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REGIONAL THEORY AND ITS POLITICAL APPLICATION
IN THE PROVINCE OF SASKATCHEWAN

by William Dale Murray

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During my three years with the Department, prior to entering graduate studies, I was frequently aware of aspects of the field of public health which would make an extremely interesting study. The regional health services were one of these many interesting areas. The genesis of this dissertation, then, was a result of my contact with the field of public health.

My suggestion for this study was accepted enthusiastically and I received full co-operation from my director and my co-workers. While this study was done independently, and did not constitute an official working paper of the Department, nevertheless I was allowed access to Departmental files.

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In the Province of Saskatchewan

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I INTRODUCTION

The aim of this study is to gather together the theories of regionalization and to examine regional experiments in the Province of Saskatchewan. Regional theory has been applied for some time now, both in government and in private industry, as an administrative tool to decentralize services. More recently, and still in the experimental stages, is the adaptation of regionalization to the theory of local government. The concept of regional units of local government is new and is being applied to strengthen and modernize local government. Regionalization is not yet well known in its new role as a political institution, and the provincial governments have stumbled onto the principle of regionalization from time to time without knowing it. Numerous special-purpose bodies have been created in the Province of Saskatchewan alone (eg: School Units). These bodies have functioned with great success, but not until recently have the various provincial governments grasped the importance of regional theory, and its use as a political system. It is hoped that this paper will throw some light on regional developments in Saskatchewan, some spontaneous, and others deliberate, and show how regionalization is beginning to develop as a definite political theory.

The basis of this study is the field of public health in Saskatchewan and the rather unsuccessful experience in regionalizing health functions under local control. Much of the data for this study was taken from the files of the Department of Public Health and constitutes original and important source material. This study is further enlarged by a general discussion of local government in the province, and an introductory discussion of regional theory. The main theme of this

study, however, is the region as a political unit.

Regionalization is the first serious attempt to relate social, economic, communicational and political factors to administrative units or to units of local government. The theory of regionalization recognizes the complicated nature of modern-day living and the interdependence of the above factors in the normal pattern of everyday activities. Regional theory represents the setting up of administrative units in a scientific manner, taking into consideration the social ties, the trading patterns and the communication networks that make up the modern-day community. The regional unit as such, promises to be a useful and lasting institution, both administratively and politically.

Regionalization, too, reflects the "shrinking" in size of the world today. The political boundaries of the world are expanding with the great steps forward in communications, and the widening interests of the individual citizen. Men are nowadays thinking of the world community instead of the small nation-state. The mobility of the world's population has increased, and distances and natural boundaries no longer confine people to small localities.

The interests of the individual in the modern community have broadened, but unfortunately, political institutions have not adjusted to this trend. The traditional local governments in Canada no longer conform with the boundaries of the social and economic community. As a result, they are proving to be unsound as administrative units, and all their duties and functions are being removed from their control by their senior provincial governments. The typical local government unit in Canada today is unable to provide even the traditional services to the

community, and, as a result, local government as a democratic institution is losing its independent voice. Local governments are no longer able to stand up against our federal and provincial leviathans, and this crumbling of the basic tier in our democratic structure is an unfortunate occurrence.

The regional concept is the antidote to this deterioration of local government in Canada. The larger units, scientifically constructed, will be able to administer many varied functions. All the old municipal powers, long since lost to the senior governments, could be returned and effectively administered by local officials. Since no governmental body is in a position of power or importance unless it exercises effective control over a number of major responsibilities, the integrity and self-respect of the local governments will not be restored until such time as these units are returned to the status of strong general purpose authorities. Thus the immediate objective of any local government reform should be to adopt political units that are administratively sound, and the long range objective of restoring local government to the position of the basic tier of government, equal in status to the provincial and federal authorities should follow automatically.

This paper is concerned with regionalization in Saskatchewan, and particularly the experiments in the field of public health. This province has begun to take the first steps to strengthen local government through regionalization. Though present efforts are not spectacular, they are a move in the right direction. We in Saskatchewan are just passing through the "study and investigation" stage, and are presently engaged in "getting our feet wet" in the practice of regionalization. Since the end of the Second

War, several very important committees and study groups have recommended regionalization as a step to strengthen local government institutions, and in addition, as a move to increase efficiency in providing services to the public. The fact that regionalization would increase efficiency had already been proven through the successful operation of regional services in several government departments, and the various study committees felt that this would be a selling point in the recommended regional schemes of local government services. It is becoming a matter of routine today to hear authority after authority recommend regionalization as a reform measure in local government. The background research has been done, and now all that remains is to convince the many local officials of its benefits.

The second stage of regionalization, that of "getting our feet wet", is currently under way. The success of regionalization in the various provincial government departments has long been acknowledged. What we must now do is prove its usefulness as a form of local government. A large portion of this paper is devoted to the recommended regionalization in the field of public health in 1944. Though the plan failed as a local government reform, it must not be discounted as a useful experiment. Regionalization in public health failed as local governmental reform not because of any shortcomings in regional theory but rather because of circumstances not foreseen and beyond the control of the architects of the regional reform. Other regional experiments, such as the School Units and the Hospital Councils, have been progressing slowly, but successfully, and since they were instituted under local initiative, they are winning over local sceptics and allaying their suspicion of regionalization.

The winds of change and reform are blowing at the level of local government in Canada, and recent attempts at regionalization in this province are the beginning of a whole new system of local institutions.

II THE PRINCIPLES OF REGIONALIZATION

1. REGIONALIZATION - ITS USES

Regionalization is a very recent innovation, having become popular only since the 1930's, but does not appear to be a passing fancy. It is being employed more and more as a planning and administrative device and its theory is strengthened with each experiment.

Since regionalization is a recent innovation, the basic theories and concepts upon which it operates are as yet very broad and flexible. However, there are several principles which may be pointed out as being present when regionalization is employed. Regionalization actually takes three forms¹ or rather fills three needs: those of physical planning, resource planning, and the provision of local government.

Regionalization is frequently used for town or area planning of streets, parks, housing and commercial development. All large urban areas have some regional committee or council made up of local officials and interested citizens to advise on the physical planning of their areas. Such bodies are often ad hoc affairs of an advisory nature, and with no legislative or administrative powers. Their success or failure usually depends on the unanimity or co-operative spirit of the officials of the various local governments or private organizations involved.

The second form of regionalization, that employed for resource planning is less common, and is perhaps the least used of the three forms. The classic example of regionalization for resource planning is that of the Tennessee Valley Authority established by President Roosevelt. Much closer to home are the South Saskatchewan River Dam Project and the St. Lawrence Seaway Project. Regionalization employed for resource planning is seldom a development of local co-operation but is rather the

¹R. E. Dickinson, City Region and Regionalism, London, 1956, p. 1.

action of a senior government aimed at aiding an undeveloped area in realizing its potential. Its concepts are usually beyond the scope of local authorities or organizations and its rewards are usually long-range and of a more national nature. While the incentive for regionalization develops from below in the case of physical planning, regionalization for resource planning is usually imposed from above. Since it is usually imposed from above it is given a legal status, (usually by legislation), and quite often the regional authority has extensive administrative functions to perform. Thus this second form of regionalization tends to be stronger and more permanent, whereas the first usually exists so long as the co-operation of all the member authorities can be maintained.

The third form of regionalization, and the one with which this paper is concerned is that of the region as a unit of government. In this case, regionalization is applied to administer some form of governmental service to the public. It may be the decentralization of a central service or the provision of a local service on a more efficient regional basis. In this case, the machinery of government is always given legal status in legislation and almost always has important administrative duties. As will be discussed later, this form of regional body may be governed by representatives of member local governments, by officials elected on a regional basis, by officials responsible to a central authority or by a combination of these.

2. THE REGION - A NATURAL UNIT

Though regionalization exists as a natural force, today we are utilizing it as a political or administrative tool. R. E. Dickinson

refers to the region as "an area of common living".¹ The populated areas of all national states divide themselves into natural social units. These areas are like the fields of a magnet, drawing all the population in towards a regional centre, from whence all their day-to-day wants and services are supplied. Such a natural unit pays no heed to political boundaries, but instead it is dependent on topographical features. In many cases, this natural phenomenon of a social, economic and cultural spheres of influence originally corresponded to political boundaries. However, political units remain static, whereas we have witnessed a tremendous growth in the natural community in the past fifty years. In 1900, men's contacts were limited to the distance a horse could travel in one day. The small prairie town, which is now becoming something of an anachronism is just such an example. At the turn of the century, a town sprang up every ten miles in the populated farm belt of the prairies. This town and those farmers within a radius of up to ten miles could be said to be a natural community. Today however, where persons are known to commute fifty miles to work and back every day, the natural community has become enlarged, while the politically established artificial communities remain as they were in 1900.

Today public officials have come to realize the importance of the social community in establishing political units. Almost every province in Canada has conducted a study of its local governments with a view to updating them. This change in the concept of the community, along with other factors, has rendered our present small rural and urban units inadequate as general purpose local authorities. In the light of these developments, Dickinson defines the new "ideal" political unit:

¹Ibid., p.4.

"The ideal political region, either large or small, has been defined as one which has a maximum number of common interests. Regionalism is an attempt to define areas which are at once units of social feeling, and, as far as possible, also areas of economic life, and suitable to serve as units for the work of administration".¹

Regionalization is the product of this awareness of the new concept of community. The region is put forward as a new political unit, which will conform with the modern community unit. It is generally accepted that government administration is more effective when political boundaries are realistically drawn to conform to geographic features, and economic, social and cultural spheres of influence. In emphasizing this need for a new political unit, Dickinson feels that regionalization holds the answer.

"The prominence accorded by the public to the idea of the region is the spontaneous expression of an urgent need in life and organization of modern society. The great mobility and the complex structure of modern society in Europe and America has meant that new areas of organization are needed for all aspects of national life, and that existing local government areas have been outmoded by a wider area organization, and act as deterrents to the efficient functioning of public services. The idea of the region has also developed in relation to the movement for the decentralization of authority from the central national government to a limited numbers of provinces, which would relieve the central government of its too onerous responsibilities, foster the development of local responsibility in the truest democratic fashion and foster the provincial and regional differences of tradition and culture".²

The above quotation refers to regionalization as applied in a national state. However, it is equally true of the provinces in Canada. Many provincial governments have examined regionalization as a new form of local government, and all provinces (excepting perhaps Prince Edward Island) have decentralized services under their control as an efficiency

¹Ibid., p.8.

²Ibid., p.245.

measure. The recommendations of a recent Saskatchewan study will be discussed in detail later in this paper. The Local Government Continuing Committee of that province was very much impressed with regionalization as a means of strengthening local government, which the Committee considered was an essential part of our democratic structure.

3. REGIONALIZATION AS A FORM OF GOVERNMENT

As was stated, this paper is mainly concerned with the region as a political unit. A region as an established political unit may vary from one of strong autonomy to merely a regional office under a central authority. In either case, however, its powers are usually delegated by a national or central political body. This is true in Canada since the British North America Act gives the provincial governments complete control over municipal institutions. Thus it may be said, technically speaking, that when regionalization is employed as a governmental unit, it is serving to decentralize a function which is the ultimate responsibility of the senior government.

A United Nations study group has noted four methods by which the central government may decentralize functions of a regional interest.¹

- i. A comprehensive local government system - In this case, most government services at the local level are administered through multi-purpose local authorities.
- ii. A partnership system - There is a sharing of responsibility, with some direct services being rendered by field units of central agencies and others by local authorities.

¹Division for Public Administration, Department of Economic and Social Affairs, Decentralization for National and Local Development, New York United Nations, 1961, pp. 16, 17.

- iii. A dual system - Central ministries administer technical services directly, with local authorities having autonomy legally to perform simple tasks at the local level.
- iv. An integrated administrative system - In this case, central government agencies directly administer all technical services, with central government area co-ordinators or district administrators responsible for field co-ordination. Rural local authorities have little control over government activities and staff in their areas.

The above four general methods of decentralization of political powers were arrived at by categorizing local government systems in various countries throughout the world. At the turn of this century, local government in Canadian provinces fell under the first category. However, the community as a social unit grew in size and local government services became increasingly technical and expensive. The local political unit remained static and was no longer able to function as a strongly independent multi-purpose authority. One by one, its functions and powers were removed to senior governments, and today, our municipal governments fall under categories three and four. Political scientists see regionalization as the antidote to this trend. Under a regional system, functions and powers, which were formerly theirs, may be returned to local hands, and local government could then be restored to its former position as a comprehensive, multi-purpose authority.

The United Nations research group, throughout their study document, stress the need for a system of local government and the consequent delegation of varied duties and powers to the local authorities. Functions that are plainly local in character should be allocated to local authorities wherever possible. Responsibility for functions should be placed at as low a level as is practicable, subject only to

the capacity of local authorities to discharge the responsibilities satisfactorily. This principle was also strongly recommended by a recent local government study conducted in Saskatchewan.¹ However, the study notes that in the case of certain technical services such as health and welfare, in which there is a national as well as a local interest, responsibility must be divided between central and local government. This exception, in the case of technical services, is especially evident in the health field. The provincial governments were forced to assume responsibility for health services, and now, with local governments still in the same weakened position, provincial authorities are loathe to return any health functions to their former local level.

Since the field of public health has broadened and services have reached an all-time high, the provincial governments feel duty-bound to maintain health services at the same high level to which the population is accustomed. Regionalization seems to offer a solution to this dilemma, whereby a local government unit of a more realistic size and of a more stable nature, can be created and vested with the power to carry out such important functions as public health services. The province, by setting very broad requirements can control the operations of these new units to ensure a minimum provincial standard of services. It seems, however, that such a great experiment is too radical to contemplate, and even in Saskatchewan, where plans for such a regional organization were drawn up, pressures resulted in the failure of the plan. The United Nations experts have suggested that devolution to local authorities at the appropriate levels should be as extensive as possible and subject only to safeguards to insure

¹Local Government Continuing Committee, Local Government in Saskatchewan, 1961, p. 25.

fulfillment of the national (or provincial) responsibility. Although arrangements should be made to ensure that the standards of performance locally do not fall below an acceptable level, the central administration should interfere with operations of local authorities only to the minimum extent necessary. While this sage advice was intended for underdeveloped or backward countries, Canadians might well take heed, if they wish to continue their present high standards of democratic traditions. Now might well be the time to return some of the expropriated functions of local government to a new regional level, before Canadians become accustomed to a remote, highly centralized and bureaucratic form of government. Canadians would then be assured of a continuance of their high democratic ideals without any loss of efficiency in the provision of services. This last remark regarding efficiency is highly controversial and as yet not tested in this country. However, the principle that regionalization can be efficient is strongly supported by many eminent political scientists and can be accepted as true, provided that a program of regionalization is carefully planned and entered into faithfully by all parties concerned.

As was stated earlier, regions as a form of government is only one of the three major uses of regionalization. To complicate matters even more, we have discussed regionalization in this third form under central control and as an autonomous local government. All this discussion is no doubt confusing but unfortunately it cannot be made clear even by experts. Regionalization is a new theory and is relatively untried. Few practical experiences can be turned to for information. Most regional schemes are attempted half-heartedly and cynics are able to find fault easily. Moreover, little is known about regionalization in its third form, that of a form of government.

The responsibility, in the final analysis, of the central authority for all functions devolved on local governments was previously stressed. Just how does this central authority carry out its responsibility while at the same time allowing the regional or local units scope for autonomous action? Allowing that a locally-controlled regional government will act in an intelligent way and administer its programs and functions in an efficient manner, all that remains is for the central government to set a broad policy of standards desirable on a province- or nation-wide basis. In order to secure regional adherence to the national or provincial policy, several controls might be used without drastically curtailing local action. Policy directives might be issued regularly by the central government, standard office and procedure manuals could be put into effect, model ordinances could be prepared, local staff (especially technical staff) could be recruited by the central body, and lastly, the central government could make available technical assistance for all programs locally administered. In addition, well known standard control measures could be applied, such as the following: inspection, progress reports, budget approval, audit, powers of default action, approval of bylaws and judicial remedies.

As was previously stated, when regionalization is applied as a form of government, its main function, is to aid in the decentralization of power. This decentralization is recommended both from the viewpoint of increasing the exercise of democracy and increasing efficiency in providing services to the public. A distinction must be made, however, between a regional office operated by a provincial department, and a locally governed regional unit. The former is a management device, while the latter is true decentralization of democracy.

4. THE PROS AND CONS OF REGIONALIZATION

Arguments for and against regionalization depend, of course, upon how you define the term. When regionalization merely involves the decentralization of a provincial service, it is easy to reach the conclusion that such a move is or is not beneficial. It is a simple principle of public administration that, where a large territory is involved, its subdivision into regions under the direction of the central authority is the only efficient way in which day-to-day operations can be handled. In addition, regionalizing a provincial function involving a service to the public, will bring this service closer to its clientele.

However, in arguing for or against a region as a unit of local government, the principles involved are often subjective and not clear-cut. There are two principles which make a strong case in favour of an autonomous regional form of local government, efficiency and citizen participation. The arguments in favour of regional local governments which will be used here are those embodied in separate reports on local government in Manitoba, Saskatchewan and Nova Scotia.¹ Since the Nova Scotia investigation preceded those of both Manitoba and Saskatchewan, the arguments should probably be credited to the authors of the Nova Scotia report.

Before going into the benefits of the region as a unit of local government, justification must be made of the assumption that, in some cases, a function is best carried out by locally elected officials. A

¹Local Government Continuing Committee, Local Government in Saskatchewan, 1961 Manitoba Provincial-Municipal Committee, Report and Memorandum of Recommendations, Queen's Printer, Winnipeg, 1953, pp. 51-64.

D.C. Rowat, The Reorganization of Provincial-Municipal Relations in Nova Scotia, A Report Prepared for the Government of Nova Scotia by the Nova Scotia Municipal Bureau, 1949.

number of services could feasibly be administered by either the local provincial, or federal governments. A vitally important consideration in deciding which should undertake the responsibility of administration is which can handle the job most efficiently. In this regard, it would obviously be sound policy to allocate to local governments the administration of services which required a detailed knowledge of the local situation, while broad uniform programs which do not include adjustments for local conditions would be best handled by a senior government.

Efficiency has now superseded financial considerations as a major criterion in placing duties and functions at the various levels of government. The "ability to pay" theory has to a large extent replaced the "benefit" theory (especially in the field of health and welfare services), and revenues are no longer raised in the area or at the level of government where the service is provided. The senior governments now have control of all the main sources of tax revenue and local governments, no matter how large they may be, will never have an adequate number of tax sources available to finance their operations. The senior governments will continue to contribute a large amount to the municipal coffers. Local governments are expected to carry some financial responsibilities, but it is no longer felt that services should be removed from their control when they are no longer able to adequately finance them. Professor Bellan feels that each level of government should levy those taxes which it is best fitted to collect, and each government should take on those responsibilities which it is best qualified to administer.¹

Assuming, then, that efficiency and not financial stability is the criterion for allotting functions to the various levels of government,
¹Manitoba Provincial-Municipal Committee, Report, p. 54.

where does regionalization fit in? In what cases is this intermediate tier of local government necessary?

In his report on provincial-municipal affairs in Nova Scotia, Dr. D. C. Rowat, gives the following reasons why a form of regionalization is necessary.¹ There are services which are of a greater than local concern, and yet still within the realm of local jurisdiction. These are the services which have developed as a result of the growth and change of the community previously discussed in this paper. Whereas fifty years ago these services did not exist, or affected a very small community, they have grown today until their scope is regional in size. Such services as education, health, welfare and roads fall in this category. As was also mentioned, it has been found that the small municipal units common to all the Canadian provinces can no longer be expected to handle their complex financial and administrative duties. Dr. Rowat believes that administration and finance can be simplified by removing some of the local functions to a regional level, without removing their control from local hands. Today, it is felt that in all services the public is entitled to a minimum level available in all areas of the province. In the light of this principle, each province is attempting to standardize all services under provincial and local control. The provincial government, in order to ensure a minimum standard in local services, exercises its powers to pass laws, regulations and broad policy commitments to which the municipal governments must adhere. In a province where municipal units number as many as 800 (Saskatchewan) provincial supervision and control are made very difficult. Also, it must always be borne in mind that, while strongly autonomous
¹D. C. Rowat, op.cit., p. 69-72.

local governments are desirable, the provincial government bears the ultimate responsibility for all the services provided locally. Dr. Rowat feels that larger municipal units would enable the provincial governments to coordinate their activities more easily, and even enable the provincial governments to allow these new and stronger local units to enjoy more latitude within the broad limits set by provincial policy. Regionalization is part of this new organization since certain services are best left under local control, but established more efficiently in areas somewhat larger than those conceived for general local government. Thus a new and more up-to-date system of two tiers is recommended, under which provincial coordination and control could be carried out more simply, resulting in a relaxation of restrictions on local government autonomy.

Throughout this discussion, it has been recommended that the region be accepted as a unit of local government. We have seen that the benefits of regionalization might also be realized just as well if the regions were nothing more than line units of the central government. Admittedly, just such units are in existence, and as a classic example, the Department of Social Welfare in Saskatchewan will be fully discussed later. However, efficiency and citizen participation are not unrelated. Dr. Rowat believes that citizen participation is keener and services more responsive to citizen needs, if services are carried out at the local level. Professor Bellan goes on to point out that local officials often perform their duties more efficiently than would a central government appointee, since they are more aware of the local situation. However, such an unqualified statement as this bears too much resemblance

to the ultra-democratic theory of direct democracy of the Jacksonian era. Nevertheless, it cannot be denied that local participation would sharpen public interest in a program and this usually affects the level of efficiency at which the program can be carried out. This is especially true in the field of public health, where the success of preventive services depends on the attitudes of the public.

The proponents of regionalization today are usually recommending it as a reform to strengthen local government. Dr. Rowat, in his study, begins with the assumption that strong local government is a desirable democratic feature, and that strong local government cannot exist unless it has important duties to perform. A program of regionalization, with the regional units under local control is recommended as a means whereby local governments may retain some of their important functions, and perhaps return to their original position as strong general-purpose authorities. This was the main concern of the Local Government Continuing Committee in Saskatchewan, and their recommendations for municipal reform will be discussed in the next major section of this paper.

There are some experts who have misgivings about this move to larger units of local government. They feel that regions may not be adaptable as units of local government. The traditional small municipalities have a purpose to serve, and to weaken or do away with them would seriously jeopardize our democratic system. Professor R. C. Bellan appears to be one of the leading spokesmen for this group.

In his special paper prepared for the Manitoba Provincial Municipal Committee,¹ Professor Bellan predicts that larger municipal units could run into problems. He is referring to the situation in

¹Manitoba Provincial-Municipal Committee, Report and Memorandum of Recommendations, Queen's Printer, Winnipeg, 1953. pp. 51-64.

Manitoba, but his comments could well apply to any province in Canada. He feels that, despite the improvements in transportation and communication facilities, a certain amount of parochialism still exists in many rural areas. Local attachments have not been completely broken down and persons in the next municipality are still looked on as strangers. This attitude of petty jealousy and parochialism has mitigated against the implementation of a county system in Saskatchewan to such a degree that for a provincial political party to espouse the cause of local government reorganization is political suicide. Professor Bellan goes on to point out that ethnic groups have tended to settle in small communities, rather than to disperse themselves throughout the population. He feels that, in many cases, these small communities of predominantly one ethnic group are not ready to be thrown together into a large county or regional unit. Such a move will only force these groups to draw closer together and as a result, slow the process of assimilation. Professor Bellan here seems to be confusing local narrow-mindedness with the broad cultural patterns upon which regional boundaries are drawn. It must also be remembered that cultural differences alone do not constitute a regional unit.

Professor Bellan goes on to point out that there are certain advantages to a small-scale political administration. The smaller the administrative unit, the closer is government to the people, and therefore the more responsive to their wishes. A small governmental unit is generally able to obtain relatively more volunteer help, thereby keeping costs to a minimum. Locally elected or appointed citizens bring with them an intimate knowledge of local conditions. Thus, from the economic point of view, small local governments may be operated at

far less the cost and by officials with a better knowledge of local affairs than can regional governments. Not to be overlooked is the fact that local government provides a training ground for the citizenry in public affairs. Local government is traditionally referred to as the grass roots of democracy. The smaller the units of government, the more the number of persons who will be involved in public service - as councilors, school trustees, et cetera - and the greater will be the number of citizens obtaining practical experience in democratic practices and procedures. While it may be true that greater efficiency would be achieved by the elimination of many municipal positions which now exist, it is nevertheless also likely that a streamlining of our administrative system would involve some weakening of our democratic fibre. Unfortunately, Professor Bellan here seems to be confusing local government consolidation with regional theory. Consolidation per se would reduce citizen participation in local government and give little in return in the way of increased efficiency, but a complete new regional scheme, scientifically applied, would produce a newer and more dynamic local institution. In this case, the qualitative increase in democracy locally exercised would offset the quantitative loss of the numerous small local elective offices. The numeric reduction of local offices, of course, need not result if a two-tiered system of municipal-regional local government were adopted.

As a parting comment, Professor Bellan states that regionalization alone will not strengthen areas in which economic stagnation exists due to inferior resources. Such a move would only create one large municipality with inadequate financial resources, and still unable to provide even a minimum level of services for its residents.

Dr. Rowat, too, feels that certain obstacles must be overcome before a new system of local government can be put into effect.¹ He also fears parochialism and an inbred suspicion of change amongst rural residents especially. He feels that such a far reaching change as regionalization would need considerable selling. In order to prevent any feeling of coercion, the legislation setting up the new units should be made permissive and the entry of local governments into these regional units should be voluntary. He also recommends the establishment of one or two experimental regions to demonstrate the benefits of regionalization, and to iron out any difficulties which might arise. He is optimistic that local governments will soon see the benefits which would accrue from regionalization, and leaving nothing to chance, he recommends that the provincial government make available financial incentives for local units taking part in any regional plan.

5. ARE REGIONS A WORKABLE FORM OF LOCAL GOVERNMENT?

Books have been written on the theory of regionalization, but the fact remains that it has not yet been proven in Canada as a form of local government. The great experiment in Saskatchewan in the field of public health has provided a very efficient administrative set-up for preventive services, but has failed as a form of regional local government. The question remains to be answered, can a regional system exist as a form of local government?

The Saskatchewan Royal Commission on Agriculture and Rural Life sets out a number of requirements for a workable system of local govern-

¹D. C. Rowat, op.cit., p. 72.

ment.¹ It might be interesting to examine regionalization in their light to determine if it can, in fact, stand up to the test.

i. The Sociological Requirement

"The area of the local government unit should correspond with the communities being developed by farm people for trade and social life to insure integration of local government with the non-governmental aspects of rural life".²

Regionalization was, of course, originally conceived to fill this very requirement. Our present outdated local units were created in a day and age when the natural economic, social and cultural community was much smaller. The move towards larger local government units today reflects this change in the size of the community. The administration of certain services through a unit which corresponds to the natural boundaries of the community is considered to be important. Since health and welfare services are so bound up with the general philosophy and spirit of community living, it is essential that they be administered through regions whose boundaries take into consideration the natural limits of the community.

ii. Political Requirements

- "1. Local government units must be capable of assuming responsibility for the performance of functions which, individually and collectively, are considered of vital importance to the local community.
2. There must be assurance that the ultimate control of the activities of the local government unit rests with the citizens as a group.
3. There should be optimum opportunity for the rendering of useful public services, through election or appointment to office, of qualified personnel.
4. The organization of local government must insure services are rendered impartially to all members of the community".³

¹Saskatchewan Royal Commission on Agriculture and Rural Life, Alternative Forms of Local Government, Queen's Printer, Regina, 1955.

²Ibid., p. 8.

³Ibid., pp. 9-12.

If you assume, as Dr. Rowat has, that strong local government is desirable, then local government must be able to administer many important functions. All recent studies point to the fact that our present small municipal units are incapable of doing this. Larger, more realistic units are recommended for general local government. Some functions, it has been found, are better administered on a regional basis, and a second tier of regional units is recommended for these special services (for example, health and welfare). Only by adopting a regional system of local government can points 2, 3, and 4 mentioned on page 23 be satisfied. A regional form of government would enable the provincial government to loosen its tight control over local government operations. Since the 1930's the unstable finances of our small municipalities have forced the provincial governments to regulate intensely local government operations. Under a regional system controls could be relaxed, allowing the elected councils truly to be masters of their own destinies. It is true that, under a single-tier system of larger local units, there would be a smaller number of elected posts and therefore, numerically, fewer citizens involved in local government operations. However, as the Royal Commission states, "there should be optimum opportunity for the rendering of useful public service". It is rather doubtful that this criterion is filled under our present system. Local governments are very much restricted by provincial controls, and the locally elected councillors have little opportunity to learn government by experience. A regional system would enable the provincial government to relax controls and, as a result, local officials could provide a more useful public service. With regard to point 4, it has been found in Saskatchewan, where municipal units are very small,

that local services are not provided impartially. Local officials are too close to their electors and are unduly subject to pressure from their constituents. In 1956, the Minister of Social Welfare in the Province of Saskatchewan despaired that local officials were not meting out social aid in an impartial manner. The cure which he put forward at the time was larger local units. Unfortunately this recommendation was never implemented, and as a result, the province found it necessary to tighten its controls over the municipal social aid program, to the detriment of local autonomy. This trend of strengthening provincial controls rather than strengthening local governments continues all across Canada, as it appears to be the lesser of two evils. No provincial government wishes to take on a general reorganization of local government at the cost perhaps of losing an election over it.

iii. Administrative Requirements¹

- "1. Units of local government should be capable of entering into mature working relationships with provincial government so as to provide efficient and integrated local services.
2. There should be optimum conditions for long-term planning of services provided by local government.
3. The organization of local government should give optimum opportunity for the economic employment of qualified personnel and the most efficient equipment for each particular service.
4. The organization of local government should afford optimum opportunity for the economy and efficiency in general administration and in integration of the various functions performed".

A system of larger local government units and regions promises to fulfill all these requirements. A regional system would do away with all the special districts which have been interposed on our municipal systems to make up for their shortcomings. In a properly set up regional

¹Ibid., pp. 13-15.

system there would be no need for the many special conservation and planning districts and, in addition, education, roads, health and welfare could all be administered through the same unit. All the confusing, overlapping jurisdictions could be eliminated. A stronger local unit would be better able to plan. With their limited finances and the tight system of provincial controls, local governments are not able at present to do any appreciable long-range planning. Both civic and provincial officials are alarmed by the municipalities' habit of ignoring long-range planning. A system of regionalization, set up properly, would overcome this. As was mentioned several times, provincial controls would be relaxed and local officials would then be allowed to prepare long-range plans on their own initiative. Moreover, a region is a more realistic planning area.

iv. Financial Requirements¹

- "1. The organization of local government should facilitate administration of the property tax and provide machinery for levying and collecting other types of local revenues that may, in the future, appear desirable.
2. Local government should be so organized as to provide increased and stable revenues.
3. The organization of local government should be conducive to the equalization of the cost of supplying a basic minimum standard of essential services for the residents of different units.
4. Local government organization should facilitate lowest cost marketing of debenture issues of all local units".

Regionalization offers some very important financial benefits. A province-wide equalized property assessment is accepted in nearly all the Canadian provinces today. The administration of such an arrangement

¹Ibid., pp. 16,17.

would be easier if large local regions were established. In addition, the provincial governments now use this equalized assessment for the purpose of apportioning various grants to municipal governments. The sheer weight of paperwork involved would be much reduced if the province could deal with several large regional authorities instead of the multiplicity of municipalities (some 800 in Saskatchewan).

While none of the experts consider that municipal units can be completely financially independent, it is felt that larger units of local government would be more financially stable. The provinces find it necessary to watch local government very carefully since they must continuously operate on a shoestring. Local governments cannot deficit finance and, as a result, their financial operations are always of a very delicate nature. A system of regional local governments would result in a healthier system of municipal finance.

The principle of equalization has already been discussed with regard to property assessment. However this principle has a much more far-reaching meaning. It is accepted today, that all citizens, be they rural or urban residents, are entitled to a certain minimum level of services. By adopting a regional form of local government, costs of services are shared among municipal units, according to their financial abilities. In addition, it is easier for the central government to implement a province-wide standard, by dealing with a small number of local authorities. Saskatchewan is presently in the unhappy situation of having a multiplicity of local governments with extreme diversity in financial ability. Through a regional system of local government, financial burdens could be shared in a more equitable manner, and a high provincial standard would be easier to effect.

Lastly, it is suggested that a regional local government acting for its municipalities on the financial market would result in great savings. The competition among municipal governments in their sale of debentures on the open market has reached the point of foolishness. It has been suggested that regional governments handle the sale of all municipal debentures thereby reducing confusion on the market. It is also believed that, with a smaller number of local governments competing in the financial market, the interest rates municipalities are charged could be forced down. Also, with regional scrutiny of all proposed debenture issues, provincial control in this area of municipal operations could be relaxed.

v. Intergovernmental Requirements¹

- "1. The organization of local government should permit optimum utilization of provincial technical advisory services.
2. Local government should be organized so that provincial financial assistance may be made available under the most satisfactory conditions.
3. The organization of local government should facilitate observance of provincial regulations without loss of local autonomy.
4. The organization of the local government system as a whole should permit optimum co-ordination of the activities of local units with different service responsibilities.
5. Local government should be organized to permit economy in the provision of all government services.
6. The structure of rural local government should make possible the integration of rural and urban local government if such integration should be thought desirable at some future date".

¹Ibid., pp. 18-22.

A serious provincial complaint against local governments is that they do not utilize provincial technical services, but this shortcoming does not necessarily spring from the municipalities' suspicion of central government. Our small local units are not large enough to make proper use of all the technical advice available. In its day-to-day operations, a rural municipality in Saskatchewan does not deal with problems which require much technical advice. Larger local units are needed to utilize provincial technical services on an efficient scale.

The benefits to local autonomy under a system of larger local governmental units have already been mentioned. Provincial financial assistance could be more effectively co-ordinated and less stringent provincial regulations would be needed if a regional program were put into effect. As a result, local authorities would be able to comply with provincial requirements and yet retain more autonomy than exists today.

The economies which would be effected through a regional organization are many. Examples exist today of intermunicipal co-operation for road maintenance, school operations, and the provision of hospital services, to cite a few examples. These regional organizations were created spontaneously to meet a particular urgent need. All that remains is for their formalization into a proper regional local government.

The integration of rural and urban governments is a much discussed topic today. Scientific investigations of community patterns indicates that the urban centre and its surrounding rural trade area are interdependent. Under a system of regions for local government, based on the natural boundaries of communities, the integration of rural

and urban governments will take place with comparatively little pain. While such an integration might not be politically expedient at the present time, regionalization is a step in the right direction. In Saskatchewan, an attempt by the province to create larger units of local government was turned down by the existing municipalities. Had a regional scheme been tried first, with the regional councils administering certain special services such as health, welfare, education and roads, the way might have been paved for an amalgamation of the small rural and urban municipalities at a later date. The spirit of co-operation that would have prevailed in a regional scheme might have won the small local units over to the proposed county scheme advocated by a special provincial committee.

6. COMMENTS

In the preceding pages, regionalization has been thoroughly discussed as a political institution. Physical planning and resource planning have only been mentioned to demonstrate that regionalization has other uses. The emphasis on regionalization as a special form of local government is intentional, because the writer feels that Canadians are on the threshold of a revolution in local government. No attempt has been made to analyse the "so called" regional systems in several of the Canadian provinces (the Ontario County system for example), because it is a moot point whether these political units would qualify as multi-purpose regional governments against the measuring sticks of modern regional theory. Our traditional local government units are an anachronism and a regional form of local government more truly reflects the new concept of community. As was pointed out by R.E. Dickinson, a

region is a natural as well as a political unit.¹

The variations in the types of regionalization, when it is employed as a political device were cited earlier.² They vary according to the presence or absence of local participation and control. The important fact is that, while regionalization remains a popular philosophy, there is a very strong trend to move from a unit under local control to one under central control. It appears that regionalization is accepted as a very useful administrative device by the provincial governments, nothing more, nothing less. The various local government study groups have entered the fray, stating that regionalization is the saving force of local government. Thus far however, they have made no impression on the provincial scene. A complete program of regional local government has yet to be adopted in a Canadian province. Though regional units of local administration are in existence for very specialized functions, however, we have yet to establish an effective comprehensive regional local government responsible for a variety of functions such as schools, roads, health and welfare.

The devolution of more functions to local governments is of course a decision which rests with the provincial governments, who are responsible for all actions of their local governments. Control measures are presently applied by all provinces to insure the local governments conform to an acceptable standard. The point to note however is that the severity with which provincial control measures are imposed will depend on the strength and efficiency of the local government units involved. A regional system of local government offers the opportunity of relaxing provincial controls without endangering the high level of services enjoyed by the people.

¹See page 8.

²See page 10.

The ability to finance a service is no longer a criterion of where that service or function should be provided. The unit of government (national, provincial or local), carrying out the function should be the one which is able to do it the most efficiently. The theory that taxation should fall where the service is being provided is no longer acceptable. Our federal system and our involved system of tax sharing makes it impossible to relate tax incidence with that of the users of a particular service.

Citizen participation was discussed and its effect on efficiency was noted. Citizen participation is a desirable thing in our democratic society and in addition heightens the interest of citizens in government functions. Regionalization was put forward as a means of strengthening local government in order that citizens taking part might truly benefit from their experiences. Municipal councillors will learn nothing if their local units exercise few functions and are hedged in by provincial controls.

The pros and cons of regionalization as a form of local government have been treated at length. Dr. Rowat emphasized that regionalization is the means whereby local government may be strengthened, and important functions may be left in local hands and at the same time a provincial standard may be easily implemented. On the other hand, Professor Bellan is sceptical as to whether Canada is ready for regionalization and large units of local government. It is true that local resistance may be strong, but a carefully planned regional system preceded by an educational program will overcome this obstacle. Professor Bellan feels that, by raising functions to a regional level, they will be removed from contact with the people they serve. In some cases

however, a service can be too close to the people it serves. A certain amount of objectivity and detachment is necessary.

Professor Bellan notes that there is a definite economy in the use of small municipal governments, since all the offices may be filled by volunteer labour (most of the functions can be carried out by council-lors, school trustees, et cetera). This is true to a lesser extent at a regional level. The regional council may do a great deal of work in committees and they might also serve unpaid, but, the services of a number of paid professionals would have to be obtained (for example, medical health officers, social workers, road superintendents, et cetera). It must be remembered that one of the reasons our present local governments are outmoded is their inability to cope with the new and varied services they find that they must provide. The elected local official is unable to administer health, welfare and educational services in an efficient manner; hence he must rely on provincial directives and advice. Volunteer administrations are a 19th century concept and an economy which we cannot afford. (It is also an economy falsely conceived, since a strongly staffed regional civil service would mean fewer professional people employed in provincial departments to advise and direct local government).

Lastly, by taking the yardsticks recommended by the Saskatchewan Royal Commission on Agriculture and Rural Life, we were able to demonstrate that a second tier of regional local government shows more promise of success as a workable form of local government than the present single-tiered, small unit system that now exists in most Canadian provinces.

III REGIONALIZATION IN SASKATCHEWAN

This chapter will deal with the existing local government situation in the province of Saskatchewan as seen in the light of a recent study conducted on the local government problems in the province. Local government reform in Saskatchewan is an urgent matter from the point of view of both administrative efficiency and the future of our strongly democratic traditions of local government. The current weakened position of Saskatchewan's outdated local government units and the unplanned and unsystematic reform measures which have been implemented threaten to topple the whole system at any moment. A recent Committee appointed by the provincial government recommends larger and stronger local governments based on the principles of regionalization discussed in the previous chapter. It is believed that, through the implementation of a regional system, administrative efficiency will be vastly improved and that additional powers and duties may be vested in these new units, thereby strengthening local government in the province and returning it to its traditional status of an autonomous general-purpose authority.

1. BACKGROUND - THE SASKATCHEWAN SITUATION

From the very beginning, local government in Saskatchewan suffered from defects in its administrative structure. The province's system of local government was developed overnight in 1905, and almost overnight was called on to provide services far beyond its capabilities. In the twenty years following the turn of this century, the province changed from an unpopulated wilderness to an agricultural area with

small towns developing at regular intervals to service the surrounding farm land. The demand for modern utilities and services placed a strain on the newly formed municipal system, and the system soon developed defects. In 1912, the first local government reorganization took place (school districts) and many such stop-gap measures have taken place in subsequent years. It was not until the late 1950's that a thorough appraisal was attempted, and a complete reorganization recommended.

As was mentioned, from the very beginning shortcomings were recognized in Saskatchewan's local government, and at various times attempts were made to correct these failings. Reorganization of this province's local government has usually taken place in one of three ways:¹

- i. New local government agencies were created and superimposed on the municipal system (for example, school districts);
- ii. Responsibilities which local governments were unable to carry out were taken over by senior governments (social welfare services are the best example here);
- iii. Local responsibility has been circumscribed by increased provincial controls.

These piecemeal attempts at local government reorganization were intended as stop-gap measures to satisfy an immediate need. As these piecemeal reforms were used over and over again they changed and weakened the position of local government. As the Continuing Committee pointed out:²

¹Local Government Continuing Committee, Local Government in Saskatchewan, p. 10.

²Ibid., p. 10.

- i. Rural and small urban municipalities have been gradually transformed from responsible general purpose local governments to mainly tax collection agencies with responsibility for roads and some minor services.
- ii. The many special purpose bodies have resulted in confusion to the voter, insufficiency in providing services and in jurisdictional conflicts.
- iii. There is no single local government which has responsibility for determining local resources and preparing a comprehensive plan of local expenditures.
- iv. Overlapping boundaries make it impossible to plan or co-ordinate related services (schools and roads, or hospitals and medical care).
- v. The expansion of conditional grants as a technique for providing financial assistance to local governments has serious implications for local autonomy, since more and more decisions are removed from local control.

These adjustments and reorganizations which have taken place in the structure of local government have been necessitated by the changing social and economic pressures in our rural communities. The Continuing Committee presented the following as some of the major factors which have influenced local government patterns in Saskatchewan:¹

- i. The population shift from rural to urban has made it difficult to plan services (an example of this is the over-provision of hospital services in some rural areas where population was declining).
- ii. Rural communities are now demanding the same level of services as is given in urban communities.
- iii. Small municipalities do not have the resources and cannot afford the staff necessary to provide modern services.
- iv. Increased mobility of farm families has produced an urban centered rural community much larger than the rural municipality.

¹Ibid., p. 9.

- v. There is an increasing interdependence of rural and urban residents.

The Local Government Continuing Committee notes that attempts at local government reorganization in Saskatchewan "have been directed primarily at providing services more efficiently, without a corresponding concern for advancing responsible local government and enhancing its democratic values."¹ The Committee felt that its objective should be to recommend measures that would strengthen local government while at the same time maintain or increase the level of efficiency of the services provided. They recommended that the aim of the province should be to:²

- i. Increase the capacity of local government to provide services effectively.
- ii. Extend local autonomy.
- iii. Restore local responsibilities.
- iv. Decentralize services with a minimum of provincial control.

In order to better visualize the situation being discussed, a thumb-nail sketch of local government in Saskatchewan might be appropriate at this time. The following table will illustrate the number of units involved in local government in the populated southern half of the province:

¹Ibid., p. 11.

²Ibid., p. 6.

Table 1. Local Government Units in Saskatchewan, 1961¹

Total local municipalities	786
Cities	11
Towns	110
Villages	369
Rural	296
Local improvement districts	12
Northern Administration District	<u>1</u>
Total local government units	799

The various local government units receive their powers from Acts of the Provincial Legislature. There is separate legislation governing each type of municipal unit (The City Act,² The Town Act,³ The Village Act,⁴ The Rural Municipality Act,⁵ and the Local Improvement Districts Act⁶). Each city, town, village and rural municipality is governed by a locally elected council. Local Improvement Districts are sparsely populated areas which are administered by officials appointed by the Department of Municipal Affairs. These five types are the basic units of general local government in Saskatchewan.

There are, in addition, many special bodies which administer services of a local concern. School Units have been established to provide primary and secondary education facilities throughout the province. Each School Unit is administered by trustees who are locally elected. The School Units have been set up on the basis of

¹Dominion Bureau of Statistics, Canada Year Book, 1962, Queen's Printer, Ottawa, 1962, p. 90.

²Revised Statutes of Saskatchewan, c. 137.

³Revised Statutes of Saskatchewan, c. 138.

⁴Revised Statutes of Saskatchewan, c. 139.

⁵Revised Statutes of Saskatchewan, c. 140.

⁶Revised Statutes of Saskatchewan, c. 141.

existing road networks and natural community boundaries. For some time now, legislation has existed which enables groups of municipalities to act together in the construction and operation of a community general hospital. These Union Hospital Districts are controlled by a board of officials appointed by the councils of the member municipalities. There are some 56¹ School Units and 112² Union Hospital Districts presently in operation. The Department of Public Health is at present trying to encourage the Union Hospitals and other hospitals operated by municipal corporations or private interests to form a regional system to further increase the efficiency of hospital operations. There are four such regions in existence and they are under local control. More will be said about regionalization in the field of hospital operations later in this paper. The School Units and Union Hospital Districts are an example of regionalization effectively applied as a form of local government in a very limited sense. They are isolated developments, implemented to serve a very specialized need. Besides these formally established examples of regionalization, ad hoc arrangements develop from time to time and often disintegrate as quickly as they are conceived. These examples of inter-municipal co-operation develop in spite of our present system and this co-operation could be greatly enlarged if a system of regional local government were actually functioning.

Besides the above mentioned formal and ad hoc local govern-

¹Saskatchewan Department of Education, Annual Report 1962-63, Queen's Printer, Regina, 1963, p. 72-73.

²Saskatchewan Department of Public Health, Annual Report 1962-63, Queen's Printer, Regina, 1963, p. 126.

ment regional arrangements, many provincial departments are organized on a regional basis. The Departments of Public Health, Welfare, Education and Highways all have a regional services branch. Their regional systems are line operations of the Department and do not involve any responsibilities for local officials. As will be discussed later, the Regional Boards of the Health Regions, while they are composed of locally elected officials, are in practice advisory units to the Department. These regional systems are merely the result of principles of good administration, decentralization and the bringing of a service closer to its clientele.

The preceding discussion of local government units and special bodies was intended to convey to the reader the multiplicity of units involved in the process of local government. The relations between the provincial authorities (Municipal Affairs, Local Government Board, Health, Welfare, Education, et cetera), their field units and the various local bodies is nothing short of chaotic. Provincial-local relations are not only restrictive (as is necessitated by the administrative weakness of the present local units) but they are confusing due to the large number of local and provincial authorities involved. It would not be exaggerating to say that the province must oversee the operations of over 1,000 local authorities in Saskatchewan. The cure of course would be to adopt a larger local unit and a system of regionalization.

2. LOCAL GOVERNMENT REORGANIZATION

Such was the situation in 1957, when the provincial government established the Local Government Continuing Committee to investigate the plight of local government in the province. The Committee made an intensive study of all local government relations and in 1961 published the fruits of their research in a series of technical documents. In the same year their formal report and recommendations were released.

The aims and objectives of the Local Government Continuing Committee's investigation have been previously stated. It is appropriate here to outline briefly the principles which guided the Committee in their proposed revamping of the municipal system in Saskatchewan.

a. The Service Centre¹

This concept is the basis of the recommended regional plan. The Committee's proposed system consists of 66 counties whose boundaries are constructed on this principle.

The term "service centre" is derived from the fact that a certain relationship exists between an urban centre and its surrounding rural area. The urban centre is the focal point of the economic, social and cultural contacts of the nearby rural population and it acts as their contact with the outside world. From this centre come all their supplies and services. The urban centre, in turn, is dependent on the surrounding rural area for a market for its goods and services.

¹Ibid., c. III.

The expression "service centre" refers to an urban unit so located in a rural community. By tracing road patterns, it was found that traffic on all secondary and market roads moved towards a particular service centre. In constructing their new units of local government, the Committee singled out all the potential service centres in the province, and drew their county boundaries to conform to the community surrounding each service centre. The interdependence of the rural and urban segments of this natural community, the one for supplies and services, and the other for a local market, was apparent.

The principles upon which the Committee based their new local government units were scientific, yet simple:¹

- i. They must contain at least one urban centre which would be the service centre and administrative centre of the county.
- ii. The county must contain a natural concentration of population.
- iii. There must be a network of roads linking all the parts of the area.
- iv. The area should not be separated internally by geographic barriers.
- v. The boundaries in the vicinity of smaller centres should be adjusted so as to include their surrounding sphere of influence, as far as is practical. Since the service centre phenomenon is common to all urban units, be they large or small, the surrounding sphere of influence of each town or village in a local unit must be included in the same local unit as is the town or village.

Each of these principles reflects the philosophy of regionalization as was stated in the previous chapter of this thesis. The

¹Ibid., p. 18.

county system recommended by the Committee was designed to conform to the natural community as it exists today. Local government services administered through such a unit would function more efficiently by making use of the natural community communications already in existence.

b. Size¹

The proper size of the ideal unit of local government was given lengthy consideration by the Committee. A major factor was the most efficient size for optimum use of administrative and technical resources. The Committee also considered the best size for the purpose of a tax base, but they were careful to explain that this was not a major consideration. It is the Committee's position that, in determining size, the municipalities' technical ability to provide efficient service is more important than their ability to pay for the service entirely out of local tax funds. In addition the Committee were most concerned with the performance of local government as a traditionally strong democratic institution. Lastly, the Committee did not lose sight of the fact that, while a larger unit may be more efficient, the principle of keeping local government close to the people was important.

c. Integration²

The Committee spent considerable time explaining this principle and strongly recommended that it be carried out. The 1961 Hospital Survey Report also stresses this principle, but in a much narrower field

¹Ibid., c. IV

²Ibid., c. V

(that of hospitals and public health). The Committee's foremost consideration was that, by implementing a policy of integration, local governments would be restored to their original position of general or multi-purpose authority. However, the Committee presented other considerations of a more pragmatic nature which may be summarized as follows:

- i. Integration will reduce confusion caused by overlapping boundaries and authorities.
- ii. Integration will reduce financial confusion - one authority is better able to allocate the limited financial resources among the competing programs.
- iii. Integration will result in better co-ordination and planning - co-ordination is better done at a local level.

It must not be overlooked that there are two aspects to integration: firstly, the combining of services, and secondly, the combining of urban and rural units. Integration of urban and rural areas is closely tied to regionalization and the service centre principle. The combining of services should be of interest to public health personnel. The Committee found that such functions as schools and roads, and health and welfare are interrelated, and strongly recommended that they be integrated on a regional basis. Strangely enough, such a move was never considered by the Department of Public Health. The idea was discussed some time ago by welfare officials but has since been dropped. Such an amalgamation may now be impractical from the standpoint of administrative efficiency. A combined Department of Health and Welfare might prove too unwieldy to manage. In the end it would probably break down into two separate organizations headed by a common Minister. However, the impracticality of a departmental merger should not dampen the

possibilities of an experimental merger of the two regional services.

d. The New System

The Committee recommends a new two tiered system of local government for Saskatchewan. The basic unit of local government is to be the county, with an average population of 9,000. In addition, the counties would be grouped into regions of 50,000 or more population. Any special districts which remained independent should have boundaries coterminous with the new units of local government. The functions and personnel of each level of local government would be as follows:

- i. County - functions¹
 - general government
 - education
 - hospitals
 - public works
 - agricultural improvement
 - protection
 - recreation
 - community planning
- personnel²
 - chief administrative officer
 - agricultural specialist
 - superintendent of public works
 - superintendent of schools
- ii. Region - functions¹
 - public health
 - medical care
 - social welfare
 - hospitals (if there is an independent hospital district, its boundaries should be coterminous with the region)
 - community planning
 - recreation

¹Ibid., p. 109.

²Ibid., p. 51.

- personnel¹
 - chief administrative officer (general administrative responsibilities, and in addition, he is secretary to the health and welfare board)
 - medical health officer
 - welfare officer
 - hospital administrator

With the strengthening of local government and a transfer of functions from provincial authorities, many of the regional personnel would be transferred from provincial to local control, (for example, the Medical Health Officer would become an employee of the regional board).

e. Provincial-Local Relations

While the province is ultimately responsible for local government, there is a great deal of room for local discretion. If local government became strengthened, more and more responsibility could be shifted to local councils. Decentralization is a most important principle in public administration. Every department providing services to the public should develop a field service administration on a regional basis. These services must be close to the people and if we are able to reconstruct a strongly local unit, these functions (many of which were previously local responsibilities) could be delegated to local authorities.

Any reorganization of local government must be accompanied by an assessment of the interdepartmental relations among the departments concerned with local government. The Local Government Continuing Com-

¹Ibid., p. 52.

mittee feel that there is not enough co-ordination of departmental dealings with local government at present, and if the proposed reorganization is implemented there will be an even greater need for inter-departmental co-operation in the future. (This lack of co-ordination and co-operation is apparent when one examines the studies done by the various departments of their regional services or relations with local government).

After a thorough going examination of existing conditions, the Local Government Continuing Committee have recommended new local government units of a more realistic size. These new units were set up in a scientific manner on the "service centre" principle which more accurately reflects the modern rural community. Working on the assumption that strong local governments are desirable, they recommend a new unit to which the province will eventually be able to return all of the traditional functions of local government. This new and much simplified setup of multi-purpose local authorities would put an end to the present system of numerous special purpose bodies. The provincial government would be dealing with 100 local government authorities, rather than 1,000, as was previously stated. Inter-municipal relations would also be simplified.

The decision whether to implement the recommended local government reforms is, of course, a political one. If the regions were set up, the regional public health program presently administered by the Department would be turned over to the regional councils. This would mean that major changes would have to be made in the whole departmental organization. In addition to public health services, hospital planning

could also become a major regional function. The recommendations of the Local Government Continuing Committee are, in fact, so far-reaching that a corresponding reorganization of the provincial departments concerned with local government would be necessary. The implementation of the Committee's County and Regional system would have to be completed in several stages. To the present, the provincial government has found it politically inexpedient to make any definite commitments as regards the recommendations of the Committee. The present municipal units are in the majority opposed to an amalgamation to form larger units. As a result, the confusion caused by the present system continues to mount and there does not appear to be much hope that comprehensive regionalization will come to local government in Saskatchewan in the near future.

IV REGIONALIZATION IN THE FIELD OF PUBLIC HEALTH

1. THE BEGINNINGS OF PUBLIC HEALTH PROGRAMS IN SASKATCHEWAN

As soon as the province was established in 1905, moves were made to provide the population with more adequate health services. In 1906, a Provincial Medical Health Officer was appointed, under the Minister of Agriculture, to enforce the provincial ordinances on disease and public cleanliness. Shortly after this, the foundations of the present Department of Public Health were laid. In 1909, legislation was passed establishing a Bureau of Public Health. This 1909 legislation intended that the Bureau would provide centralized and consultant services, while each unit of local government, having been designated a Health District, would provide local public health services. The Bureau provided central laboratory facilities, consultant services in sanitary engineering, the registration of vital statistics, and, beginning in 1916, rudimentary public health nursing services and communicable and venereal disease prevention programs.

During the 1920's there were further important advances in the field of public health in the province. In 1923, the Bureau of Public Health was raised to full departmental status, with a responsible Minister. In 1928 a Division of Public Health Nursing was established and school nursing services were transferred to this Division from the Department of Education. In 1930 responsibility for the provincial mental hospitals (North Battleford, established in 1913, and Weyburn, established in 1920) was also transferred to the Department from the Department of Public Works. As the years passed, and a new concept of modern health developed, it became apparent that our small local govern-

nents were incapable of providing even a minimum of public health services. However, the Depression and the War in 1939 perpetuated this unhappy state of affairs.

It was never intended to take public health duties out of the hands of local governments. Such measures as the provincial government introduced to improve public health services were aimed at helping the municipalities help themselves. It was always difficult to attract physicians to rural areas in the province. In 1919, the provincial government passed legislation enabling municipalities to contract with doctors to provide services in a municipality. The doctor accepted full salary, payment on a fee-for-service basis, or a combination of both. During the Depression, arrangements for full or partial salary helped to attract and hold physicians, as it guaranteed a minimum income. Previously the rural physician was accustomed to carrying a large amount of unpaid bills on his records. The legislation was later expanded to enable local governments to provide medical and hospital care insurance for their residents. The municipalities could establish their own schemes, or contract with private companies to provide insurance for the people of the area. This form of medical and hospital coverage (through municipal arrangements or through individual arrangements with private companies) was allowed to continue until very recently. In 1947 a province-wide hospital insurance plan was established and in 1962 a provincial medical care plan was set up. It was estimated that, in 1962, municipal or private companies provided medical coverage for two-thirds of the province's population.

In 1928, a very important step was taken to improve health services in the field. Legislation was enacted permitting groups of local governments to form a regional unit to administer local health services. One such unit was organized in 1929 in the Gravelbourg area of the province, to serve a population of 23,000. Unfortunately, the program was abandoned in 1932 due to a shortage of funds. This important regional experiment was far ahead of the times and it is regrettable that the Depression intervened and prevented it from being carried through.

In certain fields, health services were developed on private initiative. In 1911, a group of interested citizens formed the Saskatchewan Anti-Tuberculosis League. The League constructed and operated, by means of private funds, several tuberculosis sanatoria at various locations in the province. Their activities were supported by the government through the payment of special grants. In 1931 the Saskatchewan Cancer Commission was established as a semi-independent agency. Both these organizations have provided important health services outside the scope of the government's programs.

It was originally intended that local government should be responsible for most public health services in the province. Until the end of the Second War, the provincial government provided certain central services and established branches to give technical advice to the local governments. Legislation provided that each municipality was a Health Unit and its council was the local Board of Health. It was expected to hire a Medical Health Officer, enforce provincial health regulations, and provide public health services for all the residents in the munici-

pality.

The construction and operation of hospitals also continued to be a local or private concern. Private and religious organizations have, of course, provided a number of hospitals in the province, but most "general hospitals" are operated by the municipalities themselves. It was found, however, that except for the large towns and cities, the average local unit was unable to provide a hospital out of its own resources. In 1917, the province passed legislation enabling groups of municipalities to form a "Union Hospital District", for the purpose of constructing and operating a general hospital to serve their locality. These Union Hospital Districts have been established at a steady rate and today they serve well over half the population of the province. In providing for such a co-operative measure, the provincial government had stumbled onto the principle of regionalization, but they failed to recognize it as such, or to expand it to other fields of public health.

Thus we arrive at the end of a great economic depression and six years of war with a provincial health department offering technical and consultative services, operating two mental hospitals, and a meager public health nursing program for school children. The major responsibilities for actual health services to the people rested with local government. The programs of the municipal health boards were developing at varying rates, depending on the financial resources available, but the vast majority were grossly inadequate. The War in Europe was coming to an end and the whole nation had by this time recovered economically from the depression. The time had come for a recovery in the field of health and welfare services, and the economic and technical potential of

the nation could now be redirected from taking lives to saving them.

2. THE SITUATION IN 1945

By 1945, Saskatchewan was far behind the other Canadian provinces in the field of health services. The Depression had drastically reduced provincial and municipal revenues, and many health services had to be abandoned or curtailed. By 1945 the contraction of health programs was further aggravated by the drain of trained personnel into the war effort. The situation was critical and immediate action was needed to restore health services to a desirable minimum standard. What health services existed in the province and how were they administered?

a. Preventive Services

Preventive or public health services were provided by the municipalities under the supervision of the provincial government. As was mentioned, the local Board was required to appoint a Medical Health Officer, and they usually complied by hiring a local general practitioner on a part-time basis. The Department of Public Health was responsible for setting health standards and providing service and consultation for the local units in matters of public health (Divisions of Public Health Nursing, Sanitation, Communicable Diseases, etc., had been established in Regina for this purpose). Theoretically, the Department could enforce the provisions of the Public Health Act when they were not carried out by the municipal authorities, but in practice it was not common for the province to take action. The Department accepted the fact that it was beyond the capability of the municipalities to provide even a

minimum level of preventive health services.

b. Medical and Hospital Care

The War put an even greater strain on the already chronic shortage of physicians in rural Saskatchewan. In addition, the new trend to group practice made it even more difficult for rural communities to recruit physicians. The Municipal Doctor Schemes went a long way to alleviate the situation, but it was becoming evident that the single rural practice was an outmoded system. The new concept of the health centre and a team of doctors serving a region was taking its place.

A high quality of hospital care was not available throughout the province. Municipalities were on their own in providing hospital facilities for their residents. There was legislation to enable groups of municipalities to work together in the construction of a Union Hospital, but it became apparent that, if a modern hospital system was to be set up after the War, the piecemeal and unco-ordinated efforts of the local governments would have to be abandoned.

c. Medical and Hospital Insurance

Provincial legislation had been in existence for many years to enable municipalities to arrange medical and hospital insurance schemes for their residents. Some contracted with private carriers while others arranged for coverage through contracts with local physicians. However, municipal efforts had reached their peak. Many residents were categorized as bad risks and were unable to get coverage. Deficiencies in planning and consultant services, lack of uniformity, and lack of universal

coverage could not be overcome through the existing system. It was felt that health insurance organized at the municipal level was inadequate. Some form of larger units was advisable if coverage was to be available to all the citizens of the province.

It was apparent that the provincial government would have to embark on a considerable health reform to bring the province's facilities and services up to a desirable modern-day standard. An investigation was carried out to determine the best means of attack and, either the provincial government itself would have to embark on a considerably expanded health program, or the local governments would have to be strengthened to enable them to undertake the task.

3. THE PROPOSED REFORM

In 1944, Dr. Henry Sigerist of Johns Hopkins University, was appointed to investigate the status of health services in the province, and to make recommendations for their improvement. One of the basic tenets of his report¹ was the principle of regionalization. He felt that, in order to bring a modern health program to the people, a system of health regions must be set up. As a result, the Health Services Planning Commission was established, and further studies were conducted. A master plan for regionalization was worked out, and the first health region was established in December, 1945.

The Health Services Planning Commission prepared a series of

¹H. E. Sigerist, Saskatchewan Health Services Survey Commission Report, 1944.

memoranda outlining the situation and the policy it intended to pursue. The Commission felt that it was its duty to carry on its work in the spirit of the policy of the new government, that is "to set up a complete system of socialized health services with special emphasis upon preventive medicine so that everybody in the province would receive adequate medical, surgical, dental, nursing and hospital care without charges".¹ It was hoped that this objective would be achieved through the process of regionalization.

a. The Underlying Principles

Certain basic principles² were considered necessary for the success of the regional scheme. The Commission's statement of these principles may be summarized as follows:

- i. There must be a sound relationship between the various agencies involved in the plan - the Department, Health Region, etc. The Department must remain at the apex of all health services. The powers of policy-making with regard to matters pertaining to the health of the people of the province are delegated in the constitution to the provincial government. The division of general health policy among several agencies is undesirable. A central authority can carry out more intelligent planning since it will not be subject to local pressures.

It must be noted that this last argument of the Commission's has two edges. It may be desirable to leave general planning and policy-making in the hands of a central agency, but it is very hard to keep the central agency from invading the fields of interest of the regional boards. Just such a trend has in fact developed. We now find that the regional boards, once conceived as strongly autonomous, are little more than advisory today. The new government in 1944 was officially assuming control of health policy in the pro-

¹Health Services Planning Commission, Report on Regional Health Services, A Proposed Plan, 1945, Part II p.1.

²Ibid., Part II, p. 2.

vince. Regardless of who controlled or administered public health services, the provincial government would assume responsibility for general health planning. The social well-being of the people was being transformed from a minor local concern to a national and provincial responsibility, and the provincial Department of Public Health was to grow into the largest government department in the province.

- ii. The province must maintain some controls over any revenues allotted to the local units for health purposes. Though the Health Services Planning Commission and its advisors accepted this as a basic principle, we find that, among experts today, this principle is no longer considered necessary. Responsibility for spending should be left with an agency as long as it is using the funds in an efficient manner, regardless of the sources of those funds. Nevertheless, in 1945 the old principle of "he who pays the piper calls the tune" was very much in vogue. Confidence in local government had been destroyed and it was felt that strong provincial financial control was necessary. In addition, the principle of using conditional grants as a tool to implement a provincial policy was extremely popular at the time.
- iii. The problems of the conflicting principles of local autonomy and central supervision, and the spreading of the financial burden of health services over the whole province must be resolved. An ideal solution is non-existent, but an acceptable middle-of-the-road policy could be worked out.

A more detailed discussion of this third principle is necessary here. It was evident that local government would be unable to provide a modern health program. The question was, should all health functions be transferred to the province from whence they could be decentralized under provincial control, on a regional basis, or should the principle of regionalization be applied to create a new and stronger local authority? The Health Services Planning Commission gave considerable thought to the pros and cons of centralization¹ and attempted to reach the balance point mentioned in the above paragraph. The following is a brief summary of their analysis:

¹Ibid., Part III, p. 2.

(1) Advantage of Centralization

- (a) The then current health situation in Saskatchewan could only be rectified by strong central action. As was mentioned, health services and facilities in the province were dangerously inadequate. Due to the urgency for quick action and due to the enormity of the problem, local government could not be left to tackle the situation alone.
- (b) The incidence of illness and its effects could not be localized nor could they be adequately dealt with by local units. Patterns of illness were related to the community unit, and as was mentioned earlier, the natural community was growing in size. The traditional municipal unit was no longer a realistic size for dealing with the incidence of illness.
- (c) Equality of services and health opportunities could only be provided by a central financial and planning arrangement. The provision of health services varied with the ability of the municipality to finance them. As a result, there was a great variety of medical and hospital plans in existence in the province. In addition, no municipality was able to provide medical and hospital insurance for a certain percentage of the population classed as bad risks. The government were concerned by the inequalities of health services provided, and they felt that no citizen should receive inferior medical care due to an accident of birth.
- (d) The provision of better working conditions for the physician could be effected only through a degree of centralization. Municipal contracts and salary arrangements with physicians varied greatly. The government firmly believed that the profession should have the same rights as organized labour. They wished to establish a provincial standard whereby there was a minimum wage paid to doctors, an annual vacation provided for, a superannuation scheme established and provisions made for educational leave. It should be remembered that, since the onset of the Depression in the province, physicians had suffered with the rest of the population. Many good men had

been forced to relocate in other parts of Canada or the United States due to economic conditions in rural Saskatchewan.

(2) Disadvantages of Centralization

- (a) Health services, especially general practitioner services, are intimate and personal, and are best kept close to the people. Services must be provided rapidly and with as little red tape as possible. In addition, the physicians themselves are much concerned with medical care and are used to having a strong voice in the operation of health services. It was therefore felt that removal of health services to central control would upset the personal nature of the doctor-patient relationship.
- (b) Health services require the intimate participation and active interest of the people served. This can best be obtained if the latter have a measure of control and responsibility in the provision of these services. Preventive health programs will fail if they do not secure the interest and support of the community. This support is generally assured when preventive services are under local control.
- (c) In Saskatchewan, there is a long tradition by which the people have supplied themselves with many health services through local initiative. In 1945, many municipalities were offering more and better services than the province could at that time supply through any provincial plan. The province was financially unable to institute a complete health program throughout the province, hence a way would have to be found to utilize the work already done by the local governments. Some form of shared program would have to be adopted.

Both the advantages and disadvantages of centralization were examined and a certain amount of merit was found in both. It was decided finally that there should be a combination of centralized finance and overall policy control, with considerable responsibility for the provision of services left in the hands of the local authorities. If this

responsibility were to be left in the hands of local authorities, it was apparent that a reorganization of local government would have to take place.

b. The Health Centre Scheme and the Organization of Medical Practice

There was developing a new principle in medical practice which, as yet has not been discussed. Poor economic conditions and the war effort were the major but not the only reasons for the chronic doctor shortage in rural Saskatchewan. The era of the general practitioner or "family doctor" was coming to an end and the single rural practice was not attractive to the new school of physicians. Doctors tended to specialize and develop group practices. Medical graduates located in large urban areas where good facilities and close contact with their colleagues were available. The answer to this tendency of physicians to drift to areas of urban concentration was found in a practice currently being developed in the United States, that of the medical centre.

The medical centre concept involved the provision of preventive, curative and rehabilitative services on an integrated basis. At the community level, the small medical centre provided facilities for the community doctor to handle the day-to-day medical needs of the people. The local centre is backed up by a whole organization of district and regional hospitals, with up-to-date facilities for the treatment of disease. The regional hospital may also be affiliated with a medical school or research centre. This medical centre plan was enthusiastically accepted by the American Medical Association, and a detailed study of this form of providing medical care was conducted by a specially appointed

subcommittee of the AMA:

"The subcommittee has studied with interest the growing trend toward utilization of a relatively new type of facility called a medical centre, which combines and co-ordinates the three major aspects of modern medical care ... the preventive, the diagnostic and the therapeutic services. The medical centre brings together doctors' offices, diagnostic and laboratory equipment, hospital beds and preventive work. It further groups practice by physicians, surgeons and dentists, encourages experimentation and research, and stimulates dissemination and exchange of medical knowledge.

The physical structures required for many of these four basic types of units (medical centres, health districts, regional and base centres) already exist in many areas. Here the primary need is for regional planning and organization of the existing facilities so that they might function in a co-ordinated manner, rather than for the construction of new buildings."¹

It was along these lines that the Health Services Planning Commission wished to reorganize health services in Saskatchewan. This tendency towards group practice and location in urban centres where modern diagnostic services were available had to be compensated for. The necessary close contact between physicians and their patients would be impossible under such conditions in a predominantly rural province like Saskatchewan. The Health Services Planning Commission and its advisors proposed a regional organization through which this dilemma could be overcome. When any patient required the services of consultants, special examinations, or special treatments, he would get them through arrangements made by his physician who would be part of the district organization. Some services would be available at the regional centre only. The whole organization of physicians, hospitals, et cetera,

¹C. Pepper, et al., "Wartime Health and Education Interim Report" Journal of the American Medical Association, Vol. 127 (January, 1945), p. 40.

would be a close-knit whole, through which a patient on an outlying farm would get the same benefits of modern care as would the city dweller.¹

Under this regional scheme of integrated preventive, curative, and rehabilitative health services, the physician would be employed by the local health unit but paid from funds supplied by a central provincial organization. This central administrative body would:²

- i. Act as an advisory placement service.
- ii. Set standards for service and prepare a model physician contract.
- iii. Be a board of appeal in case of disputes.
- iv. Administer a superannuation fund.

This aspect of the scheme never got past the planning stage. It was considered to be impractical and politically undesirable. The suggestion that physicians become public servants was abandoned, and a provincial medical care insurance plan was advocated in its place.

c. Regional Organization and Administration

Health Regions were to be set up to maximize the two divergent aims pointed out earlier, that of the need for central planning and co-ordination, and that of bringing the services to the people in rural communities. The concept of the region was that of a subdivision of the province which would be able to supply those health services that were beyond the means of the local health unit and yet which need not necessarily be organized on a provincial level. Through such a unit, the

¹Health Services Planning Commission, Regional Health Services, Memorandum No. IV, p. 2.

²Ibid., p. 9.

benefit of an integrated health program utilizing public health techniques, diagnostic facilities, consultative services and hospital facilities could be achieved.¹

In accordance with the proposals of the Commission, later adopted by the government, the decision as to whether a health region was to be organized, and what services it would supply, was to be made by the people in the region itself. The first steps toward establishing a health region would be taken when requests for such establishment were received by the Minister of Public Health from at least 10 municipalities (rural and/or urban) in the proposed region. The Minister would then publish a notice of his intention to establish a health region in a defined area in 60 days, unless petitions to the contrary were received before that time. Such petitions could come from municipal councils or from 20 per cent of the electors of a municipality or groups of municipalities. They could be against the establishment of the region as a whole, or against the inclusion of any area in a particular region. If such petitions were received, a poll would be taken. Once a region was established, the regional board was to decide which services it would provide. More services could be added later, as finances permitted.

A health region would be administered by a Regional Board consisting of a representative from each municipal council or local improvement district in the region. This Board would elect a committee to carry on detailed planning of the services of the region. It would be advised by technical committees, each representing one of the

¹Health Services Planning Commission, Regional Organization, Memorandum No. 5., (mimeo), p. 2.

professional groups of the region, e.g., doctors, nurses, dentists, etc., with respect to technical aspects of the services.

The Regional Board would, like any local body, be subject to the will of the provincial legislature and would be required to carry out any Ministerial Orders or Regulations promulgated under the authority of statute. It was intended, however, that the Regional Boards would have great freedom in instituting and administering health services.

A Medical Health Officer would be appointed by the Minister, in consultation with the Regional Board. He would be the chief executive officer of the region and would be responsible to the Board for all the services provided by the region. At the same time, the Medical Health Officer would be a provincial official acting as chief of preventive services in the region. This duality of office was doomed from the start. The regional Medical Health Officers were actually provincial appointments, and their role as an employee of the Board never matured. In the one region where regional services developed as planned (Swift Current), the provincial preventive program and the regional services separated. The Medical Health Officer was a provincial official and the Regional Board appointed their own chief executive officer to operate the regional services. The Medical Health Officer was occasionally turned to for advice but he was looked on as a purely provincial official.

The financing of the regional plan was to be a combination of local revenues and provincial grants. A flat grant would be paid to the regions and equalization grants would be paid to assist poorer regions to enable them to conform to a minimum provincial standard. In addition,

the province would make grants available for special projects such as hospital construction and for the provision of diagnostic and curative services. These grants would be optional and would be paid only if a region decided to build a new hospital or develop a medical plan.

Grants would be available to the regions for the following programs:¹

- i. To retain the services of a "full-time" staff of specialists in public health and preventive medicine, (i.e., a medical health officer, nurses, sanitary officer). The provincial government would undertake payment of 50 per cent of the cost of retaining such a staff, as well as 100 per cent of capital expenditures necessary for the purpose.
- ii. To plan hospital and diagnostic facilities for the region with a view to making available to the residents of the area both emergency treatment and services of modern, well-equipped hospitals. For the building and maintaining of hospitals, the government would make certain grants:
 - (1) grants and loans for capital expenditures, to be made according to the size of the project and the need of the area;
 - (2) operating grants of 50, 40 and 30 cents per patient per day, to aid in the maintenance of hospitals or nursing homes. Hospitals would be graded according to the services they provide and grants would be paid accordingly.
- iii. To pay for medical and hospital care for its residents. The larger area, with its larger population would make possible a greater spreading of risks and costs than when such schemes are undertaken by single municipalities. This tends to place the scheme on a sounder financial basis, and also tends to reduce the costs to individuals in the scheme. The province would pay grants to the regions on the following basis:

¹Health Services Planning Commission, Organization of a Health Region, Department of Public Health Central File No. 175A, 1945.

- (1) a flat grant of 25 cents per capita for all persons included in an approved scheme;
- (2) an equalization grant, to be paid according to the financial need of the area served by the approved scheme.

As the health regions **became** established, this financial system was adopted to varying degrees, depending on the development of programs in each region. Preventive services were financed as described in (i) and the grant for staff has been increased and stands at 66.6 per cent today. Payments for hospital construction and equipment (ii (1)) are paid by both the province and the federal government today. However, financial arrangements are between the senior governments and the individual hospitals, with the regions taking no part. Grants for operating costs (ii (2)) are paid through the Saskatchewan Hospital Services Plan, but again to the individual hospitals. Medical and hospital insurance schemes were never seriously attempted in the regions. The hospital insurance schemes in two regions lapsed in 1947 when the provincial plan came into effect, and the lone medical scheme in the Swift Current Region now receives reimbursements from the Provincial Medical Care Insurance Commission.

As was previously mentioned, the provincial legislature is the sovereign body responsible for the operation of local institutions. Therefore, the provincial government of the day would determine health policy in accordance with their political philosophy. The Minister would then implement that policy, as directed in statute, by means of Ministerial Orders or Regulations. In addition to this overall responsibility for broad policy and for administrative surveillance, the provincial government would have responsibilities for definite health

services in the new regionalized scheme.

- (a) Certain facilities would be provided by the province on a centralized basis. The province would be responsible for planning, research, determining standards for all health services, the operation of a university and associated medical centre, and the operation of institutions for the mentally ill, the chronically ill and tuberculosis victims.
- (b) The preventive health services would be administered by the provincial Department of Public Health. The Department would appoint all regional preventive staff, in consultation with the regional boards concerned. Preventive services would be jointly financed. The local governments' share of the cost would be raised in each region by means of a levy on all member municipalities, payable to the provincial government. As was mentioned, the Medical Health Officer would act as the chief provincial officer responsible for preventive services in the region.

Prior to the plebiscites to be held in the first two proposed health regions, the Premier of the province delivered a radio speech which outlined the government's official policy:

"Why set up a health region? The answer is, because that is the most efficient and democratic way to organize our health program. No one imagines that a health scheme could be run efficiently for a province as large as Saskatchewan by a body of experts in Regina. There are a hundred and one day-to-day problems which can only be handled efficiently by a smaller unit of administration. Also, we believe in local self-government so that the people who are getting the services, as well as those who give them, may have some voice in administering a health program that may be set up. To do this it is necessary to have health regions directed by boards elected by the municipal councils. The second question you will probably ask is, what services will these health regional boards give? The answer is that it will depend upon the people in the region. You elect the board, and the board will decide what services should be undertaken. May I make it clear that the govern-

ment does not decide what services should be established. All the government does is to offer to finance a share of these services, but what services you will have depends upon your own elected board."

The organization of a province-wide hospitalization and medical care scheme does not mean that regional boards will be unnecessary when a complete scheme is introduced. On the contrary, these regional boards will be more necessary than ever in helping to administer what will be a very comprehensive undertaking.

The thing to remember is that the cost will be determined by you in the health region. You will decide how many health services you want and how much you are prepared to spend. The government will not tell you how much it will cost ... that is your decision. What we will do will be to assist you financially so that you can buy, as a region, health service which your community could not possibly buy for itself.

We could, of course, set up a health plan that would be operated by a group of experts in Regina. I do not think you would like such a setup. You and I like to have something to say about any scheme which is going to concern itself with so important a matter as the health of our families. In such a health scheme, there will, of necessity, be some adjustments as a result of our experiences. Such changes can best be made if the people who are receiving the services and those who are giving the services are able to express their opinions and preferences."

4. THE PERIOD OF ADJUSTMENT 1945-1950

A regional scheme did not appear overnight in the province. As was mentioned, regionalization was up to the local governments. Regions would be formed by the Minister only on request of local officials or after a plebiscite, as the case may be. In 1945, it was believed that such a gradual development would be desirable, since the provincial government did not have the resources to support extensive regional programs throughout the whole province. It was conceived that regions

would be formed gradually with a basic program which would be gradually enlarged as circumstances permitted. The regions did, of course, develop gradually, but the urgency of certain health reforms made it impossible for the provincial government to await a gradual development of health programs.

a. Swift Current - a Regional Model

The regional plan developed by the Health Services Planning Commission was a most extensive reform. The Commission realized from the start that the province had neither the personnel, resources nor the finances to develop the complete plan on a province-wide basis. As was mentioned the regions would be formed one by one, as local interest developed, and it was thought that, likewise, full health services would have to be developed gradually in each region under a combined local-provincial financial arrangement.

It was advocated, however, that one region be selected as a model, in which all the health services envisaged by the Commission could be put into operation. The Swift Current Region was accordingly selected and developed along this line. Besides the usual preventive services under provincial control, the regional board was allowed to develop a medical plan. Later, the regional medical program was expanded to cover diagnostic and outpatient services. A dental scheme was also developed for school children. Contracts were negotiated with the doctors of the region for the provision of medical services, and the Board was active in recruiting specialists for the region and improving the diagnostic services available at the major hospitals.

As a result of this ideal situation, the regional board developed into a strong local unit along the lines that the Health Services Planning Commission had intended. The many services under regional direction involved a budget of hundreds of thousands of dollars and the Board members developed a genuine interest in health matters. While the Regional Board often moved along lines at variance with central policy, the Department allowed them great latitude in conducting their affairs. In summary, the Swift Current Region developed according to the principles of regionalization envisaged by the Health Services Planning Commission and the government in 1945.

b. The Regional Board Reorganized

Soon after the first regions were set up, the composition of the regional boards was found to be unwieldy. Provision had been made for each municipality in the region to send one representative to the regional board. It was found, however, that such an arrangement made the board too large. To remedy this situation, the regions were divided into two or more districts. The municipalities each elected representatives to their district council, which in turn selected representatives from among its ranks to sit on the regional board. In addition, representation was to be determined by the Minister on the basis of population. The recommended size for the regional board was to be between 6 and 12 members. The Regional Medical Health Officer, previously a voting member of the board, was relegated to the position of an ex officio, non-voting member of the board.

Table 2. Composition of the Health Regions and Regional Boards, 1961¹

Region	Regional Board (size)	Number of Health Districts ²	Municipal Units included in Health Regions ³
<u>Health Regions</u>			
No. 1 Swift Current	12	4	76
2 Assiniboia-Gravelbourg	8	3	41½
3 Weyburn-Estevan	10	5	76
5 Regina Rural	5	5	112½
6 Moose Jaw	7	3	45
7 Rosetown-Biggar-Windersley	6	3	88½
8 Saskatoon Rural	6	3	62
9 Humboldt-Wadena	6	3	46
10 Yorkton-Melville	5	5	80
11 Melfort-Tisdale	7	4	42
12 Prince Albert	7	5	42
13 North Battleford	10	6	80½
			<hr/> 792
<u>Independent Units</u>			
Regina City			1
Saskatoon City			1
Northern Health District			5
			<hr/> 7
Total local government units			799

¹Source: Unpublished data, Saskatchewan Department of Public Health.

²Each District Council appoints one or more representatives (at the Minister's discretion), to the Regional Board.

³Each Municipal Unit Council sends one representative to the District Board.

The Department continued its attempts to strengthen the functions and authority of the Regional Boards.

"The administration of public health functions by local units is in keeping with the best modern concepts in public health and is considered to be essential if full advantage is to be derived from local participation and initiative and if certain aspects of the provincial health program are to be developed with sufficient elasticity to provide for differences in requirements and resources of different parts of the province."¹

¹Memorandum from Director of Regional Health Services to the Deputy Minister, August 8, 1947, Department of Public Health Central File No. 175A.

Under the provisions of the Health Services Act and the Public Health Act, regions were authorized to develop a wide range of services including public health services, medical care, specialists' services, diagnostic services and the development of health facilities. As regional organization developed, consideration would be given to the localization of other health functions which were then conducted on a provincial level. In establishing regional boards it was the intention that their functions should include the planning and administration of health services and the discharge of functions as boards of health for the regions. In this latter capacity, the regional board was to assume responsibility for enforcement of regulations and establishment of local policy within the standards established by the province. At that time, this function was being discharged by municipal boards of health. This move to strengthen regional authority, however, never matured and the functions previously envisaged as regional responsibilities gradually drifted from the local into the provincial sphere.

c. The Provincial-Regional Administrative Relationship

The administrative relationship between the regions and the Department had to be worked out. The directors of the various divisions of the Department of course kept a close eye on regional services and advised the Minister on progress made. All correspondence or orders to the Regions, however, had to go directly to the Regional Medical Health Officer. Although technical problems were discussed freely, no administrative orders were supposed to be issued in the field by technical personnel visiting from the Department. A Division of Regional Health

Services was established under the Health Services Planning Commission and all correspondence from the various Divisions of the Department and the Commission was to be channelled through this Division.

To ensure that the administrative relationship was quite clear, a manual was prepared by the Health Services Planning Commission outlining the functions of the health regions, the regional staff and the various agencies of the department. As a result of this, administrative matters in the regions were rigidly standardized by the provincial government.¹

The Regional Medical Health Officer was developing in a dual role, firstly as executive director and advisor for the regional board, and secondly as a provincial official representing the Minister in the region. The Medical Health Officer was responsible to the Deputy Minister through the Director of Regional Health Services for his duties as a provincial officer. In addition, he was becoming the Department's link with the regional board. This duality of the Regional Medical Health Officer was detrimental to the region as a local authority. The Regional Medical Health Officer was provincially hired and from the beginning accepted provincial directives automatically as regional policy.

d. Regional Functions Go Astray

It was expressed by many experts, even before the new health program got under way, that adjustments would have to be made. It was a

¹Memorandum from Director of Regional Health Services to the Deputy Minister, May 29, 1947, Department of Public Health, Central File No. 175A.

great experiment and no one expected it to function perfectly. Unfortunately during the first five years, the field of responsibilities allotted to the region was seriously depleted. Some government officials were forced to admit that the regional concept had so greatly changed that the regional board was a vestigial organ, somewhat like the human appendix. It appeared that, other than for educational purposes, the regional board had no functions.

- i. Dental Services - Possibly the first function to go astray was that of dental services. The Swift Current region was permitted to start a dental program for children in 1946, but, soon after, the Health Services Planning Commission changed its policy. It was felt that a dental service to children was primarily preventive, and as such belonged to the provincial preventive health program. Thus it was decided that, in future, regional dental plans should be administered by provincial field staff in the region.
- ii. Hospital Insurance - Hospital insurance had been provided by many municipalities for their residents before the institution of the new regional health program. Accordingly, hospital insurance programs were instituted in two regions under local authority. Soon after this initial step was taken, the provincial government found it necessary to reverse this policy. Province-wide universal coverage was of top priority, and since regions were being established very slowly, it must be provided centrally if it was to be achieved in the near future. As a result, it was decided to establish a provincial scheme which would be administered centrally, rather than to finance schemes in the regions as they became established.
- iii. Hospital Planning and Construction - Hospital planning and construction was a basic part of regionalization. In the newly adopted "medical centre" idea, hospital planning was a most important regional function. Again, unfortunately, circumstances were such in Saskatchewan that the provincial authority had to move into this field, rather than permitting local authorities to develop it as a regional function. The Depression and War had caused a critical bed shortage in Saskatchewan, and in addition, diagnostic facilities were almost nonexistent in the small rural hospitals. As a result,

hospital planning and construction could not wait for the establishment of health regions. The Health Services Planning Commission developed a master plan for the province and embarked on an extensive program of education to induce communities to construct hospitals. Large grants were made available, and the Commission established a Division to closely supervise all construction plans to insure a high standard.

Thus, the provincial government was forced to assume yet another regional function due to the necessity for quick action. In 1951 and 1961 the Hospital Survey Committee reasserted the benefits of an integrated regional system, but to date no decision has been made to set one up.

- iv. Medical Care Insurance - Here again this was conceived to have been an important field for the Regional Board. The province's experimental region (Swift Current) was encouraged to develop its own plan as a pilot project, but, soon after, the question arose as to whether the province should actively advocate similar plans for the new regions as they were established. There were two factors which caused hesitation on the part of the provincial advisors: firstly the idea of upward of 14 different schemes was not appealing, secondly, word had been received that Federal Health Grants might be available to the provinces for medical care. As a result, the Health Services Planning Commission decided to discourage any regional applications to operate a medical care plan.
- v. Preventive Services - The original researchers recommended that the regions administer their own preventive programs. Preventive medicine was considered to be only a part of the modern integrated health program. However, the province had an old and well established interest in preventive health and, while decentralizing it to a regional basis was considered desirable, it was decided that it should remain under provincial control. As a result the Medical Health Officer and his regional staff were provincial employees from the start. The Medical Health Officer, it is true, started out with dual responsibilities, but as the regional boards' functions failed to develop, the Medical Health Officer's responsibility to the central health agencies was confirmed.

By 1950 a trend was emerging which was to prove detrimental to the development of the regions as strongly autonomous bodies. The

major part of administrative responsibility for the Health Regions was being carried out by the administrative officers of the Department. The Regional Medical Health Officer was becoming purely a provincial official responsible for preventive public health services. A flow of orders and information developed between the Director of Regional Services in Regina and the Regional Medical Health Officers. The Regional Board was being shoved off to the side as a purely advisory body. The functions which were to be placed in the hands of the Regional Board never matured. Hospital insurance was administered centrally, the government was lukewarm to any suggested regional medical care plan, hospital planning continued to be implemented through independent union hospital districts, regional dental programs were changed from a local to a provincial function, and preventive services were never seriously considered to be a regional function.

At a conference of the Regional Health Officers in 1947, the Chairman of the Health Services Planning Commission noted that the situation was creating a sense of frustration among regional board members. The Boards must be given something to think about in order to keep them actively interested in health problems. Unfortunately, he adopted an attitude of "wait and see" and the most he could do was to assure the boards that the Health Services Planning Commission would turn to them for advice more often in the future on matters of policy.¹ This situation in the Health Regions was in sharp contrast to that of the Swift Current Region where the local authority was allowed to develop a medical care plan.

¹Conference for Regional Health Officers, Minutes, September 10, 1947, Department of Public Health Central File No. 175A.

5. A PERIOD OF REAPPRAISAL 1950-1960

The frantic efforts in the immediate post-war years had passed and, during the 1950's, independent researchers and government teams studied the various aspects of local, provincial, and national health programs. Saskatchewan was in the fore in the preparation of new reports and studies. While many dealt in an incidental manner with the progress of regionalization, none provided an adequate analysis or appraisal. A combination of political setbacks and an impatient Director of Regional Health Services finally resulted in a readjustment in the regional program and progress was made again in the late 1950's, until in 1960 the last unorganized area of the province became the Saskatoon Rural Health Region.

a. Departmental Reorganization - 1950

The rapid development of health programs from 1945 to 1950 placed a great strain on the twenty-year-old structure of the Department of Public Health. As mentioned earlier, in 1944 the permanent Health Services Planning Commission had been appointed with responsibility for advising the Minister on the extension of health services in the province. This Commission gathered a secretariat of modern and progressive health experts and began planning services to fill gaps in the provincial program. As each new program came into being it was only natural that those who developed it and set it up should administer it. As a result, hospital planning and supervision, the hospital insurance scheme, supervision of the medical insurance schemes, medical care payments for welfare cases, and general health research and planning were all admin-

istered by the Commission. In addition, a very dangerous precedent (by good administrative standards) was set when the Division of Regional Health Services was set up and made responsible to both the Health Services Planning Commission and the Department. The new programs were made the responsibility of the Commission while the old preventive services were allowed to operate undisturbed under the Minister of Public Health. While this may have saved the Department's traditional services from any disruption caused by the organization of new services, a dangerous cleavage was growing between preventive and curative services, and the confusion and friction between these two health bodies (with the Division of Regional Services caught between) may have been a direct cause of the collapse of progress in regionalization in the early 1950's. In 1957, the Director of Health Education urged the adoption of an intensive educational program, to properly explain the benefits of health regions to the people, before the Minister went ahead again with the regionalization of the province. There is evidence to support his claim that an unorganized approach had been taken by the Commission and the Department in the late 1940's and, as a result, the public was unprepared for regionalization, and thus the program suffered set backs. Besides the defeat of the plebiscite in Saskatoon, intentions to establish regions were abandoned in two other cases when it was discerned that public opinion was hostile. Regionalization was completed at a later date with no opposition because the passage of time and an intensive educational program had won over the general public.

The cleavage which had contributed to the retardation of the regional program was partly resolved in 1950. In order to achieve co-

ordination between the two agencies, which were both responsible to the Minister of Public Health, the Deputy Minister of Public Health had been appointed a member of the Commission. However, it became evident that there was a need for a greater degree of integration of the activities of the two agencies. On April 1, 1950, the two organizations were amalgamated. The positions of Deputy Minister of Public Health and Chairman of the Health Services Planning Commission were combined, and to the reorganized Department of Public Health was assigned the responsibility for administration of the Acts previously administered by the Health Services Planning Commission. Although the Commission ceased to be responsible for the administration of specific Acts, it continued to be responsible for recommending policies to the Minister on all matters pertaining to health services in the province, and for major administrative recommendations including approval of hospital construction project grants, establishment of health regions, approval of and grants to regional and municipal care programs, administration of federal health grants and similar matters. Nevertheless, one of the barriers to the completion of regionalization had thus been removed. After a trial period for the new Department had passed, and after the unhappy experience of the regional defeat had been forgotten, the plan could be resumed, this time without haste and with proper preparation.

The Departmental reorganization did, however, in the long run, have a detrimental effect on the health regions. The strengthening of the Department and the simplification of the lines of authority added further to the development of the Regional Boards as purely advisory bodies. There was no doubt now that the health regions were line agencies

of the Department. The Regional Medical Health Officer was directly responsible to the Director of Regional Health Services, who was, in turn, responsible to the Deputy Minister for all regional programs. The various consultant services (Public Health Nursing, Sanitary Services, etc.) were placed under the Director of Regional Health Services. These Divisions provided advisory services of a staff nature to the Director of Regional Health Services and consultant services for the regional staff. All relations were between the Regional staff and the central office and the Regional Board was little more than an advisory body to the Regional Medical Health Officer.

b. The Provincial Health Survey, 1951

In 1948, the Federal Government announced a far-reaching health program for the nation. The program would take the form of national health grants for specified services or in specified fields of health care, and as a preparatory step grants would be available to each provincial government to conduct a survey of health needs in their province. A Survey Committee was quickly set up in Saskatchewan and, after several years of intensive research, the Saskatchewan Health Survey Report was published in 1951.

The Report contains the following recommendations concerning regionalization in the province:¹

- i. All boundaries should be made coterminous with the Health Service Areas established for hospitals. Completely new regional units, Health Service Areas were recommended.² They were to be set up immediately.

¹Saskatchewan Health Survey Committee, Health Survey Report, Vol. 1, 1951, p. 38.

²See page 107.

for hospital operations and it was hoped that later all health services would be brought under their jurisdiction. In preparation for this, all regional boundaries were to be brought into line with these Health Service Areas. These Health Service Areas were never adopted but the 1961 Revision of the Hospital Master Plan restated the recommendations with a revised set of regional boundaries.

- ii. Regina and Saskatoon should be merged with the surrounding rural areas into one health region. There should be one health program for each city and its surrounding area. Bearing in mind what was said earlier about the interdependence of urban and rural areas, we can see why the Health Survey Committee made the above recommendation. The Committee stressed integration, and, as was mentioned, integration implied the merging of interdependent urban and rural areas as well as interrelated functions. At any rate, this recommendation was not acted on. When the Saskatoon and Regina Regions were established, they included rural residents only. Regina and Saskatoon were reserved for the special status of base centres for the province, rather than for regions. Perhaps the government realized that the people of the two cities would be hard to win over to regionalization, and that their resistance would hold up regional progress in their two areas.
- iii. While the Committee agreed with the structure and purpose of the regional boards, they felt that there was a need for greater participation by representatives of community organizations in the planning and guidance of the work of the health region. The Health Survey Committee had unwittingly hit upon the true function of the Regional Board, that of an advisory body to the Regional Medical Health Officer. It appears that, without examining the principles of the 1944 Regional Scheme, they had accepted at face value the unfortunate position into which the Regional Boards had fallen. The Committee felt that, as advisory bodies, the Boards should be enlarged to include representatives of the medical, dental, nursing and other professions concerned with regional services. The Regional Board had, of course, been geared to carry out executive functions and had been held to a workable size for this reason. The Committee recognized that the region's new role had become the provision of a decentralized program of preventive or public health services under provincial control.¹

¹Ibid., p. 77.

- iv. The Department should show more vigorous leadership in the organization of health regions to speed up the process of setting up a complete regional system in the province. The Committee seem to have recognized the Department's failings with regard to creating a favourable atmosphere of public opinion to regionalization. It is apparent that the Committee are referring to the government's lack of an educational and public relations program rather than their speed in organizing the regions.
- v. A more closely integrated working relationship between hospitals should be established. To do this, the Committee recommended organizing the hospitals on a regional basis. The concept of the Medical Centre and the back-up organization of larger district and regional hospitals has already been mentioned.¹ As was also noted, these medical centres already exist in Saskatchewan (the small community hospitals). What was really needed was the organization of these existing facilities into a regional system whereby complete and modern medical facilities would be available to all. In the second volume of the Committee's report, the Committee recommended the organization of hospitals into 12 "Health Service Areas". The name "Health Service Area" was selected because it was expected that these areas would serve not only as units for developing hospital services, but for other services such as public health services. Also in line with their policy of integration, the Committee recommended that "office space for physicians, dentists and public health personnel should be made available in or adjacent to hospitals", since "many advantages can be expected to result from the integration of medical practice, public health and hospital care".²

The Health Survey Report of 1951 was intended to be a survey of existing conditions in the province. In addition, a "Master Plan" for hospital facilities was carefully prepared. It was not intended that the Committee recommend sweeping reforms but rather to draw attention to areas where improvement was needed. They recognized the existing situation in the health regions, and they advocated a return to the original

¹See page 60.

²Ibid., Vol. 2, p. 59.

integrated plan if possible. Their specific recommendations for administrative changes and for the hospital "Master Plan" were made with a view to integration of all health programs at a future date.

c. A Critical Appraisal of Regionalization

Throughout its twenty year term in office, the provincial government adhered to its promise that regionalization would come into the province voluntarily. The people were, at first suspicious. The program suffered setbacks and a regional program was actually defeated in one area (Saskatoon). The program of complete regionalization of the province took sixteen years. After an initial spurt of enthusiasm in 1945, the program of regionalization moved slowly. At each announcement of the Minister's intention to organize a region in an area, petitions were received challenging his intent and forcing a plebiscite. As was mentioned, the government suffered a setback in 1947 when the plebiscite in the Saskatoon area showed the people to be opposed to a regional organization. A vote was forced in the Regina area, but the results were favourable and a region was established in the Regina rural area in 1952. This was to be the last plebiscite in the province and for five years no further attempts were made to organize new regions. The government, it seems, decided to consolidate their position and let time create a more favourable atmosphere in the province.

In 1955, the Director of Regional Health Services, in a series of memoranda, set down a biting criticism of the regional program. He analyzed the current situation in the light of the original plan and noted many shortcomings. I think his remarks in one of these memoranda

are worth recording, since he was in an excellent position to study the regional programs:

"Those who drafted the Health Services Act were guided by two principles:

- a) In establishing the regions they were frightened about the sensitivity of the taxpayer in regard to 'no taxation without representation.'
- b) While indirect taxation caused less pain it was felt the taxpayer would lose his sense of responsibility in the field of public health if he paid nothing.

Accordingly, to escape any charge of regimentation an elaborate facade of local representation was set up in the Health Services Act giving the appearance of decentralization but actually keeping much of the control centralized.

The net result in Regions that have no 'additional program' has been the creation of an expensive farce. Plebiscites, district health councils, regional health councils and regional board meetings are held - all giving the illusion of control but in reality accomplishing little or nothing."¹

Regional progress (or rather lack of it) during the period 1952 to 1957 has already been mentioned. No regions were set up during this period because the Minister feared they would be defeated in a vote. The Director of Regional Health Services, after describing the powerless and what he feels is unnecessary Regional Board, stated that a plebiscite in the region was superfluous. Why hold a local plebiscite on something of purely provincial concern? He felt that, if a plebiscite must be held, it should be conducted only after a region has been operating for a trial period so that the people will know for what they are voting.

The Deputy Minister agreed with the Director on the status of

¹Memorandum from Director of Regional Health Services to the Deputy Minister, January 26, 1955, Department of Public Health Central File No. 175A.

the Boards and the affects that the machinery for establishing health regions had had on regional progress. Such an arrangement was, nevertheless, politically expedient.

"I agree that the regional boards and committees, etc., are often quite ineffective and that pressures from Regina often influence them. It has always seemed to me that in a field such as public health the role of the lay person should be advisory and interpretive. Most boards would be happy to have this role if the health officer could keep them busy in this way. Since so much of our job is teaching and with the evident need for full understanding, the health officer should foster a program which leads to better understanding by his board. They, in turn, can and should be encouraged to preach the gospel in their home communities."¹

The Deputy Minister appears to be expressing the Department's official viewpoint on the concept of regionalization, and it is at the opposite pole from that of the original planners of this province's regional program. Whereas the boards were to be strongly autonomous bodies, they are now relegated to advisory bodies of citizens, which can also be used by the Regional Medical Health Officer as a tool to publicize provincial programs in the local communities.

Other memoranda from the Director of Regional Health Services followed in 1956 pointing out the shortcomings of the regional setup. The regional boards were established to maintain some pretense of local autonomy. In actual fact, the regional boards had no power. The municipal councils remained the health authority named in the Public Health Act. The regional board had neither funds at its disposal nor any legal authority to enforce its decisions. The position of the Medical

¹Memorandum from Deputy Minister to Director of Regional Health Services, February 2, 1955, Department of Public Health Central File No. 175A.

Health Officer was also ill-defined. As chief officer in the region he was a provincial official, while at the same time, he was designated in the Public Health Act as the Medical Health Officer for each municipality. It was difficult, in the case of disputes for him to decide where his loyalty lay. The regional health programs were split down the middle. Curative services were to be financed by the regional board, and staff for any of these services was to be hired by the region. On the other hand, preventive services and staff were to be provided by the provincial government. The Medical Health Officer was expected to co-ordinate these two areas of health services, even though, administratively, they were not connected. Regional boards, on the whole, had shown little interest in the programs of their regions, their meeting attendance seldom being more than 60 per cent. In regions where curative programs had been initiated the boards were more active, but not nearly as the founders of the regional scheme in 1945 had visualized. Finally, he noted, progress in the formation of regions seemed to have bogged down. Ten years after the inception of the regional program, one half of the province still remained outside the regional organization.

The Regional Health Services Director's impatience with regional progress was soon dispelled. Shortly thereafter the Minister decided to again attempt regionalization of the unorganized areas of the province, but this time after the proper educational groundwork had been laid. In 1957, the groundwork was laid for the resumption of regionalization by means of an intensive educational program launched in the field. Thereafter, no adverse petitions were received and no votes had to be taken. Five more regions were set up in the next five years, completing the

regionalization of the province. The residents of Northern Saskatchewan were provided with the same preventive services offered in the health regions, through provincial outpost hospitals, established in the Northern Administration District of the province.

Table 3. The Establishment of Health Regions¹

Region		Date of Vote (if taken)	Date of Establishment
No. 1	Swift Current	November 26, 1945	December 11, 1945
3	Weyburn-Estevan	November 26, 1945	December 11, 1945
6	Moose Jaw		May 16, 1946
14	Meadow Lake ²		July 29, 1946
2	Assiniboia-Gravelbourg	November 13, 1946	May 31, 1947
13	North Battleford		August 15, 1947
8	Saskatoon Rural	November 12, 1947 (defeated)	
12	Prince Albert		February 1, 1951
5	Regina Rural	November 5, 1952	December 1, 1952
7	Rosetown-Biggar-Kindersley		May 1, 1957
10	Yorkton-Melville		December 1, 1957
11	Melfort-Tisdale		January 1, 1959
9	Humboldt-Wadena		February 1, 1960
8	Saskatoon Rural		April 10, 1961

¹Saskatchewan Department of Public Health, Annual Report, 1945 to 1961-62.

²The Meadow Lake Health Region was merged with the North Battleford Health Region on April 1, 1958.

This democratic, but slow and very trying method of establishing the health regions had a very profound effect on the development of their programs. It goes without saying that any body without functions to carry out, is weak no matter how democratic its machinery may be. The health needs of the province were too pressing to await the complete regionalization of the province, and as the regional program slowed and came to a temporary standstill, its proposed duties or functions were postponed or allocated elsewhere. In most cases, the province stepped in and provided the service, and hospital operations were left in the

hands of the Union Hospital Districts or the individual municipalities for want of any better organization. The result has been the final attainment of a fine regional organization in preventive services only. The whole province is now covered by locally controlled regional bodies with virtually no functions or duties to carry out (save Swift Current). The principles of the original plan - integration, strong local government - have been lost sight of in the sixteen year struggle towards the goal of a regional system of health services.

Table 4. Saskatchewan Health Regions, Population and Area, 1961

Region		Population ¹	Area (sq.mi.) ²
No. 1	Swift Current	56,429	15,380
2	Assiniboia-Gravelbourg	26,303	6,894
3	Weyburn-Estevan	58,662	8,892
5	Regina Rural	75,281	12,708
6	Moose Jaw	55,993	5,868
7	Rosetown-Biggar-Mindersley	52,489	12,600
8	Saskatoon Rural	39,551	8,356
9	Humboldt-Madena	45,341	7,272
10	Yorkton-Melville	78,692	9,468
11	Melfort-Tisdale	53,039	12,096
12	Prince Albert	67,719	8,961
13	North Battleford	73,329	18,072
Regions - Total		682,828	126,720
Northern Health District (Provincial)		14,095	
Regina City (City Health Department)		112,141	
Saskatoon City (City Health Department)		95,526	
Indians (Indian Health Services-Federal)		20,591	
Provincial Total		925,181	251,700

¹Source: Population of Saskatchewan Health Regions, 1961, Research and Statistics Branch, Saskatchewan Department of Public Health, (mimeo).

²Source: Unpublished estimates, Regional Health Services Branch, Saskatchewan Department of Public Health.

6. RECENT STUDIES AND DEVELOPMENTS 1960-1965

Investigations have continued and are continuing even today into various aspects of the province's health services. One cannot pick up a report or memorandum on an aspect of health services that does not mention the principles of regionalization, integration and co-ordination. While every report devotes sections to these principles, and makes specific recommendations as to how better to effect them, the main topic receives all the attention and these subsidiary recommendations are forgotten. It is time, therefore, that a study was initiated on regionalization itself. In bringing this study up-to-date, the recommendations of several recent investigations will be discussed in the following section. Only the Local Government Continuing Committee's work gives regionalization its proper place of importance in provincial-local relations.

a. The Local Government Continuing Committee Report, 1961

This Committee was set up following the recommendations of the Provincial-Local Government Conference in 1956. The Continuing Committee spent several years examining all aspects of local government, finally presenting its report in 1961.

The general recommendations of this Committee were dealt with earlier in this paper. However, more should be said regarding the Committee's findings in the health field. The Committee had accepted regionalization as a most important concept in local government, and as a result, was most interested in regionalization as practised in the field of public health and hospital administration. In its study document

on provincial local relations, Regional Health Services and Hospital Administration were examined at great length. The Committee recognized that the regional boards were advisory bodies rather than local authorities, and that the regional plan consisted not of local "control over a local program, but rather the province utilizing a region as an appropriate basis for executing provincial programs".¹

The Committee was favourably impressed with regionalization in public health and recommended its further extension to hospital administration to bring about an integrated hospital system on a province-wide basis. Their admiration is, however, expressed with tongue-in-cheek. "The control exercised over health region functions has been effective in promoting progress towards an objective of optimum health standards, but little if any progress has been made in developing public health as a local function".² If this trend is to continue, the Committee felt, the regional boards should be dissolved and replaced by an advisory board at the provincial level.

The Continuing Committee felt that the present health region system of decentralized administration and advisory councils is far short of ideal. They recommended that an integrated health and welfare region should be developed with all programs under the control of the regional board. If the system were properly established, all the province need do is set broad standards within which the regional boards may function. Regional medical care schemes should be encouraged to bring together preventive and curative services, they thought.

¹Local Government Continuing Committee, Provincial-Local Administrative Relations, 1961, p. 161.

²Ibid., p. 162.

The functions of the region as envisaged by the Continuing Committee are outlined at the beginning of this paper. They are not a radical departure from any of the studies in the past. Health and Welfare would be integrated and the function of general region-wide planning would be added. These ideal regions, as areas, would differ little from the present public health regions. Very little change would be necessary to integrate health and welfare services under one roof, and under one administrative head. Region-wide planning would be a technical function and would stand off by itself. What is radical, and what should receive serious consideration, is the Committee's plan to turn regional program and staff responsibility over to the regional board. Integration is primarily an administrative problem but this transfer of responsibility is a political consideration of a much more far-reaching nature.

b. Report of the Advisory Planning Committee on Medical Care, 1961

The Advisory Planning Committee on Medical Care (Thompson Committee) was appointed by the government to study and report on "the extent of public need in the various fields of health care as related to a medical care program."¹ The Committee gave these terms of reference the widest possible interpretation, and as a result, heard briefs and made recommendations on all medical and related health fields.

The major work of the Committee was, of course, the recommendation of a medical care plan for the province. In recommending the administrative setup for the plan, the Thompson Committee considered three alternatives: a regional plan supported by provincial grants, a jointly administered plan, and a plan administered solely by the provincial govern-

¹Advisory Planning Committee on Medical Care, Interim Report to the Government of Saskatchewan, 1961, p. 9.

ment. The Committee finally decided to recommend a province-wide scheme administered by an independent commission.

The Thompson Committee's reasons for discarding a regional or joint scheme were as follows:¹

- i. Rates and coverage would vary according to the economic capacity of the residents of the region. As a result of this the extent to which the regions could be encouraged to implement such programs would probably differ, and the province would probably experience a highly uneven growth of medical insurance.
- ii. While the province could stipulate the exact scope of the benefits to be offered by the regional plans, nevertheless, benefits would still differ from region to region. Factors involved here are number and distribution of physicians in the region, extent and development of regional health facilities, pattern of referred care outside the region, and so forth. These factors could be expected to introduce considerable variations in benefit costs, and consequently the size of premiums and other taxes necessary to finance a regional program.
- iii. In order to smooth out variations in benefit costs, provincial grants would have to be used, but this would lead to a complex and difficult grant formula.
- iv. A certain amount of the economic advantage would be lost since the costs of medical care insurance would not be spread over the largest possible base (the total population of the province).
- v. It was doubtful at the present stage of development of the health regions, that it would be possible for some of them to organize and administer such a complex field as medical care insurance. It must be remembered that 5 of the 13 health regions had been set up between 1957 and 1961, and were still working out their preventive programs. The Continuing Committee of the Regional Boards of Health advised the Thompson Committee that they favoured a universal provincially operated and financed program and were quite prepared to accept only administrative responsibilities assigned to them under such a program.

¹Advisory Planning Committee on Medical Care, Interim Report to the Government of Saskatchewan, 1961, pp. 57-59.

- vi. Uniformity would be difficult to achieve in regional programs because of the unequal resources regions have to finance and operate programs of special benefits.
- vii. Any division of responsibility for programs which may differ from area to area raises problems of maintenance and continuous coverage, changes in premium rates, and changes in benefits as persons move from region to region. This would make for a system of complex financial and administrative relationships between different authorities.
- viii. It is desirable to maintain a balanced emphasis on prevention, diagnosis, treatment and rehabilitation. This could be done best under a single program administered provincially.
- ix. If regional areas were responsible for the development and administration of programs on a permissive basis, these would develop at different rates and under different terms and conditions for the providers of service.

Having decided on a centrally controlled plan, the Committee then gave careful study to the possibility and desirability of decentralizing the administration of the plan to a regional basis. The belief was expressed that decentralization would establish a more intimate relationship between the people of the region and the regional administrative body, would be in keeping with our democratic traditions, and would result in a more satisfying and satisfactory service without impairment of efficiency. The Committee were especially impressed with the success of the Swift Current program. However, as only the Swift Current region had overall experience in the administration of a medical plan, the Committee believed that it was unrealistic to expect the inexperienced areas of the province to develop the techniques and acquire the personnel necessary for a successful operation in the near future.

The Thompson Committee were also concerned about the duplication of staff and administrative costs. The Committee believed that a region

with a population of at least 100,000 is desirable for most efficient operation. A further problem was the uncertainty of local government reorganization and the form it might take. Regional planning would have to wait until the boundaries of the new municipal units were established, so that regional boundaries might be made coterminous.

The Thompson Committee concluded that decentralization of the medical care insurance program to regions was not practical in the initial stages. The Committee did, however, recommend that the Swift Current Region Plan be allowed to continue in operation, since it was already functioning smoothly.

The Regional Boards of Health, in a brief to the Thompson Committee made some very interesting comments and proposals on the reorganization of health services in the province. They first of all stressed the importance of the development of a co-ordinated health program.

"There has been a predominance of treatment compared with preventive service, a lag in the provision of facilities for the chronically ill and the aged sick, and for active rehabilitation services."¹

This principle of co-ordination also carries over into the field of welfare. The health and welfare of a family or of a community are interdependent and should not be separated program-wise. The Regional Boards therefore recommended a combined Department of Health, Social Welfare and Rehabilitation, with a single regional service. As part of this new integrated health and welfare region, regional medical care plans not

¹Regional Boards of Health, "Proposals for the Reorganization of Health Services for Saskatchewan," Brief Submitted to the Advisory Planning Committee on Medical Care, January 12, 1961, p. 8.

unlike Britain's National Health Plan could be developed. This plan would back up general practitioners in the field with a corps of specialists working at the regional hospital.

The Thompson Committee decided against regional medical care plans or any form of decentralization to a regional level. Acting on the Committee's recommendation, the government established a centrally administered plan. The meat of the Regional Boards' Brief, however, was the co-ordination of health and welfare services. Further study of this aspect should be undertaken, now that the medical care plan is established and out of its critical stage.

c. The Hospital Survey Committee Report, 1961

It has now been over a decade since the first Hospital Survey Report was published. The report recommended further study after a period of five years to ascertain how much progress was being made in implementing the Master Plan. The Hospital Survey Committee completed a belated review in 1961 of the progress made, and a revised Master Plan for an Integrated Hospital System was recently published.

The Committee conducted a survey of the hospitals in the province and noted the following areas in which progress was slow. The "medical centre" idea, on which the 1951 Master Plan was based, was not developing as planned. The two-way flow of patients from local to base centres and back again was not taking place. In addition, the consultative and educational functions of the regional hospitals were still underdeveloped. Perhaps more important in the light of this paper was the fact that the co-ordination of regional public health services,

rehabilitative services and the regional hospitals had not gotten under way. The Committee stressed the fact that co-ordination and integration were virtually impossible because the administrative organization of these programs differs. One of the basic difficulties is the fact that hospital region and health region boundaries are not coterminous.

To further the development of hospital services and to correct some of the shortcomings revealed by their survey, the Committee presented a "Revised Master Plan for a Co-ordinated General Hospital Program for Saskatchewan." They reaffirmed their concept of regionalization as "the organization and co-ordination of all hospital services and resources within defined regional areas for the purpose of providing and maintaining the high level of hospital care as efficiently as possible."¹

The objectives of the revised Master Plan are twofold:²

- i. "To promote and guide the development of hospital facilities in a co-ordinated manner at locations which will ensure the provision of a high quality of hospital service to the people of Saskatchewan, without duplication or waste of resources.
- ii. To outline a possible basis for the co-ordination of the general hospital program with other health programs, thereby focusing on the individual patient the entire range of services available to promote health and treat disease."

In the light of the first objective, the Committee recommended that the province be divided into six hospital regions with the co-ordination of all hospital services to the specialist and consultative services provided at the regional centre. In the light of the second objective, the committee left all their recommendations open-ended for

¹Saskatchewan Hospital Survey Committee, Hospital Survey and Master Plan, 1961, Part 1, p. 148.

²Ibid.

possible co-ordination with public health services in the future.

d. The Inter-Regional Committee of the Regional Boards

This Committee has been functioning, in an unofficial capacity for approximately three years now. The Committee consists of the Chairmen of the Regional Boards of Health and the Regional Medical Health Officers. The Committee is to work in an advisory capacity to the Minister of Public Health on regional affairs. Draft regulations (which have not yet been promulgated) list the following duties and responsibilities of the Committee:¹

- "(a) refer to the Minister the aggregate of the opinions of the regional boards of the health regions and the Committee's own opinion concerning any matter relating to health;
- (b) review and study the extent of the public health services being provided in each health region and make recommendations to the Minister in connection therewith;
- (c) review and study the health services and other services being provided throughout health regions by regional boards and make recommendations to regional boards in connection therewith;
- (d) examine the provisions of the Act and regulations thereunder applying to health regions and make recommendations to the Minister in connection therewith."

The Committee is in the formative stage right now. A Ministerial order has not yet been published to legally establish the Committee, nevertheless, it is continuing to meet. It is too soon to say whether the Committee will or will not help to strengthen the position of the Regional Boards.

¹Draft Regulations Governing the Establishment, Duties and Function of the Inter-regional Committee of the Regional Boards of Health, July 23, 1963, Department of Public Health Central File No. 175A.

e. The City Health Departments

The two cities of Regina and Saskatoon continue to provide their own preventive health services. Both cities had well established health departments in operation prior to the birth of the province's regional scheme in 1945. Although there have been many recommendations in favour, the two cities have not been included in their respective rural regions. When the Regina and Saskatoon regions were established, it was decided not to include the cities. Possibly the government felt that the cities' populations would be satisfied with their own health departments and reluctant to join a regional organization. An unfavourable vote in the cities would then bring down the whole regional scheme for the surrounding area. At any rate, no consideration was given to inclusion of the two large cities in the regional scheme.

The cities, too, had shown little interest in entering the province's regional scheme. The cities' health services were of a high calibre and regionalization offered no extra benefits in that respect. On the other hand, there were financial benefits to be derived from regionalization. The province provided health facilities in each region and paid two-thirds of the operating expenses (salaries, etc.) of the regional staff. The two cities as independent entities had to finance their health services completely on their own. While the cities were lukewarm to regionalization, they felt that they too were entitled to some financial assistance from the provincial government.

Lengthy negotiations regarding provincial financial assistance to the city health departments were concluded in 1963 and it was agreed that a grant of 50 cents per capita be paid annually to each city for the operation of their health departments.

The grant was considered to be a stop-gap measure until certain controversial questions could be worked out. Officials of the Department of Public Health insisted that the two cities be organized as full-fledged health regions, but separate from their rural areas. The two city councils objected to this. Saskatoon's Health Region Committee expressed the city's position as follows:

"The Committee feels that for the City (of Saskatoon) to lose control and local autonomy would be a disadvantage in a situation where we are rapidly growing and in a minimum number of years we will reach a population of 150,000 and over. The Committee feels that this aspect is of such paramount importance, that even though it could be demonstrated that the City would have some reduction in cost under a Health Region Plan, the loss of control and local autonomy should not be compromised."¹

Similar views as above were expressed in Council and to the press by Regina City aldermen. The City Councils were fearful, too, that financial control of health services would be removed from their hands: the province would staff the city health department and pay two-thirds of the cost, however, the City Council would be required automatically to provide the remainder, without reviewing and paring down the Medical Health Officer's budget, as they were accustomed to do. In summary, the cities wished provincial financial assistance but not provincial control of the health services provided.

The Department of Public Health has good reasons for insisting that it should control the city health services. The Department's officials view with suspicion the city councils' requests for provincial funds. It is felt that, instead of using any provincial grants to improve or expand existing facilities, they will be used to reduce the city mill rates, while health services remain the same. Since the cities

¹Saskatoon Health Region Committee Report, Saskatchewan Department of Public Health, Central File No. 018A.

object to regionalization, the only solution seems to be the provision of specially earmarked conditional grants in areas of need. The Departmental officials feel that if any provincial monies are paid to the cities for health services, the province should maintain control of their use. It must be remembered that, while the payments to the health regions are unconditional, the preventive programs upon which the funds are spent are administered by provincial officials.

At present, the cities' requests for a permanent financial arrangement are under consideration. It does appear that, in the end, their health departments will remain independent and a system of conditional grants will be used to provide provincial financial assistance.

The regionalization of the province is now complete. In 1961, the province saw the regionalization of the last unorganized area in the province. The two major cities in the province have continued to remain outside the regional scheme and to provide their own preventive health services. The arguments for and against the regionalization of these two cities vary depending upon which side of the fence you are on. It appears however, that both parties have reached a mutually agreeable solution in a system of conditional grants. Under such an arrangement the cities will receive the money they asked for and at the same time retain control of their health departments. On the other hand, the province, by stipulating how the grants are to be used, retains a measure of control over the expenditure of the grants, and also exercises some control over the type and quality of health services provided by the cities.

V REGIONALIZATION AND HOSPITAL OPERATIONS

References have been made from time to time throughout this paper to hospital operations in Saskatchewan. The various studies discussed have recommended the regionalization of hospitals along with other health services in the province. Regionalization of hospital operations is taking place, but it is developing in a detached and isolated way. Provincial and local officials both recognize the potentialities of regionalization in hospital operations, but they neglect to carry their findings to the logical conclusions, a system of multi-purpose regional local government.

1. THE SITUATION IN 1944

Until the end of the Second War, the province had concerned itself to a very small degree with hospital construction and operations. The needs of the community were met by the local governments or by certain religious groups. The provincial government did not attempt to plan hospital facilities throughout the province but allowed the municipalities or any other interested organizations to provide hospital services as they saw fit and as local opinion demanded. The province did, of course, carry out periodic sanitary inspections of the hospitals, and the Department of Public Health demanded that certain basic sanitary regulations be satisfied.

By 1944, hospital facilities in the province were vastly deficient in both quantity and quality. However the provincial government should not be held completely to account for this deplorable situation. The influence of the Depression and the war years on the effectiveness of provincial services cannot be minimized. The provincial government was not in a position to either finance a modern, expensive hospital system, or

to subsidize local efforts. By 1944, the situation had become crucial and strong steps would have to be taken even to bring the province's hospital facilities up to a minimum standard.

The seeds of regionalization are, nevertheless, to be found in these dark times. Prior to 1944, it was traditionally accepted that the construction and operation of hospitals was of local or private concern. Soon after Saskatchewan became a province, authority to levy taxes to establish and maintain hospitals was provided in the legislation which outlined the powers and authority of the municipal governments. However, it was found that few towns, villages or rural municipalities had a sufficiently large tax base to finance the construction and maintenance of a hospital. Accordingly, legislation was passed in 1916 to provide for the establishment of local authorities representing member towns, villages and rural municipalities for the purpose of erecting and maintaining hospitals. This new local authority was called the "Union Hospital District." This means of co-operating to provide hospital facilities for the community appealed to the pioneer spirit of the people of the province, and several municipalities at once applied to form Union Hospital Districts in their location.

Table 5. Union Hospital Districts,
Saskatchewan

Year	Number
1920	10
1930	20
1940	23
1950	99
1960	<u>111</u>
1964	112

The formation of new Union Hospital Districts to construct and

operate community general hospitals took place at a steady rate, and between 1944 and 1950, under the provincial government's crash program to increase the province's available hospital beds, the number of Union Hospital Districts quadrupled. Today, well over half of the province's population is served by Union Hospitals. The development of the Union Hospital may be regarded as even more important than this statement indicates, since the large hospitals in the province's cities account for the bulk of the population not included in a Union Hospital District. Thus these special local Districts have filled an important rural need which the traditional units of local government were not equipped to handle. By forming a regional organization, the municipalities were able to act together to satisfy a community need.

2. THE 1944 HEALTH PROGRAM

The Sigerist Commission's investigation and recommendations, and the health program put forward by the Health Services Planning Commission have already been outlined. Part of this great integrated regional health scheme was to be the function of hospital planning and operations. The local health centre and the district and regional hospital were all to be developed under local control through the regions.

The reasons for the failure of this plan were many: lack of financial resources and trained personnel to set up a province-wide regional scheme, the opposition of the medical profession to what was regarded as a form of state medicine, the slow process of establishing regions by local initiative, and perhaps most important, the urgency of reform in certain areas of service. This last reason was to cause a ten year post-

ponement of hospital regionalization, and when it was finally introduced in the Swift Current area in 1955 (The Swift Current Regional Hospital Council) it was in a much diluted form. Today local suspicions of regionalization are still being overcome, hence the full benefits of a regional program will not be felt for some years to come.

One of the many functions given to the Health Services Planning Commission during the period from 1945 to the reorganization of 1950 was that of hospital planning. The provincial government determined to set up a province-wide compulsory health insurance plan as soon as possible, however, the provincial officials realized that the provincial hospital bed capacity was woefully inadequate and would not be able to handle the anticipated increase in hospital admissions that would result when the financial deterrent to hospital care was removed.

The Health Services Planning Commission, then, took on the responsibility of hospital planning to try to rectify the provincial bed shortage as quickly as possible. The provincial representatives met with local councils to convince them of their local hospital needs and to advise them in drawing up their plans for construction and expansion. The war had released the finances of all levels of government and their efforts could now be turned to the improvement of local utilities. The success of the Health Services Planning Commission may be judged by the expansion of the Union Hospital scheme alone. The Union Hospital Districts in the province increased from 23 in 1940 to 99 in 1950. All of this expansion and construction took place in the postwar years. In 1944, the number of Union Hospital Districts stood at 22, one less than in 1940. The construction and expansion of other municipal and private

hospitals followed a similar trend.

With the inception of the Hospitalization Plan in 1947, the duties of the Health Services Planning Commission became even more important. It was decided that the method of payment for hospital services rendered by the hospitals would be in the form of a "per patient" grant. As a result of this, it became necessary that the provincial government exercise some supervision over the construction and operation of hospitals in the province to insure that the highest possible level of services would be available to the people:

"In 1947, with the introduction of the Saskatchewan Hospital Services Plan, all hospitals became eligible for payment of their operating costs from provincial funds. As a result, it became essential to devise procedures and controls to ensure a fair distribution of funds, to ensure that hospital authorities did not indulge in extravagant administration, to ensure that hospital facilities were distributed throughout the province according to some definite plan, and also to ensure a high standard of hospital care."¹

Such was the case after 1947, and such is the case today. The Health Services Planning Commission and now the Hospital Administration and Standards Division of the Department not only provides consultative services but also exercises important supervisory control over hospital operations. The Division annually approves the budget of each hospital and sets their approved bed capacity based on their pattern of utilization during the previous year. The Division also takes a strong hand in hospital planning in the province since it administers the provincial and federal grant programs for hospital construction.

Thus it was that hospital planning and supervision drifted from a regional to a provincial sphere. The urgency of hospital expansion and

¹Local Government Continuing Committee, Provincial-Local Administrative Relations, 1961, p.165.

the enormous effort needed all over the province forced the provincial government to take a strong hand. By 1950, this end had been achieved. The Hospital Services Plan was operating smoothly, and hospital facilities in the province had been vastly improved and increased. At the same time the planned health regions were progressing slowly and by 1950 one half of the province had been organized into health regions. It was at this time that the Health Survey Committee suggested that the government return to the 1944 plan and the principle of an integrated regional health service.

3. THE HEALTH SURVEY, 1951

As a basis for the federal government's National Health Grants Program each province was asked to undertake a survey of its health needs. The Saskatchewan survey was completed in 1951 and the second volume of the Health Survey Report reviewed hospital needs and presented a "Master Plan for an Integrated Hospital System" in Saskatchewan. The "Master Plan" was formulated on the assumption that regionalization was the best means of improving hospital services and making modern hospital care available to all the residents of the province. In order to make modern surgical and medical care available to persons in rural areas, services must be improved outside the main urban centres. It was realized that modern hospital services involved expensive equipment and highly skilled personnel and that these could not possibly be provided in the small rural community hospitals. Emphasis would instead be placed on the development of larger district hospitals rather than a large number of small, inadequate and uneconomic units. These larger centres would provide the com-

munity hospitals with such services relative to diagnosis, treatment, teaching and administration as could not be provided by the smaller hospitals on an individual basis. To do this, the province was divided into Hospital Service Areas, each area being the sphere of influence of a community hospital. These areas were grouped into Hospital Service Districts with one hospital being designated as a District Centre. The Districts were, in turn grouped into twelve Health Service Areas. Unfortunately, regional hospital operations were not turned over to the already established health regions. However, the Health Service Areas would replace the existing Health Regions as the local health unit in the province:

"The name Health Service Area was selected because it is expected that these areas will serve not only as units for developing hospital services but for other services such as public health services. It will be noted that the boundaries of six of these Health Service Areas are practically coterminous with those of six Public Health Regions already organized. It is assumed that the other Health Service Areas will eventually be organized as Health Regions, and for that reason, the logical centres of the Health Service Areas have been designated as a regional centre."¹

In addition to the twelve regional centres detailed above, the hospitals in Regina and Saskatoon were designated as base centres, serving the southern and northern population respectively.

The Master Plan was formulated on a good regional basis. The shift from rural to urban living was taken into account. The regions (Health Service Areas) were constructed on the basis of the existing trading centre and transportation pattern.

"The increasing mobility of population, with its effect of breaking down rural isolation, has,

¹Health Survey Committee, Saskatchewan Health Survey Report, Vol. 2, 1951, p.35.

therefore, like the actual rural-urban shift of the population itself, increased the need for larger hospital facilities at the main trading centres."¹

Community centres and nursing homes were not forgotten however. The Hospital Survey Committee recognized that they must be maintained in order to hold physicians in rural areas. These physicians would now have the same facilities available through association with district and regional hospitals as their counterparts in the city.

The situation in 1951 offered a real opportunity to return to the 1944 concept of a strongly autonomous, multi-purpose regional health scheme. The crash program of the late 1940's under the guidance of the Health Services Planning Commission, had overcome the bed shortage in the province, the administrative machinery of the Hospital Services Plan had been worked out and the records of all the hospitals standardized. The Health Survey Committee strongly advocated regionalization of all hospitals to insure a province-wide high standard of medical care. Their recommended Health Service Areas had been scientifically planned, taking into consideration patterns of hospital utilization and transportation facilities. It was found that these Health Service Areas were almost coterminous with the Health Regions then in existence. There would thus be little confusion if the regional services were amalgamated with hospital operations in one regional organization.

Unfortunately, it was at this crucial time that the government were suffering political setbacks in their process of regionalization. In 1952, after the formation of the Regina Rural Health Region, it was decided to forestall any further organization of regions in order to con-

¹Ibid., p.40.

solidate present gains and to give the public a chance to see the Health Regions at work. By 1957, when it was considered that the public was ready to accept regionalization again, the Health Service Areas and other recommendations of the Health Survey Committee were out of date. More important, a Continuing Committee had been just established to examine local government in Saskatchewan and it was considered desirable to await the findings of this Committee and to see how they would affect regionalization in the field of public health.

4. THE BEGINNINGS OF HOSPITAL REGIONS, 1955

In the end, regionalization came to the field of hospital operations but not from the expected source. It was not the local governments who sought to strengthen their position by banding together to operate modern hospitals, but rather it was the new school of trained hospital administrators who regarded regionalization as a powerful administrative tool. The fact that these hospital regions were a form of local government is really a by-product of their real *raison d'etre*. They were established to improve hospital operations and the initiative for their establishment came from the hospital administrators rather than the hospital boards.

The highly successful example to which hospital administrators turned for guidance was that of the Rochester Regional Hospital Council.¹ The Council was established in 1946, through the efforts of the hospital boards, physicians, hospital administrators and other interested professionals and was supported by a large grant from the Commonwealth Fund. The Council included a population of 700,000 in an area of about 5,000

¹L. S. Rosenfeld and H. B. Makover, The Rochester Regional Hospital Council, Harvard University Press, 1956.

square miles centered around the city of Rochester, New York, and by 1950 it had grown to almost 7,000 square miles with a population of 950,000. The Council was a result of the wide experience gained in the large organizational structures necessitated by the war in the United States:

"It [the Council] constitutes a pioneering effort by a community agency to marshal the efforts of a large number and variety of voluntary and public agencies toward the achievement of common goals in the provision of community health services. It represents the first effort of any area in the country to co-ordinate a hospital program with a wide range of services, many of which had not been tried on so large a scale in civilian practice."¹

The Council was governed by a large body known as the Board of Directors and its standing Executive Committee. It was in addition advised by a number of special professional advisory groups. The actual day-to-day business was carried out by the Executive Director and his permanent secretariat.

The Council's primary services to the member hospitals were educational (training programs and the like), and advisory and consultative. The Council employed a number of experts in the various fields of hospital operations to enable the hospitals in the region to improve their own technical and administrative services. The Council also began working with state and private agencies to co-ordinate health programs in the community.

The Council was extremely successful in its operations and was enthusiastically supported by the member hospitals, but unfortunately local governments showed little or no interest. When the initial Com-

¹Ibid., p.13.

Commonwealth Fund grant was terminated, the Council held little hope that local governments would take sufficient interest in its operations even to consider giving the Council a grant from municipal funds. The member hospitals have been forced to continue Council operations with what funds they are able to spare, and with little support - moral or financial - from the municipal authorities.

A similar regional system to the pioneer Rochester Council has also developed in Saskatchewan. These regional organizations developed in much the same way as did the Rochester Council. The principle of regionalization was becoming popularized amongst hospital administrators and in 1955 a number of hospitals in the Swift Current area took the bold step of becoming the first Regional Council in the province.

In 1956, legislation was enacted giving Regional Hospital Councils a legal, corporate status.¹ The Act provides that "any two or more hospitals may co-operate with each other in the establishment of a hospital council consisting of representatives of each of the participating hospitals."²

- "i. employ consultants and other technical personnel for improving the services of the participating hospitals;
- ii. procure equipment, materials and supplies for the use of the participating hospitals;
- iii. provide appropriate training for such classes of persons employed in the participating hospitals as it deems advisable;
- iv. make rules and regulations governing the convening and conduct of meetings, the appointment and duties of officers of the council and ... all other matters incidental to the proper carrying on of the business of the council;

¹Statutes of Saskatchewan, 1956, c.48, Act to Amend the Hospital Standards Act.

²Ibid., s.14 (1).

- v. acquire, hold and dispose of real and personal property for its corporate purposes;
- vi. enter into agreements with each participating hospital where necessary to the carrying out of any of the objects of the council and receive money to assist in the financing of anything undertaken by the council in the exercise of its powers under this section;
- vii. do such other things as it deems necessary for improving the services, and the efficiency of the operation, of the participating hospitals."¹

There are now four Regional Hospital Councils functioning in the province. Their boundaries are not permanently established and may be adjusted to include hospitals on the fringes who apply to join at any future date. The costs of the Regional Councils are apportioned among the member hospitals who may recoup their payments from the province. The Saskatchewan Hospital Services Plan allows the hospitals to claim these expenses as ordinary hospital operating costs. The province, in turn, claims from the federal government under the National Health Grants Program. While the province encourages the Regional Hospital Councils, it exercises no control over their boundaries or programs.

The Councils' programs and policies are administered by a Regional Co-ordinator and a staff of professional and technical experts, as shown in the following table:

¹Ibid., s.15.

Table 6. Staff Employed by Regional Hospital Councils, 1964

Staff	North West Council	Quill Plains Council	Swift Current Council	North Central Council
Co-ordinator	1	1	1	1
Pharmacist	1	1 (part-time)	--	1
Accounting consultant	1	1	2	1
Nursing consultant	1	1	1	1
Dietary consultant	1	--	1	1
Lab. Tech. and consultant	--	--	2	1
X-ray Tech. and consultant	1 (part-time)	1 (part-time)	1	1
Medical Records Librarian	--	--	1	--
Medical Social Worker	1 (part-time)	1	1	1
Radiologist	1	--	--	--
Clerical	1	2	5	1
Total staff	9	8	15	9

Source: Files of the Hospital Administration and Standards Division, Saskatchewan Department of Public Health

The Regional Hospital Councils have gone a long way to improve the standards of hospital operations in the hospitals served. The staff of the Councils through training, consultation and advice have improved services and administrative procedures greatly. There is, however, room for improvement in the area of centralized services, such as central purchasing and regional planning. The services of the Regional Councils are continually expanding and improving, and as the individual hospitals' confidence in the regional system grows, the Council will be able to embark on stronger and more far-sighted programs. The Regional Co-ordinators and their staffs are now engaged in "selling" the principle of regionalization to the hospitals. When this is accomplished they will be able to turn their efforts to more important fields.

This currently popular form of regionalization - the co-operation of individual hospitals in an area - while it is a step in the right direction, is not considered adequate by certain hospital experts. The

present system of independent and unco-ordinated hospitals falls far short of the modern concept. The present system has progressed as far as it can go and if our hospitals are to meet the higher standards of efficiency and service now demanded, a certain amount of centralizing (especially in planning facilities) will have to take place. Some far-sighted hospital administrators realize that if the hospitals themselves do not submit to some type of regionalization and thereby control their own development, it will just be a matter of time before the provincial governments themselves institute a system of tight control over all aspects of hospital operations. An official of the Ottawa Civic Hospital puts forward the following sound reasons for the regionalization of hospital operations in the Ottawa area. His argument may be summarized as follows:¹

- (a) Regionalization will effect economies through the integration of hospital facilities.
- (b) Highly specialized and expensive equipment can be purchased by the region as a whole which small hospitals could not afford on an individual basis.
- (c) A properly integrated hospital system is a very sound organizational principle.
- (d) An end must be put to the competition between hospitals. Hospitals cannot justify their operations to the public at large unless they co-operate with each other to provide the best service at the least cost, and if hospitals do not take action on a voluntary basis, regional planning will be forced on them by government.

The need for regionalization as a matter of efficiency and economy

¹F. G. Anderson, "Blueprint for Regional Planning", Hospital Administration in Canada, April, 1964, pp. 28-33.

has been recognized for some time now. However the threat of government intervention becomes more real every day that action is not taken by the hospitals themselves. The threat of government control has added a sense of urgency and it appears to have jarred hospital officials out of their narrow-minded local outlook and petty jealousy.

Mr. Anderson in Ottawa has looked favourably on the progress in Saskatchewan and recommends a similar Regional Hospital Council for the Ottawa area. This may be a step in the right direction, but there are others who think it is not enough. While the Saskatchewan Councils have been able to function well due to a co-operative spirit, the Council as a corporate authority has no power to enforce its decisions:

"In accordance with the best traditions of a free enterprise system, autonomous hospital boards have built their hospitals where they feel they would be most advantageous to themselves and to any community interest they might represent Over building occurred in some areas along with duplication of special equipment and facilities."

The answer to all this is regionalization, but, steps towards regionalization have not always been successful:

"Many planning groups have been markedly unsuccessful. The reasons may be many, but the main one, it seems, is that the tradition of the voluntary hospital with its background of local community support mitigates against the basic concept of regionalization. Thus, while the part which a particular hospital should play in a regional plan may seem entirely logical in the overall scheme of things, it could very well be in direct conflict with the long range objectives and policies of the board, the medical staff and administration of the hospital concerned.

Hospital planning has not been observed because it [the regional council] has had no leverage by which to force individual decisions and local com-

¹L. F. Detwiller, "Why We Need Regional Planning", Hospital Administration in Canada, November, 1963, p.25.

munity decisions into line with the best interests of the community at large Hospital planning implies a controlled pattern of development."¹

The above articles were quoted to show how regionalization in hospital operations is gaining strength. The fear of government control which is expressed in the second quotation is well founded. In Saskatchewan the newly created Regional Hospital Councils do not have any planning authority:

"The effectiveness of any program which they [the Regional Hospital Councils] wish to implement depends entirely upon the support of each member hospital. They function, therefore, in a staff capacity and have no direct administrative authority. In their present organizational structure they sometimes find themselves defending or supporting measures of individual member hospitals contrary to their own use. The functions of the Regional Hospital Council are adversely affected by such relationships."²

As a result, hospital planning has been retained in the provincial sphere. The Hospital Administration and Standards Division exercises strict control over the location and facilities of all hospitals in the province, since this agency of the Department approves all agreements for payments under the Hospital Services Plan and the grants for hospital construction. Hospital planning will become a confirmed provincial function unless the hospitals themselves take the initiative to establish their own effective regional organizations. The Regional Councils are now well on their way to becoming service agencies for their member hospitals and perhaps the desire to retain local control over hospital planning and operations will act as a factor in the further strengthening of the Regional Councils' authority.

¹Ibid.

²Hospital Survey Committee, Saskatchewan Hospital Survey and Master Plan, 1961, Part 1 p.139.

5. THE LOCAL GOVERNMENT CONTINUING COMMITTEE STUDIES HOSPITAL OPERATIONS, 1961

The Local Government Continuing Committee was, of course, concerned with the operations of general local government in Saskatchewan. After a thorough investigation of the system in Saskatchewan, the Committee listed its many shortcomings and recommended a completely new local government organization more in keeping with modern needs. Hospital operations were examined and discussed at some length, for they were conceived to be an important responsibility of a new regional unit in the Committee's proposed county system of local government. The Committee was much concerned over the apparent transfer of the control of hospitals to the provincial government. Each transfer of a function from local to provincial control further weakened municipalities as units of government. The Committee felt this trend could be reversed if a more efficient unit of local government could be devised. They hoped that their recommended two-tiered organization would be able to administer efficiently many of the local functions being removed to provincial control and thereby end this trend that is weakening our local institutions.

The Committee noted five important areas of provincial control by which the Department of Public Health ensured that a high standard of hospital facilities and services was available throughout the province.¹

- i. Budget Control - The hospitals are required to submit their budgets annually to the Hospital Administration and Standards Division of the Department. The Division approves the budget

¹Local Government Continuing Committee, Provincial Local Administrative Relationships, 1961, pp. 168-170.

and establishes the basic "readiness to serve" grant which covers the fixed operating costs of the hospitals. In addition, the provincial authority determines the "rated capacity" of the hospital, based on utilization during the previous year. The Saskatchewan Hospital Services Plan will then make payments to the hospitals on a patient-day basis, up to this approved capacity. In effect, the province dictates the number of beds a hospital may set up, based, of course, on the demand for service in its area.

- ii. Control of Hospital Construction - The above mentioned Division of the Department of Public Health receives and approves all plans for hospital construction and expansion. Most projects thus approved qualify for large provincial and federal financial contributions under the National Health Grants programs. The plans must also be approved by the Department's Sanitation Division.
- iii. Control over Purchasing - All purchases by the Union Hospital Boards of equipment that is valued at over \$300 must be approved by the provincial government. This control, while it does not include municipal or private hospitals, is important when one remembers that the majority of the province's rural hospitals are operated under the Union Hospitals Act.
- iv. Control over Records - The province is greatly concerned with the method of keeping records, since the relationship of the Hospital Services Plan with all the hospitals is a major administrative routine. This is a function that has commonly been developed under regionalization. However, due to the existence of a provincial hospital insurance scheme, the government could not allow the standards of hospital records to vary.
- v. Consultation and Advice - Through the Hospital Administration and Standards Division, the province provides extensive administrative and technical advice to the individual hospitals. Through its consultants and fieldmen, the Division subtly encourages the local hospitals to meet a pre-determined provincial standard. This function has become less significant in certain areas since 1955 with the development of the Regional Hospital Councils.

The above mentioned five controls have been a considerable restraining force on the local autonomy of the hospital boards. It is certain that these controls would not have developed as fully had there been no extreme bed shortage in the province after the war, had there been no government hospital insurance scheme and had the hospitals themselves been able to develop their own control agency (i.e.: a regional authority). It is doubtful that any program of regionalization could develop successfully or with significant authority if these provincial control measures were not reduced and a number of them turned over to the regional authority. Though the provincial program has been successful in raising the quality and quantity of hospitals in the province, the local initiative of the community hospitals has been significantly reduced and the integration of hospital services has not been encouraged.

The Local Government Continuing Committee recommends the handing over of hospital control to a new regional form of local government. While the Committee's main objective is to strengthen local governments and to allow them more discretion in the operation of community hospitals, they also emphasize efficiency and the improvement of services:

"There is a strong case for regional integration of hospitals both to improve access to service and to achieve economies Regional integration under a single authority would permit ease in referral of patients from less to more specialized hospitals. It would also permit the ready interchange of services and equipment. Economies in mass buying of supplies could be achieved. Regional integration would make possible equitable distribution of costs among the population using hospitals. It would, in a word, permit the rational development of hospital facilities in a manner analogous to the development of school facilities under the larger school unit."¹

¹Local Government Continuing Committee, Local Government in Saskatchewan, 1961, p.29.

The Committee feel that their recommendations are sound since the development of regional units is already under way, under local initiative. Should the county system be adopted, the Committee feel that a great many provincial controls could be relaxed if the local government regions take over the planning and supervision of hospitals in their areas.

6. THE HOSPITAL SURVEY REVIEW, 1961

The Health Survey Committee in 1951 recommended that a review of progress under the "Master Plan for an Integrated Hospital System" in the province be conducted after a period of five years and that adjustments in the Plan be made where warranted. This review finally took place ten years later in 1961. The 1961 Hospital Survey Committee found that much progress had been made in implementing the Master Plan; however, plans were not moving ahead with equal success in all areas of hospital operations. As a result, the Hospital Survey Committee found it necessary to issue a "Revised Master Plan" to allow for changes over the past ten years.

One of the basic recommendations contained in the 1951 Survey was that the planning of hospital facilities in the province should be more systematic. This function of hospital planning was to be shared by the proposed regional authorities and the province. The regional bodies did not develop as planned and as a result the province became the sole responsible authority for hospital planning. All plans for hospital construction were to be approved by the Minister of Public Health, and a comprehensive body of regulations was built up under the Hospital Administration and Standards Act. One would expect that under conditions of such complete control the province would easily have been able to imple-

ment the Master Plan as recommended, but this was not the case. There were many very powerful pressures on the Minister and he was forced many times to deviate from the Plan. Even today there is great difficulty in overcoming localism in the provision of hospital facilities. Local communities and officials appear to have an insufficient understanding of the concept of co-ordinated health services. In spite of the recommendations contained in the 1951 Health Survey Report, it has been found that a number of hospitals which were stated to have no useful place in an integrated plan are still in operation and a few have been replaced. Certain construction has occurred and some institutions have been perpetuated because of the exertion of local community pressures.¹

This tendency to localism is very hard to overcome. The provincial government, though backed with the legislative powers necessary to implement the Master Plan, felt they had to bow to the demands of the local hospital boards in certain cases. Unfortunately, moves that are politically expedient are sometimes made at the expense of administrative efficiency. Though provincial controls abound in Saskatchewan, it does not appear that the local boards are at the mercy of the province.

One of the difficulties caused by this narrow-minded local spirit has been the retardation of integration within the province's hospital system and between the hospitals and the province's preventive health services. The two-way flow of patients between the small hospitals and the regional hospital centres has not occurred to the degree anticipated. The regional centres have failed to develop for various reasons and patients go or are referred directly from the local hospitals to the two

¹Hospital Survey Committee, op.cit., p.133.

base centres in Regina or Saskatoon. It had been further recommended in 1951 that, in order to bring preventive health and hospital care programs closer together, offices should be provided in the regional hospitals for the province's health region staffs.

After weighing the developments up to 1961, the Hospital Survey Committee decided to add its voice to those already advocating stronger local institutions to which more responsibility could be decentralized:

"The interest and participation of people at the local level is essential to the development and operation of hospitals. On the other hand, it is recognized that there is need for central direction and guidance if hospital services are to be integrated and the hospital program co-ordinated with related health programs. However, because the general hospital system is composed of many hospitals scattered over a large geographic area, it is difficult for a single agency located in one centre to effectively encourage local participation in a co-ordinated hospital program. The Committee believes, therefore, that the best interests of the public will be served by a measure of decentralization of the detailed financial aspects of hospital operation and administration to the regional level, which may permit a greater degree of responsibility and participation to take place at the local level. This would involve a study of the functions that can be decentralized and those that should remain with the central agency with a clear definition of responsibility and authority."¹

The Committee feels that a clear-cut delegation of authority to the various bodies concerned (the Department of Public Health, the Regional Hospital Councils and the individual Hospital Boards) is urgently required. In its survey, the Committee noted a large number of areas in which there was a duplication of effort or a lack of any program at all. The operation of a modern hospital system is a difficult undertaking and if Saskatchewan is to progress further towards this goal, a strong regional program must be implemented.

¹Hospital Survey Committee, op.cit., p.137

The passage of ten years had resulted in a further adjustment in the forces in the province upon which regionalization is based. The population in Saskatchewan was continuing its shift from rural areas to urban centres. This trend was further reinforced by a shift from the small towns and villages to the eleven cities in the province. A new pattern of trading centres has also developed. The number of distribution centres in the province declined with the improvements in the province's highway and market road system. A small number of trading centres were now influencing large areas of the province. All of this is reflected in the utilization pattern of the province's hospitals. The people of the province are able to and are accustomed to travel farther for hospital services. There is also a growing trend to go directly to the half dozen major centres in the province for hospital treatment, thus bypassing the designated regional and district hospitals. This trend is further accelerated with each passing year, as it is becoming apparent that only a few very large hospitals can afford to provide complete modern medical facilities. All these above mentioned factors were unearthed by the Hospital Survey Committee in 1961, and they pointed to larger regional units than had been recommended ten years earlier.

The principle of regionalization in hospital operations is being adhered to but progress is slow. The strong co-ordination of all hospitals with the regional centre is not developing as quickly as is desired. The rural hospitals are still not taking advantage of the consultative services available from the regional centre. The two-way flow of patients is also slow in developing.

It seems to me that the most biting criticism that can be made is the isolated way in which regionalization of hospital operations has

allowed to develop. Despite the comments of various authorities and committees since 1944, very little attempt has been made to integrate hospital and public health services. There is no good reason why a long-term program cannot be implemented to make hospital and public health regions coterminous, at which time the two functions could be amalgamated under one council of local officials. If the responsibility for hospitals were given over to the regional health boards, the effect of raising their status from that of a mere advisory body might instill new life in them.

The success or failure of the present regional hospital councils remains to be seen. The councils have been in operation since 1955, but, they have not completely lived up to expectations. Hospital planning and consultant services have remained in the hands of the Department, and there are very few other functions which could be delegated to the regional authorities. The operations of the hospital designated as the regional centre is still the responsibility of its local hospital board. It appears that these councils will develop as a means of discussing common problems rather than a formal second tier of local government between the hospital boards and the government, but if the government should accept and implement the major recommendations of some of the studies and reports mentioned, this trend could be reversed.

VI REGIONAL SERVICES IN THE DEPARTMENT OF SOCIAL WELFARE

In contrast with the attempts to create an institutional framework wherein local authorities could retain and efficiently carry out health functions, the regional scheme of the Saskatchewan Department of Social Welfare was conceived solely as an administrative device to decentralize a provincial function. A short outline of the Regional Services of the Department is useful here, as it will serve to emphasize how easy regionalization can be when no political considerations are involved. The comparative speed and smoothness with which the Social Welfare regional scheme was implemented is in direct contrast with the struggle to establish the Health Regions. The Department of Social Welfare was merely moving to decentralize its services, while in the case of Public Health, the government was attempting to delegate various functions to local authorities. As we have seen in the latter case the government has met largely with failure.

1. BACKGROUND

In the British system of government, which was adopted in Canada, poor relief was traditionally the responsibility of the parish. In 1867, not much thought was given to this subject, since local governments traditionally handled the very simple relief arrangements in their communities, however, the British North America Act, in its division of powers, places what we now conceive as modern social welfare services under provincial jurisdiction.¹ From the formation of this province in

¹Revised Statutes of Canada, British North America Act, 1867, s. 92.7.

1905, until 1930, relief payments remained the responsibility of local government. During the Depression, however, relief costs grew to such proportions that the local governments were unable to cope with them. The provincial government, and, in turn, the federal government, had to step in and assume financial responsibility for a large portion of relief costs.

As the Depression wore on, the provincial government gradually assumed more and more of the financial and administrative burden of welfare services, which the local governments were only too willing to give up. By the end of World War II, the province and the federal government had assumed almost all the burden of providing welfare services. It was generally accepted that the administration of modern social welfare programs was not a function of local government, and no attempt has been made to restore any of the welfare functions to local governments.¹

Since 1930, the scope of welfare services has increased immensely. No longer are they thought of merely as doles to the poor. Welfare services now stress rehabilitation and the restoration of the individual to a useful place in society. The province's welfare program was substantially modernized during the 1940's with the establishment of a full fledged Department of Social Welfare. The administration of welfare payments was transferred from the Department of Municipal Affairs to this new Department. In 1945, a Welfare Services Division came into being to co-ordinate the various welfare programs, and in order to reach the people, regional offices were opened.

¹There are some important exceptions to this generally accepted principle. D. C. Rowat, and more recently the Local Government Continuing Committee recommend the return of welfare services to local control in a regionalized system of local government.

2. REGIONAL SERVICES

Regionalization, as it was applied by the Department of Social Welfare, was an administrative reform for greater efficiency. The provincial programs could not be administered efficiently from the central office, and in addition, it was important that the social workers be in close contact with their clientele. As a result, the Department embarked on an orderly program of decentralization of provincial welfare programs.¹

The specialized welfare programs were combined in a Welfare Services Branch (now the Public Assistance Branch) and the staff re-trained to provide generalized social work. In addition, a Regional Services Branch was established and the province divided into regions for the purpose of administering the social welfare program.

The regions were formed one by one due to restricted staff resources, but, as the regions became established, each regional office was given a greater degree of responsibility. The regional administrators were made responsible for carrying out welfare programs in their regions and all supervision of field staff emanated from the region itself. By allowing the regional directors great latitude in the administration of the Department's program, welfare services are carried more quickly and efficiently to the people.

The responsibility for welfare services is divided between the Public Assistance Branch and the Regional Services Branch. The Public Assistance Branch is responsible for setting departmental policy and welfare standards, and the Regional Services Branch is responsible for implementation of the programs.

¹Department of Social Welfare, Annual Report, 1950-51, p. 112.

When the Regional Services Branch was established in 1945, the province was divided into 27 districts of approximately 35,000 population each, and each district was assigned one social worker. These districts were further grouped into nine regions. A tenth region was recently created to serve Regina City and its environs. The region is the headquarters for the field staff, and the regional director exercises broad control over the district workers in his region.

All welfare services are completely integrated at the regional level. The district social worker is fully prepared to handle child welfare cases, juvenile delinquency cases, rehabilitation cases, mothers' allowances cases, old age pension interviews, and applications for admission to geriatric centres.

The regional structure of this Department was originally designed for close co-ordination with public health programs. It was envisaged that contact with public health field staff would be both advisable and necessary:

"During the early part of the year we found it advisable to adjust our Regional boundary lines to conform with those of the Department of Public Health Regions. We were able to follow the health boundary lines very closely except in those areas where the health boundary lines encompassed only part of a municipality. Our boundaries follow those of the rural municipalities throughout. The arrangement has proved very satisfactory in that it gives our workers an opportunity to have mutual discussions with officials of the Department of Public Health concerning related problems in the same geographical area."¹

A similar viewpoint existed among members of the Department of

¹Ibid., p. 112.

Public Health. The Chairman of the Health Services Planning Commission stated in a memorandum in 1945:

"There would be considerable scope for co-operation and back and forth referrals even when only a preventive service was being provided. At the time when diagnostic and therapeutic services were being provided, the scope for consultation with social workers would be greatly increased.... Every effort should be made to work out an integration of the two services."¹

The government in 1948 was, in fact, on the verge of trying an experiment in integration of regional health and welfare services:

"The project which the [Interdepartmental] Committee has in mind is a demonstration in one region adopting regional boundaries for social welfare as well as health. The Department of Social Welfare is willing to make certain suggestions and the first step would be an administrative amalgamation. It is proposed that there would be joint staff conferences and that the staffs would be in the same regional and district offices. It is also proposed that the field staff of Adult Education, the Department of Agriculture, and the Department of Education may participate in the program."²

These plans for co-ordination in areas of mutual concern never matured. Perhaps the growth in size and importance of the two departments has necessitated the postponement of any plans for co-operation in field services. Such experiments would be almost impossible today since the regional boundaries of the two services are not coterminous, but a reorganization of local government along the lines recommended by the Local Government Continuing Committee would offer an opportunity to try a system of jointly administered regional health and welfare services.

¹Department of Public Health, Central File No. 175A.

²Ibid., Minutes of the Interdepartmental Committee, March 11, 1948.

3. THE ROLE OF LOCAL GOVERNMENT IN SOCIAL WELFARE¹

Social aid administration is the only welfare field left in the hands of local government. Subject to close supervision by the Public Assistance Branch, the municipalities administer their own relief programs and they pay 25 per cent of the cost. Field workers of the Regional Services Branch are available for consultation, but otherwise take no part in this aspect of welfare services.

The province is not happy with this present social aid program. In a brief to the Provincial-Local Government Conference in 1956, the provincial department complained that the municipal social aid programs were often inadequate and the local officials were slow to grant social aid.

The Social Aid Act of 1957 was implemented to overcome this intolerable state of affairs. "The new system of social aid administration imposes a very large number of controls where previously local discretion has been almost unqualified."² The previous policy of the province had been one of persuasion and advice, however, the new Act laid down mandatory standards. It was felt that a strong policy was needed due to the weak structure of local government in Saskatchewan.

This drastic increase in provincial control over the municipal social aid program was necessary under the circumstances. In an address to the Provincial-Local Government Conference in 1956, the provincial Minister of Social Welfare noted that larger units were needed to admin-

¹Local Government Continuing Committee, Provincial-Local Administrative Relations, 1961, Appendix I.

²Ibid., p. 91.

ister municipal social aid programs. A local body organized along the lines of the principles of regionalization could provide an adequate administrative and financial base for social aid. Professional workers could be engaged by local governments and a program could be implemented which would more than meet a provincial minimum standard. Unfortunately, the problem proved to be too acute to await any forthcoming reorganization of local government and the province was forced to introduce the less desirable but equally as effective central controls.

In summary, almost all of the social welfare programs are administered by the provincial government. Aside from the Local Government Continuing Committee, very few authoritative sources consider social welfare to be a local field. During the 1930's and 40's the province gradually assumed more and more of the social welfare burden. Today's extensive program was completely developed by the provincial Department, mostly since the end of the war. The Department's very efficient regional services were set up as an administrative move to decentralize a provincial service and to bring it closer to the people it served. Social Aid is still administered locally, but it is heavily subsidized with provincial grants and, under the new Social Aid Act, the Minister has passed very stringent regulations over all aspects of the local program. For all intents and purposes, it may be said that the municipalities are merely used as the administrative means of providing social aid in the province. Under the present regulations, there is no room for local discretion in social aid policy.

Regionalization was applied in this field as a means of efficiently decentralizing a central service, not to strengthen a local func-

tion. If, however, the recommendations of the Local Government Continuing Committee were put into effect, the autonomous regions could handle the provincial services in just as an efficient manner.

Mention was made of the early intentions to integrate or at least co-ordinate social welfare and public health services. This co-ordination was, as far as is known, never even tried on an experimental basis. Both Departments should investigate the possibilities of operating an integrated service in one region for a period of five years. It is all very well to write memoranda on the subject of integration, but only an actual experiment or pilot project will yield an accurate assessment of the proposal.

VII CONCLUSIONS

After having discussed regional theory and the Saskatchewan experience, it is fitting to close with a statement of general conclusions which might be drawn. The specifics have been outlined in the summaries at the end of each section of this dissertation. What will follow will be comments on regional philosophy and some comments on the future of regionalization as a political institution.

The democratic element in regionalization must not be overlooked. It is true that regions are best known in their role as a purely administrative unit, but this is not their sole use. When regionalization becomes involved in the political process as a unit of government, its effects on the functioning of democracy must be taken into account. In considering whether our democratic way of life is improved or damaged by the adoption of regions as an intermediary tier of government, no amount of administrative efficiency will cancel out even the smallest detrimental effect on our democratic tradition. The principles of democracy as understood in our western society must remain paramount.

Two works have been quoted¹ which maintain that strong local government is a desirable element in our political system. Both writers are staunch advocates of grass roots democracy. Our local governments must continue in their traditional roles as multi-purpose authorities, keeping matters of local concern at the local level, where they belong. Nevertheless, in order to do this, these local units must

¹See Chapter II. 4, The Pros and Cons of Regionalization, pp. 15-22.

take a serious look at their administrative abilities. While it is accepted that, as a democratic safeguard, a certain amount of authority should be delegated to local government, local governments should be so organized as to exercise this delegated authority efficiently, or the process of delegation becomes a farce. Paradoxically, we cannot expect our provincial legislatures to repose trust in the hands of our local institutions if their ability to exercise that trust is clearly doubtful. In this respect, I accept Professor Rowat's thesis that regionalization and the adoption of regions as an intermediate tier of government will strengthen local government and restore the balance or division of power among the federal provincial and local spheres.

The several references throughout this dissertation to the belief that regionalization would strengthen and revitalize local government are evidence that it is gaining support. It will just be a matter of time before local officials turn, in desperation or as a last hope perhaps, to regional theory as a bulwark against the provincial centralist tide. I would especially refer to pages 114 and 115 in reference to hospital planning and operation. In the next decade, we must accomplish a thorough reorganization and revamping of local government or face almost complete centralization. We have but two visible alternatives, regionalization under local control, or centralization and the breakdown of our democratic tradition of local self-government.

One of the basic principles of western and especially American democracy is citizen participation. In our federal system, vast numbers of elective posts exist, and thousands of interested citizens vie for them in our frequent elections. These political offices, from the exalted

heights of Parliament to the grass roots of local government, are elective and limited to a set term as a safeguard against tyranny and dictatorship. The incumbent holds his office in trust, and must return after every term to the people for a fresh mandate. Such a democratic tradition is both necessary and desirable, and the value of wide citizen participation in safeguarding democracy is herein accepted.

What must be pointed out is the pragmatic consideration involved in citizen participation in local government. Local institutions provide the first training for many citizens entering politics in Canada. Often the interested citizen first ventures onto the political scene as a representative on his local school board, hospital board or municipal council. It is here that he gets his first education in the workings of our political system and its lofty principles of democracy. From thence he may aspire to the provincial house or to Parliament in Ottawa. What is most important is how valuable is his training and how his philosophy of democracy is shaped by this first encounter in serving his fellow citizens through an elective office. It is apparent that today's municipal units are not providing useful or valuable training for our citizenry. The councils of our small municipalities are delegated relatively unimportant functions which are further restricted by provincial regulation. It is assuredly true that our local officials could serve more usefully and more effectively in a system of political regionalization. It was pointed out earlier by one expert,¹ that any system of larger local governments would cut down numerically on the number of elective posts available to the population at large; yet

¹See p. 21.

we must be concerned with quality as well as quantity. Citizens serving in our present rural and small urban municipalities will gain little or no experience in governing, and will be ill-fitted to carry on to higher provincial or federal offices. The fewer representatives on councils governing larger areas would be much wealthier for their experience in taking part in more important political decisions. Of course, if regions are set up as an intermediate tier of local government, there may well be more, not fewer locally elective posts.

~~What~~ seems to be lacking is a well-defined philosophy of regionalization. References to the various writings on regional theory and to the number of regional schemes in Saskatchewan only serve to point out the fact that regionalization is not fully understood by those who would use it. Few provincial and local officials seem to have fully grasped the fact that the region, besides being a mere geographic division, can also be a unit of local government. Regional theory is scientific and reflects modern needs, but what is most important is the fact that regionalization can combine democracy and efficiency. Here is our chance to have an effective system of municipal government which, while strengthening the administrative aspects, does not sacrifice the principles of democracy.

At present, there seems to be a schism between the academic and professional supporters of regionalization and the lay element in local government. A considerable number of esteemed academics and pragmatic administrators have praised regional theory, but it does not seem to have been espoused by local officials. Possibly their suspicion comes from the fact that most of the important regional studies have been

carried out under provincial auspices. It appears that, as the present trend to centralization continues, it will narrow the gap between the two groups and cause them to join forces to protect local institutions.

It must be admitted that the great barrier to the acceptance of regionalization is the education of the public. The setbacks suffered in Saskatchewan were a direct result of public misunderstanding. The great gap between the professionals and the laymen in local government can also be attributed to an apparent failure on the part of the academics and professionals to explain their stand to the public. Perhaps the blame would be better placed on the shoulders of the provincial governments which have failed to launch educational campaigns once they have accepted the recommendations of their advisors.

One of the most important forces in the field of public health is that of citizen understanding of the philosophy behind preventive health programs. No scheme can be successful unless the public are interested and willing to make use of the services offered. Most provincial governments in fact employ experts in health education to get preventive programs across to the people. Similarly, until the philosophy of regionalization is fully understood and accepted by the people (who are also potential local officials), regional schemes will never be implemented with any success.

There seems to be some question as to whether a regional system of local government is workable. Regionalization as a political institution is a relatively unknown quantity. There are no important regional schemes in operation at present from which we could draw experience. The field of hospital planning and operations is a classic field ripe

for regionalization, and it seems that this would be an excellent area for provincial governments to test an intermediate regional tier of local government. In setting up such a scheme, experience could be drawn from private operations such as the Rochester Council or from the Saskatchewan Regional Hospital Councils. If regionalization proved successful in this field, it could be expanded and more general areas of local government could be delegated. There is no doubt that a strong regional tier of local government would allow for greater local discretion and would result in an appreciable reduction in the mass of provincial statutes and regulations of a technical nature.

Earlier in this dissertation, a guide or measure of the workability of a system of local government was discussed, and it was shown that, without a doubt a regional scheme properly set up and with the support of both local and provincial officials would almost certainly be a success. There seems to be no doubt then, that regionalization is workable.

A closing comment on the Saskatchewan experience is appropriate here. The philosophical schism previously mentioned has plagued regional attempts in this province. Both the Health Region program and the more far reaching reform of the Local Government Continuing Committee failed to reach the public or to excite widespread interest. Parochialism or ignorance, plain or simple, has reduced the effectiveness of the Health Regions and has caused the Continuing Committee's Report to be shelved. The provincial government cannot, of course, go against the wishes of the people, but they have not made sufficient attempts to educate the public to the benefits of regionalization which seem so plain to the academics

and professional administrators. The government seem aware of the benefits of regionalization (witness: the administrative regionalization of Social Welfare), but they seem to lack the political backbone to institute an overall regional reform of local government. A compulsory reorganization along these lines is progressing nicely in Alberta. The Alberta provincial government apparently is willing to chance arousing the ire of intrenched local interests in the name of progress and better government.

It is evident that local efforts, unsupported by the province, are not enough. The Regional Hospital Councils in Saskatchewan were begun on local initiative and have been developing slowly due to the lack of provincial interest or support. The province, in fact, chooses to duplicate their functions rather than supporting them. One of the basic tenets of successful local government is that it must be delegated sufficient functions of an important nature to make its existence worthwhile. For the most part, the provincial government in Saskatchewan has refused to do this, and, as a result, the regional schemes in existence are withering on the vine.

If it is to succeed, regionalization must be accepted as a valuable form of local government and supported whole-heartedly by both provincial and local officials. The democratic and administrative importance of local institutions is so great that further delay in accepting regional reform will only serve to damage our democratic tradition.

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Bibliographical Note

While this bibliography is by no means complete, it is a fairly good representation of the type of material available on regional theory.

It seems that regional theory has, as yet, not reached the level of sophistication that would necessitate a full study of the subject alone. Since it is closely involved with decentralization and local government, regional theory is usually discussed as part of a wider study. While Dickinson's monologue is entitled City Regions and Regionalism, the emphasis falls decidedly on the study of the metropolis phenomenon. Regionalism applied to rural areas receives scant notice.

The best analyses of regional theory can be found in the various government studies on local government, or at the national level, studies of national decentralization, such as that contained in the United Nations Study Document referred to in this bibliography.

The main portion of this study is devoted to public health in Saskatchewan, and specifically to a critique of the Health Regions in that province. The major sources of information were found in the central files of the Department of Public Health (listed as Central File Numbers 018A, 019, 175, 175A and 175A1). These files contain a great assortment of material, from the working papers of the Health Services Planning Commission, which studied regionalization and finally recommended its application in the field of public health in Saskatchewan, to memoranda and correspondence of the Minister, Deputy Minister and the Director of Regional Health Services. These documents were for the most part untitled and often undated. To attempt to classify them would have required almost the same amount of time as was put into the writing of this dissertation. It was therefore decided that only the files themselves would be referred to, thereby identifying any sources quoted as government documents.

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IX APPENDIX (Maps)

In order that the various regional schemes, either proposed or in existence, which are discussed in this thesis may be more clearly pictured by the reader, six maps are appended showing their boundaries.

While each of the schemes' boundaries differ, two basic principles were observed in drawing these boundaries:

1. Generally speaking, the regions were drawn around the same urban centres in the province. There are a dozen or so major urban centres in the province which exercise influence over a large area of the surrounding country-side.
2. The major geographic features of the province (for example, the two large rivers) are always taken into consideration in drawing regional boundaries.

These principles are emphasized here to point out that basically the same considerations are used to construct regional boundaries. The regions may vary in size but the large units (or smaller units taken in groups) usually conform to area breakdowns dictated by the above mentioned two principles.

The six maps included here are representative of the two dozen or so regional organizations, all different in shape, which are used for purposes varying from local school units to Department of Highways administrative regions. This hodgepodge of regional boundaries is confusing both to the tax-payer for whom the services are being provided, and to the government administrator who may have interdepartmental dealings.

The province has at no time made any serious attempt to standardize or work out a system of coterminous regional units. It is hard to understand how such a simple common sense measure could be overlooked. The benefits of uniformity are too obvious to mention here. Naturally there would have to be some compromise and the standard regional units adopted would not be ideally suited to each use, but these difficulties

would be far outweighed by the benefits. _It is simply ridiculous to think of having a half dozen different regional units in the field of public health alone.

There do not seem to be any signs of provincial action in the near future to standardize regional boundaries in Saskatchewan. The differences are merely pointed out here to emphasize the evils of compartmentalizing administration or planning in a vacuum.

1. Coterminous Local Government Areas,
Recommended Boundaries, 1960

Source: "Local Government in Saskatchewan, Local Government Continuing Committee Report, 1961"

2. Department of Social Welfare and Rehabilitation

Welfare Regions, 1963

Source: Department of Social Welfare and Rehabilitation, Annual Report, 1962-63, p.37.

3. Established Regional Hospital Council Boundaries,
Saskatchewan, 1964

Source: Hospital Administration and Standards Division, Saskatchewan Department of Public Health.

North-West Council - 19 Hospitals
North-Central Council - 18 Hospitals
Quill Plains Council - 14 Hospitals
South-West Council - 21 Hospitals

4. Saskatchewan Department of Public Health,
Health Regions, 1964

Source: Research and Planning Branch, Saskatchewan Department of Public Health, 1964.

5. Proposed Health Service Areas,
Saskatchewan, 1951

Source: Saskatchewan Health Survey Report, 1951, Vol.1, p.36.

6. Proposed Hospital Regions,
Saskatchewan, 1961

Source: Saskatchewan Hospital Survey Report, 1961.