacking. In another, the method of costing was not ascertained, but the way in which the money was accounted for raised questions. Accurate cost accounting is necessary to implement this principle.

No evidence was uncovered that government had established procedures by which it assessed the standards of service it purchased. This was true even in instances of hospitals not under the Hospital Plans, the administration of which was delegated by the government to the voluntary organizations. One director reported that the government did not "interfere", although it was paying full costs.

Public grants by different levels of government are given to almost all citizen-member voluntary organizations. They come from as many as four different departments of the same government. Although in a few instances some formulae or criteria have been established to determine the amount of the grant, this is not usually the case. There are several instances in which grants have been given when the organization was quite able to finance the undertaking from its reserves or operating funds.¹¹ It is suggested that there is a tendency to assume that the amount of support an organization receives from the community should be one of the determinants of a government grant, but the organization with strong support may be in least need of the financial assistance. It is probable that the "salesmanship" of the organization is an important factor in determining the amount of the grants.

A scrutiny of the public accounts makes it difficult to discover what public funds an organization is receiving, partly because of the listing under several departments, partly because of entries which do not make clear the organization receiving the money, or what part of a total amount it received.

It is suggested that grants to one voluntary organization should be channelled through one department, although the source may be in the budget of another department. Only in this way would it be possible for government to assess the position, and the extent to which grants are necessary or desirable. It is suggested that criteria for determining the amount of money to be given be established, and that this should take into account the need for the service and the financial position of the organization. Where a grant is given, under legislation or otherwise, government should require an accounting of the expenditure. This recommendation implies the right of government to satisfy itself regarding the financial

¹⁰ "Full cost" includes the appropriate administrative costs.

¹¹ Certain legislation provides for grants, for capital construction for example, without regard to the financial position of the organization, but the grants in question were not of this type.

transactions of the organization and the standards of its services. If the suggestion regarding incorporation is accepted, the surveillance required would assure the public of the financial position, but not of the standards.

Senior government officials are frequently members of the boards, executives or committees of the health organizations. In some cases they participate as officials of the government, designated as its representatives. In other instances the government does not make the appointments, and technically the person acts as an individual. There is one instance in which the constitution specifies that all Deputy Ministers are ex-officio members with their consent, and the assumption within the organization, and probably within the mind of the public, would seem to be that they sit in their official capacity. This would appear to give official support to the organization.

It is impossible for officials in high position to participate in a private capacity in organizations the work of which is related to their official duties. It is suggested that such officials should only be publicly identified with an organization when they are appointed to represent the government. Their positions are particularly open to question when the organization receives a government grant or criticizes the government.

Government or government departments assist voluntary organizations in some other questionable ways. Government concessions for canteens, cafeterias and stands require further study. The use of the school system for the work of the Junior Red Cross gives that organization a preferred position through public recognition, but also for publicity and the recruitment of support. The use of school children to assist in a mail campaign by "stuffing" envelopes, or even to participate in an inter-school poster competition, should be based on policies defined by educational authorities. The use of school children to raise funds is very unfortunate, and presents a very undesirable situation for the child of poor parents. The dramatization of certain campaigns through the use of firemen in uniform and with full equipment should also be a matter of public policy. Such situations are likely to arise through the particular enthusiasm of one or two people, without due regard to the competition between the organizations for such services and a proper assessment of the particular "cause".

Voluntary Contributions to Government Services

Some of the voluntary organizations are making substantial financial contributions to the costs of services for which government has assumed direct responsibility. These include contributions to capital construction of public buildings and the provision of essential equipment to public hospitals. In some instances the hospital equipment is of a nature that might be considered by some administrators as "extras", but should be standard equipment or furnishings for hospitals which have accepted the concept that the patient – and not his illness – is the focus of medical treatment.

Hospitals, clinics and health centres under government auspices should provide from public funds for the complete operation of the facility for which the public has accepted responsibility. The cost to the public through taxes should not be subsidized by voluntary funds. The expressed point of view that this voluntary contribution makes the community consider the service "theirs"¹² strengthens the public attitude that government is something divorced from the citizens, and the public policy should be to change this attitude rather than to reinforce it. When the contributing agency is a provincial one and the facility local, it is difficult to see how the voluntary contribution can be interpreted locally as the community's personal contribution.

Some organizations provide second-hand clothing for hospital patients. Where indigent patients require clothing, the provision should be the responsibility of either the health or welfare departments. This has long been accepted by public welfare departments in the provision made for indigents and should apply equally to persons in hospitals and institutions. In these settings attractive, individually selected clothing can be a constructive element in the rehabilitation process.

Volunteers can play an important part in public institutions through their own services, and the above discussion should not be interpreted as suggesting their exclusion from hospitals.

Government Support of Patient-member Organizations

It has been pointed out that the patient-member organizations provide, through their small local units, support for their members and satisfying activity for interested persons who wish to give direct personal service. Some of these groups are unwisely endeavouring to provide professional services, and they should not be helped to do so. Their educational and social activities should be encouraged, as it is through corporate activity that they help each other. If they are able to raise funds for research or participate in it themselves, this also provides constructive, useful activity.

Apart from their interest in research, the local groups require limited funds. The development of a staff would generally defeat their unwritten purposes, as some of the members are aware. Their numbers are small, and their fund-raising ability frequently limited by their disabilities. This suggests that their limited financial requirements deserve careful consideration from federated funds and other organizations.

Their more important need is for a professional consultant who can help their members to obtain the services they need through existing public and private

¹² It is interesting to compare this with the frequently expressed opinion that citizens should be fully aware of their contribution through taxes to various benefit programmes, such as medical and hospital care.

services and can act as an advisor in their activities. Such a relationship has developed between the Canadian National Institute for the Blind and the Clubs for the Blind. There is not generally as natural a partnership between the citizen-member group and the patient-member organization, and such a relationship might sometimes defeat the purpose of the latter.

It is suggested that the provincial governments provide, in the appropriate department, staff to act as consultant to these groups. Since the services they require for their medical conditions are increasingly provided by government, this seems more appropriate than provision of consultation by a voluntary co-ordinating council. An analogous position is that of the liaison officer attached to the Department of Citizenship and Immigration in some cities, to work with the ethnic groups.

FINANCING THE VOLUNTARY ORGANIZATIONS FROM VOLUNTARY FUNDS

This study shows that a minimum of \$23,000,000 was received in 1961 by the major voluntary health organizations from voluntary contributions for operating costs and research. Local organizations and local branches of some of the provincial and national organizations are not included in this figure, nor are organizations the revenue of which, excluding their hospitals, was under \$100,000.

Some of these organizations have built up surplus funds over the years and are having difficulty in spending the money. At the same time some of the smaller ones - patient-member ones - are in financial difficulties. Other types of voluntary organizations providing community services are unable to obtain the money they need.

The development of increased public services through the Hospital Services Plan, other public health and welfare activities, and the increase in medical knowledge have already reduced the need of funds for some of the health organizations. Further reductions can be expected. The public is donating money to some causes for which it is not needed, and public grants and indirect subsidies are also being provided.

While there has been heavy pressure upon the health organizations to participate in federated funds, the policies of the funds have not been able, as yet, to adjust themselves to the inclusion of national and provincial organizations. The traditional form of "budget review" is not effective, and it is suggested that the desire of the fund supporters to avoid multiple appeals has placed some of the health organizations in preferred positions. Some funds seem to have departed from the objective of allocating funds to enable a service, important but lacking emotional appeal, to be developed.

It is suggested that the National Agency Review Committee be strengthened and that it provide also for the review of provincial organization budgets, since it would be impossible for the smaller provinces in Canada to develop effective provincial Budget Review Boards. National and provincial organizations should be classified according to the seat of financial control. Where the control lies with the senior body, the national review should include the complete budget at all levels,¹³ since the national organization has the final control legally. Where the financial control is local, and the national body financed largely by an assessment on its divisions and units, the national review would be of the national budget only and of the fairness of the formula for assessment purposes. It is suggested also that this Review Committee undertake an intensive campaign to encourage full use of its findings.

It is suggested that local federated funds revise their membership policies, where necessary, to give more weight to the value or need of the service given or proposed by the organization, that they demand of their members standards of administration and service, that they recognize the needs of new agencies with expanding programmes, and that they assess more realistically reserves and special funds held by the organizations at the time they become participants.

Voluntary organizations should not be discouraged in their efforts to contribute funds to research. Their efforts are likely to be more fruitful when the appeals are made by a disease-focused organization rather than one appealing on behalf of research in general. The work involved in obtaining the funds is of constructive value to patient-member organizations particularly. It is suggested that thought should be given by community planning and federated fund-raising groups to the desirability of excluding research funds from federated fund raising except where the request is for funds to support a particular project which the organization itself would like to undertake, e.g., the evaluation of its services, or clinical research in which its members participate. This is suggested on the grounds that research funds, like capital grants, cannot be budgeted for by any acceptable criteria, and the budgeted amounts can express little more than the aim or hopes of the organization. It is also suggested because the incentive to give for research in the abstract is likely to be less than for research related to a particular disease entity. Voluntary funds for research are not in fact "voluntarily given" if the conviction of their need is in the minds of the budget committee of the federated fund and not of the donors.

All bodies concerned with the allocation of voluntary funds – Budget Review Boards, Chests, United Appeals, governments and the voluntary organizations themselves – should recognize that the philosophy that funds raised locally should be spent locally is not tenable. It has long been recognized in the public sector that local financial responsibility for health and welfare costs means that the economically deprived community cannot support the services it needs. Yet

¹³ To ensure that the local activity was acceptable to the community planning bodies in the large communities, some assessment from those bodies might be obtained.

in the voluntary sector, the federated appeals are based on local responsibility, and many of the national organizations demand that local or provincial units be self-supporting. This means that, with the economic variations across Canada, the voluntary services available, even through the divisions and units of national organizations, are dependent upon the local financial position, and are least well-developed in those places in which the economic level is low. Voluntary organizations should be prepared to adopt an "equalization policy", similar to that practised, to some degree, by provincial and federal governments. It is natural that people who spend time and effort to raise money in a local area should want to control its distribution but, at this point in our history, it should be possible to implement another point of view.

The question of voluntary organizations giving grants to other voluntary organizations is a difficult one. Since federated funds do not permit this, the practice is limited to those organizations which conduct their own campaigns. (The one exception discovered was the Canadian National Institute for the Blind, which finances the independent Clubs for the Blind, which it "advises" but does not control.) Many organizations pay the fees for particular services given by other organizations to the patients in whom the fee-paying organization is interested and these should cover the actual cost. The purchase of service is similar to the arrangements between public bodies and the voluntary organizations. It is recognized that grants are sometimes in lieu of fees, but they do not permit the same degree of accountability.

A policy supporting grants from one voluntary organization to another assumes that the organization raising the money can redistribute it among other organizations as it sees fit. In federated fund raising this redistribution requires a complicated budgeting process, related to community planning and, at least theoretically, to standards of service. The same process does not appear to be attempted in this other form of distribution, which in some instances seems to consist of the organizations dividing the proceeds amongst themselves. If the funds are being distributed within the objectives of the organization, duplication of objectives is implicit. The policy means that the public is, in effect, being asked to contribute twice to the same organization.

Grants may be justified where a citizen-member organization sponsors a patient-member one, but if they are based on budgets or standards they must involve some degree of control. Other grants counteract the efforts of community planning and standard setting. It is therefore suggested that grants to other organizations be discontinued, except for the payment of fees for service, the establishment of a fund for a special purpose to be administered by the other organization, the sponsorship of a patient-member organization serving the patients in which the granting organization is interested, or similar payment for specific purposes. These restrictions might be included in the laws suggested regarding incorporation and accountability.

Since these grants are generally made by organizations which are unable to spend their money for their own services, the restrictions may lead to increased surpluses, unless the fund-raising activities of these organizations are curtailed. Surplus funds should not be allowed to accumulate beyond a reasonable reserve, but should be distributed, through equalization grants within the parent organization, or contributions to community planning and standard-setting bodies, charitable foundations, research, or other acceptable purposes. Such distribution must be within the objectives for which the money has been raised.

When an organization is basically "public" – hospitals, rehabilitation centres, and sanatoria – the voluntary funds should be kept separate from the public funds, the purposes for which they are to be used should be clearly defined, and a separate financial statement issued to account for the expenditure to the contributing community.

Where two campaigns are conducted by one organization under different names (if this procedure is permitted to continue), two separate funds should be established, and expenditure accounted for in relation to the publicized objectives of each campaign.

The question has been raised whether increased assumption by government of responsibility for services now provided by voluntary health organizations would affect voluntary donations. It has been noted that salesmanship is an important factor in the amount of funds collected. This is demonstrated particularly by those organizations which are able to collect more funds than they can use for causes for which government has assumed major responsibility or for which medical discoveries have reduced the need. At the same time other causes in both the health and welfare fields have insufficient money for their needs. Were government to assume responsibility for many of the services now financed by voluntary funds, the donated funds could be diverted by the donors to other equally important causes under health and welfare organizations, if the same qualities of salesmanship were used. And if volunteers were used more effectively in the giving of services, the motivation to give money and the ability to "sell" the cause would be increased. It is probable that the amount of voluntary giving depends more heavily upon economic conditions and salesmanship than upon any other factors. To inquiries made of a number of persons as to whether research could discover any relationship between voluntary giving and governmental activity, no suggestions were forthcoming.

The publicity of federated funds implies that a plateau in receipts may have been reached, although voluntary organizations can not be adequately financed. This is questionable, in view of the success of the newer organizations running their own campaigns, and the steadily increased returns achieved by some of the older, well-established organizations. There would appear to be two basic problems – the education of the public to give intelligently and, in federated financing, the equitable allocation of the funds donated. A large percentage of federated funds

are obtained from corporate givers and from payroll deductions. Some of the independent campaigns draw heavily upon the small givers, and this may be the explanation for their success. The proposals regarding the increased use of volunteers in services to which they can make an effective contribution through personal service is likely to increase still further the financial contribution of the small givers.

Whatever answer is given to the question of the effect of governmental activity upon voluntary giving, it is the opinion of the writer that it should not be a consideration in the decision about government's responsibility in the health field. Voluntary services should supplement government activity through partnership, and voluntary organizations should adjust their services with changes in governmental responsibility. Government can not fulfil its own responsibility effectively by substituting the uncertainties of voluntary giving and activity for those services which the people want to provide for themselves through their government.

Canada needs an "accrediting" organization to provide an objective evaluation of national and provincial organizations, on the basis of established standards — an organization on the pattern of the National Information Bureau in New York. This would be of value not only in providing information to corporations, federated funds and individuals to guide them in their voluntary giving, but also to guide the newspapers, radio and television networks, periodicals, etc., regarding the support they should provide through their media to the public. The effectiveness of such a Bureau is dependent upon its complete integrity and its ability to resist pressure from power figures in the community in favour of the organizations in which they are interested. Although it might be partially supported by government, it must be independent. Foundation grants and allocations from federated funds might be obtained.

CITIZEN PARTICIPATION

In present-day society materialistic values need to be balanced by the expression of the social conscience in assistance to those who have not achieved material success, and in sympathy for those who, for health or other reasons, need a helping hand. The need to give, and the opportunity to express these social values must be preserved. Paying one's taxes or giving to a federated fund does not provide the same satisfaction as helping one's neighbour. In the development of social attitudes towards people, personal contact is of extreme importance. The difference between the expression of international good will through the giving of help by government or by a voluntary organization to people in Africa and of participating directly in a Canadian-African friendship group in Canada is obvious. The same difference is present in the giving of money to a campaign for retarded children and assisting as a volunteer in a day-centre for these children, or of subscribing to a fund for a blood transfusion service and being a blood donor.

Voluntary welfare organizations have become professionalized to the extent that their use of volunteers is generally limited. It is recognized that volunteers usually cannot provide professional service, the "leisured class" is no longer available to provide the former amount of voluntary effort, and the complexity of our life and the needs of the clientele of a particular agency limit the services which a volunteer can give. It is suspected however that the distinction between services which are "professional" and those which are "good neighbour" activities is not clearly recognized, owing to the understandable desire of social work as a relatively new profession, developing from activities previously attempted by volunteers, to make distinct the professional component of its services. The result has been that volunteers, who formerly received intensive "in-service training" through their activities within the organization, with the best people working their way up to board membership, now become board members with the important functions of policy-making and planning and ultimate responsibility for all of the activities of the agency, with no previous knowledge of and no direct contact with its work. Since agencies need on their boards people high in social status and in the community power structure to obtain the funds they require, the agency seeks to obtain the names and nominal support – if not the active participation – of such people, who presumably support the "good cause", but may make little contribution to it except their names.

While some of the health organizations have followed the pattern of the welfare organizations, others make very extensive use of volunteers. The reasons for this are related to the objectives of some of the organizations. They seek to educate the public and develop public opinion regarding health or a particular disease with the purpose of working for action by government or by individuals when the control or early diagnosis of the disease requires personal action. Since most illness does not carry with it the stigma which tradition has attached to financial need – still associated in the minds of many with welfare agencies – direct contact with the sufferer is not considered to have the same undesirable "Lady Bountiful" connotation. Hesitation regarding the use of volunteers is based on the emotional response to suffering of the volunteer, who may upset the patient by his expression of sympathy.

Some health organizations are able to use volunteers effectively in direct contact with patients. When an organization's effort is directed to the community at large in, for example, training in home nursing and a public education programme, the conflict regarding the use of volunteers does not arise. In the provision of social activities for handicapped people, volunteer activity is in those areas in which welfare agencies also use volunteers – planning a programme, providing refreshments, arranging transportation, etc.

Citizen participation in voluntary activity can be the expression of the "democratic way of life" not only as freedom to organize, but as the direct contribution of citizens to each other's well-being as members of one community. It

can be training in democracy and in social responsibility. Government in a democracy also represents such an expression, and the effective activities of voluntary organizations in conjunction with government produces a desirable partnership. The emphasis is upon the partnership and not on opposing forces.

In most of the organizations studied, there seems to be an assumption that public services cannot use volunteers except through co-operation with a separate voluntary organization. The pattern of Canadian government has not encouraged citizen participation in the activities undertaken by government, except through the elected representatives of the people and in limited use of advisory committees. There are a few examples of the development by government hospitals of hospital auxiliaries, of well-baby clinics under public health departments enlisting volunteer services, and of homes for the aged encouraging the help of volunteers. Some of the activities of the health organizations, such as the Tuberculosis Associations, might be carried on more effectively by volunteers enlisted directly by the public body. The limited finances needed could be provided by government or by special fund-raising projects.

The importance of providing outlets for the activities of volunteers should be recognized. Public departments and services should be more fully aware of the effective contribution which citizen participation in its activities could provide. Volunteers could frequently be used in its services, as they are in those administered by the private organizations. Citizens on boards and advisory committees could give more service in the interpretation of the community needs to the department, and of the department to the community, in the development of policy and the co-ordination of the public and private services. Such participation would also help to remove the present "separatist" attitude to government activity.

COMMUNITY PLANNING FOR HEALTH

The stated objectives of the voluntary health organizations show relatively little duplication, and this mainly where the purposes relate to the broad field of "health" and "the relief of suffering". The citizen-member organizations with these objectives limit their activities so that the duplication is less evident than the statements of purposes suggest. Some duplication is evident when an organization limits its services to an age group — the child, for example — while others define their scope by nature of the disease.

When organizations are focused upon a particular disease or organ, duplication or overlapping of services is unavoidable. For example, many of the organizations are interested in research with a particular focus. The interest in research is duplicated, although the focus is not.

It is highly desirable that people interested in a particular disease should be permitted to organize to pursue their interest. The community planning objective should be to influence the ways in which this interest is pursued. A "mutual

aid" society generally seeks to obtain services for its members and it can be encouraged to do this through services available also to patients who are the members of other organizations. The provision of equipment for home nursing or of wheelchairs, for example, should generally be the responsibility of one organization in any geographic area, to be used by patients referred by their physicians, with the public and voluntary organizations facilitating the referrals. Government is increasingly assuming responsibility for the payment of the costs of these items to the medically indigent, and in some instances provides the source of supply — e.g., prosthetic appliances through the Department of Veterans Affairs. It could exert its influence to facilitate the development of centralized supplies, under public or voluntary auspices. The channels of supply for some of the requirements should be directed through the hospitals from the central source.

It is assumed that with the development of public or public-sponsored medical care plans, the participation of government in such provision will increase. This will automatically decrease the activity of the voluntary organizations in providing the services, but leave with them the important function of facilitating the use the patient makes of them. Many patients need help in this regard. As medical care plans develop, government has a responsibility to see that adequate services of good standard are available to all patients. The voluntary organizations have a responsibility to work in partnership with government to this end, and to inform the citizens of gaps or unsatisfactory standards in the government's provision.

Patient-member organizations should not provide professional services, because the members are too involved in the problem to do this effectively. This injunction includes the provision of schools for handicapped children. The voluntary organizations have made a notable contribution in this field in forcing upon public attention the need and the practicality of such schools. In some instances, however, the original purpose of persuading the educational authorities of the need through demonstration, seems to have resulted in so much enthusiasm for their own efforts that "vested interests" have developed. Educational authorities appear to be willing to give financial support to educational classes over which they exercise little or no control. It would seem to be preferable to have such schools part of the regular educational system, and designed for all the appropriate children, and not only — as under some of the voluntary auspices — for children classified by particular diseases or disabilities. These comments apply to centres for educable children; centres for "trainable" children have not been accepted as the responsibility of the educational authorities.

An area of activity in which a number of the disability-focused organizations are engaged is that of sheltered employment, including workshops, planned for work adjustment or "conditioning", training and terminal employment,¹⁴ and income-producing work for the home-bound. Some of the workshops, run by one organization, accept persons served by other organizations also. Some are only planned

¹⁴ "Terminal employment" is the phrase used for the employment of persons who are not considered to have the potential for work in competitive industry.

for persons with a particular disability and use able-bodied workers for the tasks which the disabled cannot undertake. Some have been organized by independent groups or sponsored by a rehabilitation council, and are not limited to persons suffering from one particular disability.

Reports suggest that there are inadequate workshop facilities for the disabled in many communities. In all probability the automation of industry will increase the numbers who cannot compete in the open labour market. For terminal employment it would seem appropriate to have these workshops available for persons with varied disabilities, since the part of the work for which one person is handicapped can often be performed by a person with another handicap. For work conditioning, and the first attempt to work of a person who doubts his capabilities, temporary employment with the "like group" may be desirable. It is also argued that terminal employment should be distinct from temporary conditioning or training because of the obvious differences in objectives and hence of organization and programme. The organization of workshops which are competing with commercial enterprise should probably continue as a voluntary effort, although official agencies can, and at present sometimes do, provide those designed for conditioning and the development of work tolerance. The importance in any community of the assessment of the need and the co-operative support of different organizations emphasizes the part the community planning organization should play in their development and subsequent operation.

The provision in each community for the rehabilitation and vocational assessment by the necessary team of specialists should also receive attention from the community planning body. In all but the largest communities this should be centralized with well-defined channels of communication between the assessment body and the wide variety of specialized organizations from which the patients will come and of community services to which they may be referred.

Public education is an area in which many of the organizations are engaged. When the education is focused on the sufferers from a particular disease, to help them, their families and the professional people related to them – the teacher of the epileptic child or the dentist of the hemophiliac – it is a logical function of the disease-focused organization. When the scope of the health education programme moves into the broad area of "total health", as it has in several of the organizations, the duplication of costly effort becomes serious. This is an area, too, in which Departments of Health are active. The admission of several – and an increasing number¹⁵ – of the organizations to the schools to "educate" the children is undesirable. Health education should be an integrated part of the school curriculum, in which films, etc., provided by the health organizations, can be used by the regular teacher. Schools can be subjected to heavy pressure by the various organizations, both for education and fund-raising purposes, and it

¹⁵It is reported that the Cancer Societies are now negotiating with schools to provide an educational programme on smoking.

would seem desirable that policies be established to exclude their use by "special interest groups", partly to avoid the complications of making a choice among them. The organizations should work through the teachers, but the support of the school should not be placed behind particular organizations.

The effect of education designed to make the public conscious of symptoms and seek immediate medical advice may create anxiety to the extent that it defeats its purposes. Research on this question would be very valuable. Comments have been received which suggest that a "symptom-conscious" population is being created rather than one with positive attitudes to health and healthy living. Too much concern about illness, with the fear and anxiety associated with it, could produce a generation of hypochondriacs, or one partially paralyzed, unable to venture into certain activities for fear of ill-health.

The education provided to the medical profession by the special interest groups is reported to be of great importance. The provision of up-to-date knowledge to the general practitioner on such subjects as tuberculosis and arthritis, and his preparation for greater responsibility for the patient in his own home, are assuming increased importance. Similarly efforts to have certain subjects included in the undergraduate curriculum are made by several of the organizations. With the reported shortages in personnel in a wide variety of professional and technical fields, the development of fellowship and bursary programmes also is valuable. If co-ordination of these were attempted, it would seem desirable that it be done at the national level.

The area in which there has been most criticism is probably that of multiple financial appeals. Control of fund raising, and the consequent control of activity through the allocation of funds or the refusal to allow independent fund raising, may seem highly desirable in theory, but there are valid questions regarding the exercise of such power. When a democratic government determines what services are to be provided and what money is to be raised and spent, it represents the people – at least theoretically – in making the decisions. Many of the individual organizations are under the effective control of a few people, who are not representative of a constituency and who in some cases are self-perpetuating, i.e., the existing group selects the newcomer when a vacancy occurs. In the federated funds, created through the pressure of "big business", control again appears frequently to lie with a small group which through its fund-raising effort and its allocation of the money received can dictate the programme of any organization or even determine its continued existence. Such groups represent relatively small sections of the community. It has been noted that they appear to favour successful organizations, which have also enlisted in their support respected members of the same economic and social groups. Some local federated funds are still stressing the outdated philosophy that money raised locally should be spent locally, with the result that the services for which funds are available are most numerous in the prosperous communities, and the attitude to national or provincial organizations which provide no direct service within the area is often negative.

Effective community planning bodies exist only in the larger communities, yet it must be through such bodies and their evaluation of the need and standards of a service that constructive decisions can be made regarding the allocation of funds. Every effort must be made to ensure that such bodies are in fact representative of the community. The increased activity of government in the areas of service under discussion points emphatically to the necessity of active governmental participation in – and financial support of – planning bodies.

It has been suggested in the United States that a small group of people, selected by a committee from names submitted by national bodies, should determine what national health organizations should be given financial support. A small group of the present organizations would be "approved", and federated funds throughout the whole country would be urged to allocate money only to this national group. Through the cutting off of financial support, the other organizations would be forced to seek amalgamation with one of the groups selected or to go out of existence. This assumes that a small group selected in this way has the right to try to enforce its decision, that the funds would support the plan and that their position in the community would be sufficiently strong to prevent the success of independent fund-raising efforts of the omitted organizations. This approach seems to be in direct opposition to the often quoted philosophy that democratic people have the right of "free association" and hence a right to establish an organization to pursue an objective which they consider is in the public good.

The position taken here is that groups have that right. This does not imply governmental support of all such organizations through grants and indirect subsidies. Government also has a function to perform on behalf of the citizens in protecting them from misleading salesmanship and from the misuse of the investment they make in the organization, by at least ensuring that they can obtain a true picture of how the funds are spent. The right of an organization to conduct its own campaign under these protections gives to some degree the right of appeal to the people against the decision of the federated fund-raising bodies.

Community planning, in the sense in which it is used here, requires a meeting ground for the representatives of the community whose group decisions will carry weight with its members. It uses influence, not authority, to achieve its objects.

Various organizations are presently aware of the need for the co-ordination of services and there is evidence of some competitiveness regarding the establishment of leadership in this. The existing pattern of community planning councils should be utilized where it exists, and extended to other geographic areas. In the opinion of the writer, a co-ordinating and planning body must consist of equal partners. It cannot function effectively if for some members it is providing the fund-raising machinery, for others exercising control through grants, and for still others offering democratic participation in planning.

Health and rehabilitation services cannot be "planned" independently of other community services. They are intimately related to welfare services at many points. It can be argued that the public provision of services or of facilities is the function of the health department while the payment of cost for those who are unable to pay is the responsibility of the welfare department. The promotion of health, the prevention of illness and accident, the medical care of the ill and the disabled, and social and vocational rehabilitation require the combined efforts of the health, welfare, education, employment and recreation services. In the rehabilitation process, for example, the emphasis upon the activities of the medical members of the rehabilitation team at the beginning of treatment gives place, as progress is made, to those of other professions. Although all aspects of public and voluntary health and welfare activities are not related closely, the interrelationship is so essential in many of the activities that community planning cannot be carried out effectively without recognition of this fact.

Community planning councils, most of which – at least nominally – include both health and welfare organizations, should give more attention to health services and needs than they do at present. Effective budget review must be related to community planning activities, and in view of the competition between the health and welfare organizations for funds, their joint activity in planning has important implications for fund raising. Planning activities however should not be limited to the requirements for budget reviews.

Community planning cannot be effective unless both the private and public sectors of the health and welfare services participate. Although public officials are often members of planning councils, their participation is limited because of their status as civil servants and the fact that ultimately public policy lies with the elected bodies. Within established policy, many planning activities are within the scope of the civil servants. Their participation is essential to enable the voluntary organizations to plan effectively, and they will be immeasurably assisted in their own work through it. Government can be represented by politicians as well as by civil servants. When the planning activity involves criticism of government or pressure for governmental action, the representatives can disassociate themselves from it and, as observers, be of constructive assistance to the government they serve.

The public services get their mandate to provide services and facilities from the citizens. When such a mandate is granted, the private sector must adjust its activities to that of the public one. Within the public mandate, a degree of flexibility always exists, and hence government's representatives can also be influenced by the planning process or, as a result of the process, the government may ask for a different mandate. The participation of government's representatives in community planning is thus essential for both sectors. The co-ordination of services on behalf of a patient or a community also depends on the close working partnership of the public and the private organizations.

CONCLUSION

This study of the voluntary health organizations has shown the outstanding accomplishments of many of these bodies and the great contribution they have already made in Canada in the provision of services, influence upon government, education of the public, research and other activities.

Facts have been uncovered which suggest that some changes are desirable in the complicated, largely unco-ordinated pattern which has developed. The altered division of responsibility between the public and the voluntary services and the scientific discoveries of recent years have created the need for adjustment in some instances. The growth of a new type, the patient-member organization, brings new factors into the situation.

Resistance to change is evident in some quarters. Within the separate organizations and within the bodies responsible for federated fund raising, community planning and co-ordination, strong leadership of persons dedicated to community service is necessary. Public authorities, which seem to have concerned themselves with individual organizations rather than with the complicated questions of integrated and co-ordinated services, have an important role to fill in defining their own functions, exercising a degree of control on behalf of the public, developing policies regarding their considerable contribution to the voluntary activities, and entering into a more effective partnership in the planning and operation of activities in the field of health.

The importance of the continuing activity of the voluntary organization in this field cannot be overstressed. Its changed role needs to be recognized more fully by some of the leaders. In developing the closer partnership with government which the present situation demands, the voluntary organization should not forsake its role as critic of public services, interpreter of community needs, and leader in the development of public opinion. Neither should the government underestimate the value to the volunteers and to the community which the opportunities for the practical application of the social values of community service provide. Democracy does not consist only of a form of government but of a concept of the contribution of each member of society to the common good.

SUMMARY OF MAJOR FINDINGS

1. The voluntary health organizations in Canada are making a very significant contribution to the health of the people. Somewhere within the country they provide almost all the services which might be included in a comprehensive health programme. The provision varies greatly in different provinces and different areas within a province.

2. The present organization and activity of many of the voluntary health organizations demonstrates that they have not adapted themselves fully to the changed role of voluntary organizations in a democratic community.

3. The functions of the voluntary organizations and government in the health field are intermingled to an extent that little differentiation in function can be realistically drawn between them.

4. The amount of support that the health organization gets from the community is based on salesmanship rather than on public recognition of a particular "cause". The basic motivation in organizations consisting of patients and their parents is mutual aid. Many of the organizations are not democratic in theory or in practice.

5. The direct services to patients provided by the voluntary health organizations are those not available through other public or voluntary organizations and hence show the facets of medical care which are difficult for some patients to obtain.

6. Where government assumes responsibility for a service it should, generally speaking, provide that service itself. When it chooses to purchase it from a voluntary organization it should pay the full cost and exercise supervision and control of standards, since it is held accountable for the service given.

7. It is suggested that:

- (i) government assume direct responsibility for public health services, employment services and schools for educable handicapped children;
- (ii) organizations administering hospitals, sanatoria, and rehabilitation centres, should make clear the distinction between those activities provided by public funds and other services provided by voluntary funds so that it can account accurately to the public which provides the funds;
- (iii) out-patient treatment centres, including clinics, stationary and travelling, and nursing stations be included under the Hospital Services Plan;
- (iv) bedside nursing and homemaker service be made available in all communities, with the assumption of responsibility for their provision by government;
- (v) equipment necessary for home care be supplied through the organization providing home nursing;
- (vi) physiotherapy, occupational therapy and social work be provided at the hospital centre wherever possible, and through travelling teams located in the hospital or the public health department;
- (vii) the provision of prosthetic appliances be co-ordinated by the hospital or the health department;

- (viii) the costs of the above services, and also of drugs and surgical dressings, be paid by the government for those unable to meet the costs, and that they be provided as benefits in any extended medical care programme.

8. The Blood Transfusion Service and the Eye Bank should continue under their present auspices.
9. Transportation to a medical centre and accommodation at the centre should be co-ordinated closely with the administration of the medical centre, and not related to a specific disease except in special hospitals; and that costs be paid by government on proof of financial need, with volunteers undertaking the administration.
10. It is suggested: (i) that federal and provincial governments pass specific legislation for the incorporation of charitable organizations and the control of public campaigns, and that the laws require certain standards of membership control and accountability to the public; and (ii) that "charitable donations" deductible for income tax purposes be defined more specifically.
11. Public grants to voluntary organizations should be based on established criteria and be channelled through one department to one organization, and government should require accounting for its expenditure.
12. Public departments, including schools, should support directly or indirectly, the activities of particular voluntary organizations only on the basis of established policy.
13. Voluntary funds should not be used to subsidize services provided directly by government. Government policy in the establishment of services should be designed to build up a positive attitude on the part of the public to government as the servant of the people.
14. Provincial governments should provide staff to act as consultants to patient-member organizations, to help their members to obtain professional services and to foster their contribution of mutual support.
15. The National Agency Review Committee should be strengthened, it should provide for the review of provincial budgets, and where the national body has the financial control of the units, it should review the entire budget at all levels.
16. Federated funds should revise their membership policies to serve non-local organizations more effectively.
17. An independent accrediting organization should be established to evaluate national and provincial organizations on the basis of established standards.

18. All voluntary bodies concerned with the distribution of funds should recognize that in Canada the philosophy that funds raised locally should be spent locally is not tenable.
19. Voluntary health organizations should not be permitted to give grants to other voluntary service organizations except in the formal payment of fees for patients, for activities of "sponsored" patient-member organizations, or for special projects, and surplus funds should not be permitted to accumulate.
20. A new national Health Research Foundation should be established, with a Board representing all health organizations which wish to participate, with the object of receiving funds for research and of allocating them on the basis of expert advice.
21. Consideration should be given by federated funds to permit members to conduct separate campaigns for research funds.
22. Voluntary organizations should emphasize more than at present the use of volunteers in their activities. Governments should encourage citizen participation in the services provided by public departments.
23. Increased public provision for medical care will decrease the activities of voluntary organizations in providing direct service, but will leave to them important functions, including that of facilitating the use of the services by the patient.
24. Community planning organizations should include both health and welfare in their spheres of activity at local, provincial or national levels, and governments at the different levels should recognize the necessity of their effective participation in, and support of such bodies.