THE PATTERN OF

LOCAL PUBLIC HEALTH ORGANIZATION

IN CANADA

A Thesis Submitted

by

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CHAPTER I

INTRODUCTION

The protection of public health is today generally recognized as one of the most important functions of government. Few others are more vital to the welfare of the whole population. The sanitation of the physical environment, the control of communicable infections, the education of the individual in personal hygiene and the organization of medical and nursing services for the early diagnosis and preventive treatment of certain diseases - all these health functions and many more are the concern of the various levels of government in Canada.

Although many public health programs are now carried on directly at the federal and provincial level, it is the local organization, whether municipal, or provincial, or a combination of both, which may be considered as the "ground-floor" of the Canadian public health structure. The local health department renders on-the-spot direct service to a local jurisdiction and the people it includes. "It is here that direct person-to-person contact is made between the individuals comprising the public and their locally employed public health personnel."(1)

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(1) Hanlon, John J., Principles of Public Health Administration, St. Louis; C.V.Mosby Company, 1950, p. 270.

In its broadest sense, local public health organization includes both the preventive and curative health services provided through the community. However, curative services such as local hospital programs and local treatment services for indigents have usually been separately developed by welfare departments or special agencies not concerned with the direct provision of preventive public health services. Therefore, despite recent trends toward integration of prevention and treatment at the local level, this thesis will deal with public health organization in the limited sense used by Smillie as "those activities that are undertaken (primarily) for the prevention of disease and the promotion of health ..."(2)

The present scope and nature of local public health functions is a product of about seventy-five years of rapid development. From preoccupation with simple regulatory measures such as sanitary inspection and quarantine, local programs have evolved to include a wide variety of special services. As with other social services, the expansion of activities has greatly increased per capita costs and enlarged the sphere of local administration. Efficient performance now requires the integration of associated public health functions in a unified organization, an administrative unit of adequate size, a broad basis of financial support, and special measures to attract the necessary qualified personnel.

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(2) Smillie, Wilson G., Preventive Medicine and Public Health, New York, MacMillan Company, 2nd ed. 1952, p. 6.

Generally speaking, Canadian municipal units, with the exception of the larger cities, are too deficient in area, population and financial resources to support separately modern local public health organizations. To meet public demand for efficiency in the provision of local services, provincial governments have intervened either to promote and participate in the operation of enlarged special purpose inter-municipal units of public health administration, or to assume direct responsibility for local services. This expansion of the "physical dimension" of government in the field of public health, to parallel the expansion of functions, has raised the problem of reconciling local self-determination with the need for technical efficiency.

The purpose of this thesis is to examine and compare the pattern of local public health organization in the various provinces with special reference to problems of provincial-local relations. This involves consideration of the different types of organization, the size of administrative units, administrative structure and relationships, methods of financing and the problem of personnel. In order to understand these questions, however, it is necessary to trace briefly the historical factors which have led to the existing local public health structure in Canada.

Public Health Functions

At the time of Confederation when Canada was still predominantly rural, urban centres small, and the movement of population restricted, public health was not considered an important service. Edwin Chadwick's famous "Report on the Sanitary Conditions of the Labouring Population of Great Britain" in 1842 had pointed out the close connection between environmental conditions and disease, and had focussed attention on the eradication of filth. Such a concept of public health, restricted to regulation of the environment, fitted well into the prevailing laissez-faire philosophy which narrowly limited the scope of government action.

This situation was altered by Pasteur's discovery of the microbic origin of disease (1870) and Koch's description of the tubercle bacillus (1882) which shifted emphasis from the regulation of the environment to the regulation of the individual. As pointed out by Grauer, these medical discoveries were made all the more important by the intervening development of the steam railway, the steamship and better roads which greatly increased the danger of spread of infection. And both the microbe and sanitary approaches to public health became of crucial importance with the continued growth of large industrial cities and the highly complex social organization characteristic of mature industrial society.(3)

(3) Grauer, A.E., Public Health, monograph prepared for the Royal Commission on Dominion-Provincial Relations, Ottawa; 1939, p.1. (mimeo.)

Modern public health activity, in the sense used here, is a combination of regulatory activity and the direct provision of services, preventive and educational in nature. The development of these services was made possible by a general climate of opinion which increasingly favoured the extension of government activity to promote the health of the individual, since the ill health of the individual represents a menace to the general welfare of the community. The trend towards personal health services followed also from the change in emphasis to the individual instead of his environment as the source of disease and from the demonstrated inadequacy of regulatory activity unaccompanied by education in the principles of personal hygiene. In turn, effective health education of the individual had to be accompanied by case finding and diagnostic services to locate disease.

Today, the scope of public health includes environmental sanitation, communicable disease control, child health and adult health. Changes in the character of public health activities reflect, in large measure, the success of early public health programs in reducing the occurrence of, and deaths from, infectious diseases. Preventive methods have been extended and applied to general problems of maternal health, infant health, pre-school health, and school health since obviously the state of child health directly conditions the health of the future adult population. Special clinicial

services have been developed under public auspices for tuberculosis, venereal disease and other conditions. In recent years increasing attention has been directed to the application of preventive techniques to problems of adult health and the chronic diseases such as cancer, arthritis and rheumatism, mental illness and so on. This expansion of activity is breaking down the separation of public health from general health care services.

Changing Responsibilities and Structure

When public health was simply a matter of environmental sanitation, it was regarded as essentially a subject of local concern which could best be handled by municipal authorities conversant with local conditions. However, although newly formed Canadian municipalities were delegated permissive powers to take appropriate sanitary measures for such things as "the removal of nuisances" and "the regulation of injurious odours in certain trades", there was little local organization apart from the formation of boards of health and the employment of part-time untrained sanitary inspectors by some municipalities. Provincial control was exercised only intermittently during times of serious epidemics.(4)

Provincial statutory control and supervision of municipal public health activities was first established

(4) Defries, R.D., ed., Canadian Public Health Association, The Development of Public Health in Canada, Toronto: Toronto University Press, 1940.

on a continuing basis towards the end of the nineteenth century when public health began to achieve recognition as a problem of province-wide concern. With the development of the germ theory of disease and of new techniques of infectious disease control, each province enacted legislation and regulations designed to protect the health of the population as a whole. Permanent provincial Boards of Health were set up in all the provinces, the dates of establishment being as follows: Ontario - 1882; Quebec and New Brunswick - 1887; Nova Scotia, Manitoba and British Columbia - 1893; Alberta - 1907; Prince Edward Island - 1908; and Saskatchewan - 1909.(5)

Under province-wide provincial legislation and regulations, pertaining mainly to sanitation and infectious disease control, the municipalities were assigned the role of local enforcement, acting in effect as the administrative agents of the provincial authority. Further control was exercised by most provinces through statutory provisions making it mandatory for each municipality to set up a minimal public health organization to undertake the required enforcement measures. In most provinces, each municipality was required to establish a board of health and/or appoint a medical health officer.

While provincial legislation also provided the municipalities with optional powers to enact local by-laws

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(5) Defries, R.D., ed., Op. Cit., pp.15,35,49,56,67,90,101, 115, 131.

and develop further services, very little was done except in the larger cities where problems of sanitation and infectious disease control were more obvious to the taxpayer. At a time when public health was largely regulatory in nature and scientific knowledge limited, the employment of a sanitary inspector without special training and of a local physician as a part-time health officer was sufficient for most municipalities.

As public health functions expanded, the provinces were increasingly forced to adopt administrative techniques of control and supervision, because of the failure of municipal boards of health and medical health officers to function effectively. "There seems to have been little co-operation between the Provincial Board and the local boards; some submitted annual reports, others did not. Some local boards seldom if ever met, the duties being carried on by the chairman. These local boards mostly had no funds from which to work, and when expenses were incurred it often took years before the bills were paid..."(6) "The part-time medical officer of health has been to a large extent a failure. He is untrained for his work. is paid very little and that grudgingly for his services. His official position brings him into conflict (1) with his fellow-practitioners who will not report (contagious diseases, etc.) to a rival in practice, (2) with possible clientele who fear quarantine if communicable disease is found in the family. This fact and the dissatisfaction of persons who are isolated for the public good, interfere with the doctor's practice and since the

6) Warwick, Wm., "Public Health in New Brunswick", in The Development of Public Health in Canada, Defries, R.D., ed., Toronto: Toronto University Press, 1940, p. 49.

practice of his profession is his chief interest it is readily seen that in the endeavour to serve two masters the less remunerative and less attractive one of public health is neglected."(7)

To enable effective administrative control at least five provinces established provincial health districts and appointed district health inspectors to serve as liaison between provincial and municipal boards of health. The system of provincial health districts was instituted by Manitoba in 1893, Qiebec in 1910, Ontario in 1912, New Brunswick in 1918 and Nova Scotia in 1919.(8) Generally, the functions of district health inspectors were two-fold; to provide guidance and technical advice to municipal health officials, and to ensure that all public health legislation, regulations and by-laws were being properly enforced.

Direct services were originally a provincial responsibility only in municipally unorganized territory. However, with the change in emphasis to health promotion and the provision of personal health services, provincial governments increasingly assumed direct responsibility for various specialized services. Certain specific disease problems of particular public interest clearly required province-wide control programs because the extent of the disease in each local area was insufficient to justify separate local organizations.

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(7) Mc Cullough, J.W.S., "The County Health Unit", in Can J. Pub. Health, Vol.20, No.3, p.119

(8) Defries, R.D., ed, Op. Cit., pp.16,36,50,72,90.

Similarly, provincial administration was necessary for certain technical advisory and assistance services designed to support and stimulate local direct service activities. In consequence, most provinces have developed centralized administrative services for the disease problems of tuberculosis, mental illness, venereal disease, cancer, poliomyelitis and others, as well as technical assistance services such as public health laboratories, sanitary engineering, epidemiology, public health nursing, health education, vital statistics, nutrition, occupational health and preventive dental health. These and other services concerned with general medical and hospital care have been organized in separate health departments (Alberta, Saskatchewan, Ontario, Quebec, Nova Scotia and Newfoundland) or in combined health and welfare departments (British Columbia, Manitoba, New Brunswick and Prince Edward Island). The dates of establishment of provincial departments were as follows: New Brunswick - 1918; Alberta - 1919; Saskatchewan - 1923; Ontario - 1925; Manitoba - 1928; Nova Scotia - 1931; and Quebec - 1936;(9) as well as Prince Edward Island - 1931;(10) Newfoundland - 1931;(11) and British Columbia - 1946.(12)

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(9) Defries, R.D., ed, Op. Cit., pp.25,37,50,73,91,117,133.

(10) Prince Edward Island, Provincial Health Planning Commission, A Report Prepared by the Provincial Health Planning Commission for Presentation to the Government of the Province of Prince Edward Island, Charlottetown: The Commission, n.d., (mimeo), p.8.

(11) Statutes of Newfoundland, 22 Geo.V, c.12.

(12) British Columbia: Dept.of Health and Welfare (Health Branch) First Annual Report, 1946. Victoria, B.C., Kings Printer,1947

At the local level, basic public health functions were rapidly increasing in scope and complexity to include vital statistics, general sanitation, the control of communicable diseases, the protection of health in maternity, infancy and childhood, public health education, and some aspects of special problems such as tuberculosis control, venereal disease control, mental health, occupational health, community nutrition, dental health and latterly the chronic diseases. Developing public health functions could no longer be undertaken adequately without the employment of full-time professional personnel such as medical health officers specially trained in public health, public health nurses, trained sanitary inspectors and various others. As stated some years ago in a United States survey report "...Only through the leadership of specially trained and experienced medical officers of health employed on a full-time basis, and by the provision of other professionally and technically trained members of an organized staff, can the desirable local health services be provided with competence and economy".(13)

Special Purpose Local Health Units

Until recent decades in Canada, the municipality was still considered as the basic unit of local health administration, while the local school district provided school health services. However, as functions changed and only the larger urban municipalities possessed the population and financial

(13) Emerson, Haven, Local Health Units for the Nation, New York: The Commonwealth Fund, 1945, p. 1.

resources necessary for the development of full-time local services. an increasing imbalance was apparent between the municipal structure and local health organization requirements; rural municipal units were individually too small to support full-time services. The result was the gradual development of enlarged special purpose units of administration with varying degrees of provincial participation and weakening of local control.

In the early development of enlarged health districts, emphasis was placed at first on co-operation between adjacent municipalities without provincial participation or financial assistance. As far back as 1890, Ontario made provision for the appointment of county health officers, but the project failed to gain support due to hesitancy on the part of county councils to incur expenses hitherto borne by the municipalities.(14) Similar lack of success marked 1918 Nova Scotia legislation providing for the optional establishment of county boards of health at the request of included municipal and town councils,(15) and Quebec legislation in 1919 enabling adjacent municipalities to combine their local services under a joint board of health.(16) In New Brunswick, however, permanent intermunicipal boards ..

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14) Phair, J.T., "Public Health in Ontario", in The Development of Public Health in Canada, Defries, R.D., ed., Toronto: Toronto University Press, 1940, p. 71.

15) Forbes, F.G., "Public Health Act - Its Scope and Application", in Can. J. Public Health, Vol.9, No.10, p.462.

16) Pelletier, Elz., "Public Health in Quebec", in The Development of Public Health in Canada, Defries, R.D., ed., Toronto: Toronto University Press, 1940, p. 16.

were set up through mandatory legislation in 1918 which required the formation of county boards of health composed of members appointed by the county and towns and cities located in the county.(17) Other provinces encouraged the joint provision of school medical and nursing services by municipalities and school boards.

In the absence of effective action by the municipalities efforts were made to strengthen provincial district health services. District health inspectors became responsible for the medical inspection of schools in Nova Scotia in 1920 and in New Brunswick in 1922.(18) Ontario and the Western Provinces introduced provincial public health nursing in the following order: Manitoba - 1916; British Columbia - 1917; Alberta - 1918; Saskatchewan - 1919; and Ontario - 1920.(19)

Further progress towards full-time health units was arrested until financial assistance was forthcoming from provincial governments. During the late nineteen twenties and early thirties, experimental and demonstration health units were launched in several provinces with joint financial participation by municipalities, the provincial governments and the Rockefeller Foundation. The Rockefeller Foundation provided

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(17) Warwick, Wm., Op. Cit., p. 50.

(18) Defries, R.D. ed., Op. Cit., pp.36,50.

(19) Defries, R.D., ed., Op. Cit., pp. 78,96,107,120,138.

assistance to most demonstration units for a three year trial period following which financial support was withdrawn. Altogether, seven provinces set up one or more experimental units, with the first units in each province being established in the following order: British Columbia - 1921; Quebec - 1926; Saskatchewan - 1929; Manitoba - 1930; Alberta - 1931; Ontario - 1934 and Nova Scotia - 1937.(20)

With the progressive extension of the health unit system in recent years the pattern of administration and financing has become largely standardized in each province. In five provinces, intermunicipal units are now jointly administered and financed by provincial and local authorities. Of these, Alberta and Ontario place the greatest emphasis on local administrative responsibility, while in British Columbia, Saskatchewan and Manitoba administration is more highly centralized, with the local role being mainly advisory; Quebec's health units are entirely administered by the provincial health department, although the municipalities make a small financial contribution. In the Atlantic provinces, almost all local public health functions are administered and financed directly by the provincial health departments, although the municipalities may retain certain minor public health responsibilities.

Coverage of Full-Time Organization

At the end of 1952 as shown in Table I below, almost

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(20) Defries, R.D., ed., Op. Cit., pp.21,37,107,128,139. Manitoba, Advisory Health Survey Committee, An Abridgement of the Manitoba Health Survey Report, Winnipeg: Queen's Printer. 1953, p. 31. Ontario, Health Survey Committee, Report of the Ontario

10,400,000 Canadian or 74.1 percent of the total population were served by 180 full-time units of local public health administration. This compares with 1268 full-time units in the United States covering 75.8 percent of the population at the end of 1951.(21)

TABLE I NUMBER OF UNITS AND POPULATION COVERAGE OF FULL-TIME LOCAL PUBLIC HEALTH ORGANIZATION BY PROVINCE - DECEMBER 31, 1952.(1)

Province	Number of Units	Population Served	Population Served as Percentage of Total Population
British Columbia	17	1.086,963	95.5
Alberta	16	677,296	72.1
Saskatchewan	10	502.212	60.4
Manitoba	14	520,667	65.2
Ontario	41	3.013,039	65.5
Quebec	72	3,890,579	96.0
New Brunswick	-	-	-
Nova Scotia	9	642,584	100.0
Prince Edward Island	-	-	-
Newfoundland	1	52,873	14.6
Canada	180	10.386,213	74.1

1) Based on unpublished material supplied to Research Division, Department of National Health and Welfare, by provincial health departments.

21) U.S.Department of Health, Education and Welfare, Greve,C.H. and Campbell, J.R. (editors), "Report of Local Public Health Resources. 1951", Public Health Service Publication No.278. Washington: U.S. Government Printing Office, 1953, p.3.

Such full-time or fully organized services include urban health departments, intermunicipal health units and provincial health districts. Each of these departments, units or districts comprise an organized local health service under the direction of a full-time local medical health officer; the staff includes public health nurses, sanitary inspectors, clerks and frequently other professional personnel such as dentists or nutritionists. Outside the fully organized areas, municipalities and municipally unorganized territory are either serviced part-time by medical health officers and/or full-time or part-time nurses and sanitary inspectors or else have no service at all.

CHAPTER II

EXTENT AND TYPES OF LOCAL PUBLIC HEALTH ORGANIZATION

As indicated in Chapter I, local public health services have been developed partly through municipal health departments, partly through provincial health districts and partly through joint provincial-local health units. While full-time services are provided through each of these three basic forms of organization, the extent of coverage varies considerably between urban and rural areas. Table II below shows that almost 91 percent of Canada's urban population benefitted from full-time services in 1952 as compared with 63 percent of the rural population.(1)

In Canada's larger cities full-time municipal health departments have been established for many years; Tables II and III show that they are still the main form of health organization in urban areas. In 1952, 27 full-time municipal departments covered 4,313,419 persons including more than 71 percent of the urban population or 30 percent of Canada's total population. Recently, various urban municipalities have been combined with

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(1) For purposes of this thesis, urban territory includes incorporated cities, towns or villages containing 10,000 or more population according to the 1951 census.

TABLE II TOTAL, URBAN AND RURAL POPULATION, AND PERCENTAGE OF TOTAL, URBAN AND RURAL POPULATION COVERED BY LOCAL PUBLIC HEALTH ORGANIZATIONS BY TYPE OF ORGANIZATION, DECEMBER 31, 1952.

Type of Organization	Total Population Covered		Urban Population Covered(2)		Rural Population Covered(3)	
	Number	Percent	Number	Percent	Number	Percent
Population of Canada, 1951	13,984,329	100	5,635,878	100	8,348,451	100
All Full-Time Organizations	10,386,213	74.3	5,124,092	90.9	5,262,121	63.0
Urban Health Departments(4)	4,313,419	30.8	4,013,604	71.2	299,815	3.6
Intermunicipal Health Units	5,462,926	39.1	964,496	17.1	4,498,430	53.9
Provincial Health Districts	609,868	4.4	145,992	2.6	463,876	5.5
No Full-Time Service	3,598,116	25.7	511,786	9.1	3,086,330	37.0

(1) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by provincial health departments. These data include total population covered (according to the 1951 census) by various types of full-time organization at the end of 1952, and the names of incorporated cities, towns and villages over 10,000 population provided with full-time organization.

(2) Population located within incorporated cities, towns and villages containing 10,000 or more population according to the 1951 census.

(3) Population located outside incorporated cities, towns and villages containing 10,000 or more population according to the 1951 census.

(4) Includes Greater Vancouver Metropolitan Health District, Victoria-Esquimalt Union Health District, York Township Health Department and Scarborough Township Health Department.

surrounding rural territory in local health units; others are included in provincial health districts. Only 9.1 percent of the urban population lack full-time services but in most such municipalities fairly extensive programs are organized by part-time medical health officers.

In small communities and rural areas considerable progress has been made in developing full-time services through intermunicipal health units. As shown in Tables II and III, full-time intermunicipal units numbering 144 in 1952, covered 5,462,926 persons or 39.1 percent of the Canadian population, this covered population was mainly located in rural territory. Full-time provincial health districts are much less extensive; in 1952 they numbered 9 and served 4.4 percent of the population. It should be noted that 57 percent of the non-urban population wtill lacked complete full-time services at the end of 1952.

TABLE III NUMBER OF UNITS OF FULL-TIME LOCAL PUBLIC HEALTH ORGANIZATION BY CLASS OF UNIT AND TYPE OF ORGANIZATION, DECEMBER 31, 1952.(1)

Type of Full-Time Organization	Total Units	Urban Units(2)	Combined Rural-Urban Units(3)	Rural Units(4)
Urban Health Departments(5)	27	24	1	2
Intermunicipal Health Units	144	4	38	102
Provincial Health Districts	9	0	5	4
All Organizations	180	28	44	108

(1) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by Provincial Health Departments.

(2) Includes units entirely composed of incorporated cities, towns and villages, containing 10,000 or more population according to the 1951 census.

(3) Includes units partially composed of incorporated cities, towns and villages of 10,000 or more population according to the 1951 census.

(4) Includes units not containing any incorporated cities, towns and villages of 10,000 or more population according to the 1951 census.

(5) Includes Greater Vancouver Metropolitan Health District, Victoria-Esquimalt Union Health District, York Township Health Department and Scarborough Township Health Department.

Municipal and School District Health Services

Local self-determination is greatest where services are still provided directly by municipal corporations and local school boards. In the larger cities, full-time health

departments offer more intensive services and a wider variety of specialized services than any other form of full-time local public health organization. By contrast, grossly inadequate municipal services are provided wherever the traditional municipal public health structure has been retained in rural communities.

Full-time city health departments are found in every Canadian province except New Brunswick, Prince Edward Island and Newfoundland. As shown in Table IV below, about one-half of these departments are located in the province of Ontario. The number of municipalities with such departments varies directly with municipal size. While all ten cities having populations in excess of 100,000 had full-time health departments in 1952, only 14 of 33 cities and towns between 25,000 and 100,000 in population operated their own full-time health departments, and just one between 10,000 and 25,000 in population separately provided its own full-time service.(2) Each municipal department is administered by a full-time medical health officer responsible to a quasi-independent board of health or a health committee of the city council.

The problems of urban growth and the development of suburban communities have raised the problem of amalgamating urban health services in metropolitan areas. As yet, however, the joint provision of services has been undertaken only by certain municipalities in the Greater Vancouver and Victoria-Esquimalt metropolitan areas in British Columbia.

(2) Based on unpublished material supplied to Research Division Department of National Health and Welfare by provincial health departments.

TABLE IV NUMBER OF UNITS OF FULL-TIME LOCAL PUBLIC HEALTH ORGANIZATION IN CANADA BY TYPE AND BY PROVINCE, DECEMBER 31, 1952(1)

Province	Total	Urban Health Departments	Intermunicipal Health Units			Provincial Health Districts		
			Total	Rural-Urban(2)	Rural(3)	Total	Rural-Urban(2)	Rural(3)
British Columbia	17	2(4)	15	3	12	-	-	-
Alberta	16	2	14	1	13	-	-	-
Saskatchewan	10	2	8	2	6	-	-	-
Manitoba	14	1	13	2	11(5)	-	-	-
Ontario	41	14(6)	27	12	15	-	-	-
Quebec	72	5	67	22	45	-	-	-
New Brunswick	-	-	-	-	-	-	-	-
Nova Scotia	9	1	-	-	-	8	4	4
Prince Edward Is.	-	-	-	-	-	-	-	-
Newfoundland	1	-	-	-	-	1	1	-
Canada	180	27	144	42	102	9	5	4

(1) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by provincial health departments.
(2) Includes units containing incorporated city, town or village of 10,000 or more population according to 1951 census.
(3) Includes units not containing incorporated city, town or village of 10,000 or more population according to 1951 census.
(4) Includes Greater Vancouver Metropolitan Health District and Victoria-Esquimalt Union Health District.
(5) Two of these health units are made up of municipalities officially designated as suburban municipalities.
(6) Includes health departments of York Township and Scarborough Township.

In the rural areas of Canada, municipal public health organizations are, in the words of an official report, "vestiges of a gradually shrinking system of small independent local health units which came into existence when organized public health was in its infancy".(3) They exist mainly because most provinces still require the appointment of a municipal board of health and a medical health officer in each municipality not located in a full-time health unit. Municipal boards are chiefly concerned with local sanitary measures and the control of minor communicable diseases; the medical health officer is a local physician appointed part-time. The appointment of a medical health officer is often nominal, although in some communities local physicians may organize and maintain fairly extensive programs. In a few larger communities, particularly in Ontario, full-time public health nurses and/or sanitary inspectors may be employed.

School health services, originally the responsibility of local school boards in most provinces, are now usually provided by municipal health departments, local health units or provincial health districts. In areas without full-time organization, school boards may transfer responsibility to the provincial public health nursing service and the municipal part-time medical health officer. In a few cities,

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(3) Nova Scotia, Health Survey Committee, Report on the Survey of Health Facilities and Services in Nova Scotia 1949-1950, By Stewart, C.B., Halifax: The Committee 1950, (processed), p.61.

however, school health services are still separately administered by school boards.(4)

Provincial Health Districts

The organization of provincial health districts as field service areas of the provincial health department represents the strongest form of provincial reaction to the inability or unwillingness of the municipalities to provide adequate health services. The provision of direct local services through these districts is in most cases an expansion of an earlier system in which provincial districts served as a means of providing advice and supervision to municipal health authorities. Wherever they exist today, such districts provide most of the basic local public health services needed in the contained local jurisdictions, although they may not entirely replace the municipal health structure. The municipalities often retain minor public health responsibilities and finance their own activities, while the provincial government pays the entire cost of its personnel and activities. The boundaries of provincial health districts are determined by provincial regulation or administrative discretion.

Provincial health districts are characteristic mainly of the Atlantic Provinces where relatively low per capita income has meant either low standards of service or a strong emphasis on technical efficiency through provincial

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(4) Further detail on municipal and school district health organization by province is set out in succeeding pages of this chapter under provincial headings.

administration. As indicated in Table V below, full-time provincial health districts serve most of Nova Scotia, and a small portion of Newfoundland. In other parts of Newfoundland, partial local public health services are made available through the provincially administered system of cottage hospital districts; Prince Edward Island also provides partial district services. In New Brunswick, the entire province is serviced by a few full-time district medical health officers, each covering from two to four health sub-districts. Elsewhere, in some remote areas of other provinces, partial provincial district services are provided as a stop-gap measure until special-purpose full-time health units can be established.

Nova Scotia: With the exception of the city of Halifax which has a full-time municipal health department, the province of Nova Scotia is serviced by full-time provincial health districts, numbering eight in 1952. These provincial health divisions, as they are termed, conduct the major field activities of the provincial health department and undertake about 95 per cent of the local health work in district areas. City, town and municipal boards of health retain certain minor functions relating to sanitation, communicable disease control and school health services.(5)

Prior to about 1934 the major responsibility for local public health services was vested in local boards of

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5) Nova Scotia, Health Survey Committee, Op. Cit., p.62, and Health Survey Reporting Form D.

TABLE V POPULATION COVERED AND PERCENT OF TOTAL POPULATION COVERED BY FULL-TIME LOCAL PUBLIC HEALTH ORGANIZATION BY TYPE AND BY PROVINCE, DECEMBER 31, 1952[1]

Province	Total Full-Time Organizations		Urban Health Departments		Intermunicipal Health Units		Provincial Health Districts	
	Population Covered	Percent of Total Population	Population Covered	Percent of Total Population	Population Covered	Percent of Total Population	Population Covered	Percent of Total Population
ritish Columbia	1,086,963	95.5	531,614[2]	46.7	555,349	48.8	-	-
lberta	677,296	72.1	288,691	30.7	388,605	41.4	-	-
askatchewan	502,212	60.4	124,587	12.9	377,625	45.4	-	-
anitoba	520,667	65.2	235,710	29.5	284,957	35.7	-	-
ntario	3,013,039	65.5	1,729,022[3]	37.6	1,284,017	27.9	-	-
uebec	3,890,579	96.0	1,318,206	31.8	2,572,373	64.2	-	-
ew Brunswick[4]	-	-	-	-	-	-	-	-
ova Scotia	642,584	100.0	85,589	13.3	-	-	556,995	86.7
rince Edward Is.	-	-	-	-	-	-	-	-
ewfoundland	52,873	14.6	-	-	-	-	52,873	14.6

1) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by Provincial health departments. These data include total population covered (according to the 1951 census) by various types of full-time organization at the end of 1952.

2) Includes Greater Vancouver Metropolitan Health District and Victoria-Esquimalt Union Health District.

3) Includes health departments of York Township and Scarborough Township.

4) New Brunswick's full-time district medical health officers cover very large areas, and each health sub-district receives only part-time attention.

5) Prince Edward Island has a district nursing service and a sanitary inspection service which are under the part-time direction of the chief medical officer of the province.

health. Althought statutory provision for the appointment of provincial diviaional medical health officers had existed since 1919, their functions were limited largely to the operation of travelling tuberculosis clinics. Three divisional medical health officers were supplemented by a number of provincial field nurses beginning in 1932.(6)

Expansion of provincial health divisions in terms of both functions and number of districts was recommended in the McIntosh Report of 1933.(7) The first experimental full-time health division established in Cape Breton Island in 1937(6) was followed by the organization of additional units until the entire province was covered by full-time services. Each health division now has a staff of full-time medical health officers, public health nurses, sanitary inspectors and clerks.

In Nova Scotia's dual system of local public health organization, each unit of local government still performs certain health functions. There are two cities and 40 towns in the province as well as 24 rural municipalities. The rural area is divided into 18 counties which, in themselves, do not represent units of local government; 12 of these counties each comprise one rural municipality, and the other six have two

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(6) Campbell, P.S., and Scammel, H.L., "Public Health in Nova Scotia", in The Development of Public Health in Canada, Defries, R.D., ed., Toronto: University of Toronto Press, 1940, pp.36-37.

(7) McIntosh, W.A., An Administrative Study of the Nova Scotia Department of Public Health with Recommendations, Halifax, N.S: Kings's Printer, 1935.

municipalities each.(8) The appointment of a board of health is mandatory for cities and towns, as well as polling districts within each rural municipality; county boards of health may be set up with the consent of the rural municipalities and towns concerned. Mandatory provision is made for the appointment of medical health officers and sanitary inspectors who may have jurisdiction over a municipality alone, a town alone, both a town of less than 2,000 inhabitants and the municipality of which the town is officially a part, two or more towns combined by agreement or two municipalities within the same county.(9) In 1950 there were 64 part-time medical health officers in the province, 37 acting for a town, 22 for a municipality, 3 for a town and muncipality, and two for sub-divisions of a municipality.(10)

New Brunswick: Nova Scotia's dual system of local public health organization is parallelled in New Brunswick where the major local public health services are also provided through provincial health districts, numbering six in 1952. Unlike Nova Scotia, however, municipal boards of health have been superseded by 16 sub-district health boards for the 15 counties of the province and for the city of Fredericton. The provincial health department appoints full-time district medical

8) Dominion Bureau of Statistics, The Canada Year Book, 1952-53. Ottawa: King's Printer, 1953, p.78.

9) Statutes of Nova Scotia, 2 Geo. VI, c.4.

10) Nova Scotia, Health Survey Committee, Op. cit., p. 61.

health officers and public health nurses, while sub-district boards appoint sanitary inspectors, vital statistics registrars and other auxiliary personnel.(11)

The existing system of local public health organization in New Brunswick dates from amendments made to the provincial Public Health Act in 1918. At that time the province was divided into several health districts, and full-time medical health officers employed by the province were placed in charge of public health services in each district. At the same time each district was divided into a number of sub-districts corresponding to the counties in the province; sub-district health boards assumed the public health responsibilities of cities, towns and villages within their jurisdiction. In 1921, a provincial public health nursing service was established, and in 1922, six full-time physicians were employed by the province to provide a province-wide school medical inspection service. In succeeding years the district medical health officer service was gradually merged with the school medical inspection service, while the provincial nursing service was discontinued and nurses were employed locally. Although the provincial public health nursing service was re-

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(11) New Brunswick, Health Survey Committee, Report of the Health Survey Committee, Fredericton, N.B: The Committee, 1951, (mimeo.) pp. 19-29.

established in 1942, the system of dual responsibility for local health services has continued up to the present time.(12)

It is difficult to judge whether or not the population of New Brunswick is covered by full-time local health services because the district medical health officers and nurses divide their time between various counties in the province. Since each medical health officer usually serves three or four counties, while sanitary inspectors, clerks and a few nurses are locally employed, it may be said that the New Brunswick system provides rather less than a unified full-time local service.

Newfoundland: Special economic and geographic circumstances have moulded an unusual pattern of health organization in Newfoundland. One feature is the high degree of centralization of health administration resulting from the absence of local government institutions. Recent developments of local government in some areas have not yet resulted in locally administered health services. A second characteristic is the emphasis placed on public provision of medical and hospital care for large areas of the island. In outlying regions around the coastline prepaid treatment services are provided for all residents in provincial cottage hospital districts, medical practice areas and nursing areas; public medical care for indigents is provided in St. John's. Only partial public health services are available except in the St. John's

12) New Brunswick, Health Survey Committee, Op. Cit., pp. XIX - XXII.

area where a full-time public health organization is operated by the provincial health department.

The 17 cottage hospital districts existing in 1952 covered 152,654 persons or over 40 percent of the Newfoundland population. Each hospital district is supervised by a medical health officer responsible for prepaid medical care in a hospital medical practice area adjoining the hospital. Domiciliary medical and nursing care in outlying parts of the cottage hospital district may be provided by additional medical health officers and nurses in medical practice areas and nursing areas which are sub-divisions of the cottage hospital district. A few medical practice areas and nursing areas are located in isolated regions outside the boundaries of any cottage hospital district.

Some 34 medical health officers employed by the province in cottage hospital districts and various private practitioners in other areas did part-time public health work in 1952. They were all paid on a fee-for-service basis for certain public health functions such as immunizations, child health clinics and school health inspections. Provincial public health nurses, usually stationed in settlements lacking physicians' services, spent much of their time on work such as maternity care, dental extractions and home nursing.(13)

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(13) Based on unpublished material supplied to Research Division Department of National Health and Welfare by the Newfoundland Department of Health, and on material collected by the writer during a visit to the Newfoundland Department of Health in 1948.

Prince Edward Island: Because of the small size of Prince Edward Island, the Health Branch of the provincial Department of Health and Welfare acts in effect as a local health department. The provincial Department was set up under a full-time Health Officer in 1931, the same year that public health nursing became a provincial service.(14) Under the Public Health Act, the respective city and town councils of the eight incorporated municipalities, and the school boards of the approximately 480 school districts, were the local boards of health in these areas.(15) An amendment in 1949 provided for the grouping of rural school districts into health districts with local boards of health.(16)

Despite the existence of local boards, almost all public health services are provided directly by the provincial Department of Health and Welfare, under the general direction of the Deputy Minister of Health who is also Chief Health Officer. In 1952 there were 10 specialized provincial health divisions, including a Division of Sanitary Engineering with a sanitary engineer and three sanitary inspectors, and a Division of Public Health Nursing consisting of a director and 10 district nurses.(17)

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14) Prince Edward Island, Provincial Health Planning Commission. A Report Prepared by the Provincial Health Planning Commission for Presentation to the Government of the Province of Prince Edward Island, Charlottetown: The Commission. n.d., (mimeo.) pp. 7-8.

15) Prince Edward Island, Provincial Health Planning Commission, op. Cit., p. 21.

16) Statutes of Prince Edward Island, 1949, c.18.

17) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by Prince Edward Island Department of Health and Welfare.

Intermunicipal Health Units

Intermunicipal health units have been co-operatively developed by provincial and municipal governments in six provinces: Quebec, Ontario, Manitoba, Saskatchewan, Alberta and British Columbia. Wherever they are established, health units replace municipal public health services, although municipal councils retain powers to enact public health by-laws. Health units are a form of joint administration, but the degree of local participation varies greatly between the provinces. Administrative structure and provincial-local relationships are discussed in detail in Chapter IV. The present chapter is concerned with extent of coverage, historical development and methods of establishment within the context of the general local governmental structure in each province.

Health units are authorized by provincial statute, but the method of establishment varies. In Quebec and Alberta, health units may be established by provincial order-in-council, although in practice approval by municipal councils is sought. In Manitoba and Saskatchewan, approval by participating municipal councils is required prior to passage of a provincial order-in-council; in the absence of such approval a local vote on the question may be held. There is no provision for local voting in Ontario and British Columbia, but units are set up through mutual agreement between local authorities.

The wide spread local demand for health unit services has been mainly stimulated by the promise of

provincial financial assistance, Provincial health departments guide and control the pattern of development. In Quebec and Ontario the existence of counties has shaped the health unit structure; many city-county units have been formed. In the western provinces, health units make up part of a general trend towards the amalgamation of municipalities for special-purpose functions.

Health unit functions are limited to preventive public health except in Manitoba where prepaid laboratory and x-ray services may be provided, and in Saskatchewan where prepaid dental care, medical care, hospital out-patient services and radiological services may be introduced,

Quebec: Almost the entire province of Quebec is provided with full-time local public health services, covering about 96 percent of the population in 1952. Rural areas and many urban communities were serviced by 67 "county" health units, while the cities of Montreal, Outremont, Westmount, Verdum and Quebec had full-time city health departments. The city health departments are independently maintained by the municipalities concerned, but the "county" health units are operated by the provincial government almost as provincial health districts except for two different features. Health unit services have entirely replaced municipal health services in health unit areas, and included municipalities are required to make a financial contribution for the support of each unit.(18)

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(18) Quebec, Ministere de la Sante, L'Enquete sur Les Services de Sante de la Province de Quebec, Quebec: Ministere, 1951,

The health unit organization in Quebec represents a modification of the earlier system of provincial district health inspectors described in Chapter I. Following two studies between 1921 and 1926 undertaken through the auspices of the Rockefeller Foundation, the first health unit was established in Beauce County in 1926.(19) In 1928 a special act respecting health units was passed by the Legislative Assembly, and in 1933 a new Health Unit Act was enacted making permanent the existing organizations and authorizing the government to order the establishment of units wherever deemed desirable.(20)

Although under the Quebec Health Units Act, the provincial government has discretionary power to establish health units in counties or groups of counties, in practice units are set up only after a resolution by majority vote of the county councils concerned.(21) Although cities and towns are administratively separate from counties cities and towns within county boundaries are required to form part of the health unit. The only exception is that cities and towns of more than 20,000 population already maintaining a sufficient

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(19) Quebec, Ministere de la Sante, Op. Cit., Tome III, pp. 64, 100.

(20) Pelletier, Elz., "Public Health in Quebec", in The Development of Public Health in Canada, Defries, R.D., ed., Toronto: University of Toronto Press, 1940, p.21.

(21) Quebec, Ministere de la Sante, Op. Cit., Tome III, p.66.

health organization in the opinion of the Minister of Health may be exempted from the Act.(22) Seventy-five out of 76 county municipalities are served by health units; in 1952, there were 57 single county units, 8 multi-county units and 2 units serving half a county each.(23) Cities, towns and villages and other municipalities may have local boards of health, but they let the county health units do the work. Outside health units, every municipality with a population of more than 5,000 persons is required to maintain a health service directed by a medical health officer.(24)

In addition to health units, the provincial health department provides a special service to settlements in remote and municipally unorganized sections of the province which lack the services of physicians and trained nurses. One public health nurse is appointed to each settlement, to provide public health nursing services as well as medical care in obstetrical cases. Although she is under the administrative supervision of the provincial Division of Medical Services to Settlers, each nurse receives medical direction from the nearest practising physician who also provides part-time medical and public health services. In 1948, 134

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(22) Statutes of Quebec, 23, Geo. V, c.74.

(23) Based on Quebec Ministere de la Sante, Op. Cit., Tome III, pp. 84-162.

(24) Revised Statutes of Quebec, 1925, c. 186.

nurses were employed full-time and 109 physicians were employed part-time in this service.(25)

Ontario: While most of the larger cities in Ontario independently operate full-time city health departments, inter-municipal health units have been developed for smaller municipalities and rural areas. In 1952, municipalities with separate health departments included the cities of Belleville, Guelph, Hamilton, Kingston, Kitchener, London, Oshawa, Ottawa, Peterborough, Sudbury, Toronto and Windsor, Scarborough township and York township; full-time local health units totalled 27. Altogether 65.5 per cent of the population had full-time services available.

In contrast to Quebec, the Ontario health unit system is of recent origin and marks a reversal of trend rather than a modification of the earlier provincial health districts. In 1934, the same year that provincial health districts were discontinued in Ontario, an experimental health unit was established by the four eastern counties of Stormont, Glengarry, Prescott and Russell. The principle of local responsibility followed in the development and operation of this unit was continued in the formation of later units, and administration by local boards of health was authorized by the Public Health Act.(26)

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(25) Quebec, Ministere de la Sante, Op. Cit., Tome III, pp.55-56.

(26) Ontario, Health Survey Committee, Report of the Ontario Health Survey Committee, Toronto: The Committee, 1951, pp. 398-400.

The Ontario Public Health Act permits any county, city, town, village or township to establish itself as a health unit by municipal by-law, or to enter into agreement with other municipalities to form a health unit. The only limitation on local autonomy is the requirement that all "non-separated" municipalities within a county participating in a health unit, must also form part of the unit. In provincial territorial districts, health units may comprise one or more municipalities, one or more school sections, and any area prescribed by the Lieutenant-Governor-in-Council.(27)

As in Quebec, Southern Ontario's two-tier system of rural local government has meant that most health units are made up of counties. Of 43 Ontario counties existing in 1951, 36 were included wholly or partly in health units.(28) In addition, quite a number of "separated" cities and towns within county boundaries have voluntarily amalgamated their health services to form joint city-county health units.(29)

Outside of health units and the health departments in the large cities, all municipal health service is on a part-time basis with a part-time medical officer of health, a full or part-time nurse, and sanitary inspector. Each city, town village or township is required to have a local board of

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27) R.S.O. 1950, c. 306.

28) Based on Ontario, Health Survey Committee, Op. Cit., p.403.

29) All Ontario's 29 cities and 7 of the 149 towns are administratively "separated" from the counties in which they are situated.

health and a medical officer of health.(30) Often several adjacent municipalities are covered by a single physician, nurse or sanitary inspector. In 1948, there were 294 part-time medical health officers, 52 full-time and 50 part-time nurses employed in these municipalities. In a number of areas outside health units, school health services are provided by local boards of education.(31)

In municipally unorganized territory every magistrate is ex-officio a medical officer of health and every constable is ex-officio a sanitary inspector. In addition, the provincial Department of Health is responsible for health administration in these areas. The Lieutenent-Governor in Council may establish health units and appoint medical officers of health, and the Minister of Health with the approval of the Lieutenent-Governor in Council, may appoint sanitary inspectors.(32)

Manitoba: In 1952, Manitoba had 13 local health units, jointly operated by provincial and local authorities, which, together with the city of Winnipeg Health Department, brought full-time services to 65.2 percent of the population. Outside these areas the services of part-time municipal medical

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(30) R.S.O. 1950, c. 306.

(31) Based on Ontario, Health Survey Committee, Op. Cit., Reporting Form D.

(32) Ontario, Health Survey Committee, Op. Cit., p. 400.

health officers were supplemented by 3 provincial public health nurses and 7 provincial sanitary inspectors.(33)

Prior to 1945 there were several fullptime health districts set up by the provincial government under the authority of an amendment to the Public Health Act in 1934.(34) These early units which were mainly located in urban and suburban areas, were established during the thirties, partly to cope with the problem of medical relief. Following a special survey in 1941 which recommended the extension of full-time services to rural Manitoba,(35) new provisions for the establishment of health units were incorporated into the 1945 Health Services Act.

Manitoba, mainly a rural province, has 4 cities, 33 towns, 35 villages, 109 rural municipalities, 5 suburban municipalities,(36) and approximately 1800 school districts.(37) In contrast with the lack of consolidation of municipal and school units, the Health Services Act makes comprehensive provision for the consolidation of local areas for health purposes.

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(33) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by Manitoba Department of Health and Public Welfare.

(34) S.M. 1934, c. 35.

(35) Buck, Carl E., Public Health in Manitoba 1941, Report of a Study made by the Americal Public Health Association, New York: The Association, 1941.

(36) Dominion Bureau of Statistics, The Canada Year Book, 1952-53, Ottawa;: Queen's Printer, 1953, p. 80.

(37) Brittain, Horace L., Local Government in Canada, Toronto; Ryerson Press, 1951, p. 178.

The Act has four main divisions providing for: (a) preventive medical services through the establishment of local health units, (b) diagnostic services by the establishment of laboratory and X-ray units, (c) medical services by the establishment of medical care districts and (d) hospitalization by the establishment of organized hospital districts.(38) While each type of unit or district may include one or more municipalities, there is great overlapping of boundaries; health units and laboratory and X-ray units may coincide, however. In 1953, there were 13 local health units, 3 laboratory and X-ray units, 18 medical care districts and 34 hospital districts set up to administer local hospitals.(39)

As with other health districts, public health units are a matter of local option. They are established by provincial regulation following approval of a proposed scheme by each of the municipal councils concerned. If any council fails within 60 days to approve a scheme submitted by the Minister of health, a vote must be held in the municipality concerned if a petition is received signed by at least 10 percent of the qualified electors.(40) Following the establishment of the unit with a unit advisory board of health, each municipality signs an agreement with the provincial government;

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(38) S.M. 1945, c. 22.

(39) Manitoba: Dept. of Health and Public Welfare, Annual Report for the Calendar Year 1952. Winnipeg: Queen's Printer, 1953, pp. 112,114,115,135.

(40) S.M. 1945, c. 22.

no municipality may apply for withdrawal from the unit until two years have elapsed from the date of the agreement.(41)

Under the Manitoba Public Health Act each city, town, village and rural municipality not included in a health unit must retain on a part or full-time basis, the services of a duly qualified medical practitioner to act as medical officer of health and may appoint sanitary and other inspectors deemed necessary.(42) The provincial Public Health Nursing Service supplies public health nurses for areas outside health units, while the provincial Section of Environmental Sanitation has a staff of inspectors located in areas of the province having no local units or sanitary inspectors of their own.

In municipally unorganized territory outside health units, the provincial government provides the same health services for residents as the organized cities, towns, villages and rural municipalities. The Minister of Public Health and Welfare may designate any area as a health district and may appoint district health officers (usually part-time), public health nurses and sanitary inspectors.(43)

Saskatchewan: In Saskatchewan, full-time local public health services are being developed through a system of health regions. At the end of 1952, 8 health regions had been organized in addition to 2 long established full-time city

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(41) Manitoba Regulation 36/48.

(42) Revised Statutes of Manitoba 1940, c. 171.

(43) Manitoba, Advisory Health Survey Committee. An Abridgement of the Manitoba Health Survey Report. Winnipeg: Queen's Printer, 1953, p. 49.

health departments in Regina and Saskatoon; 60.4 percent of the population was covered. Elsewhere partial local services were provided through about 15 nursing districts, 5 nurses located in the Northern Administration District, 14 provincial sanitary inspectors and about 200 part-time municipal medical health officers.(44)

Provincial-municipal co-operation in developing health regions in Saskatchewan is part of a general trend towards the development of local authorities along functional lines. Joint action by groups of municipalities to provide hospital facilities was authorized as far back as 1916 by the Union Hospital Act.(45) Any combination of cities, towns, villages, rural municipalities and local improvement districts is permitted to establish an administrative board for the construction and operation of a community hospital; 104 union hospital districts existed in 1952. Similarly, to bring medical services to rural areas, individual municipalities or groups of municipalities may contract with a physician or physicians to provide prepaid medical services in municipal medical care districts; these covered about 180 municipalities in 1952.(46) Considerable progress has also been made since 1944 towards the creation of 60 enlarged units of school administration designed

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(44) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by Saskatchewan Department of Public Health.

(45) Statutes of Saskatchewan 1916, c. 12.

(46) Saskatchewan: Dept. of Public Health, Annual Report for the Fiscal Year April 1, 1951 to March 31, 1952, Regina, Sask: Queen's Printer, 1953, pp. 92, 108.

to replace some 5000 local school districts.(47) Nothing has yet been done, however, about the large number of tiny rural municipal units. In 1952, there were 388 villages and 299 rural municipalities, as well as 90 towns and 8 cities.(48)

Authority for the organization of health regions was first contained in the Public Health Act as amended in 1928, and the Health Services Act of 1944 as amended in 1946 and subsequent years. Under the 1928 amendment to the Public Health Act, full-time health districts composed of at least eight rural municipalities or urban municipalities under 20,000 population could be established by order-in-council, subject to the consent of the municipal councils concerned.(49) One full-time health unit was inaugurated in the Gravelbourg area in 1929, but the depression terminated this experiment in 1932.(50)

Following the recommendation of the Saskatchewan Health Services Survey Commission in 1944,(51) the new Health Services Act permitted the establishment of health regions composed of any combination of cities, towns, villages, rural

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47) Saskatchewan: Committee on Provincial-Municipal Relations, Report of the Committee on Provincial-Municipal Relations Saskatchewan 1950, Regina, Sask: King's Printer, 1951, p.46.

48) Dominion Bureau of Statistics. The Canada Year Book, 1952-53, Ottawa: Queen's Printer, 1953, p. 79.

49) R.S.S. 1930, c. 217.

50) Saskatchewan, Health Survey Committee, Saskatchewan Health Survey Report I. Health Programs and Personnel, Regina, Sask: The Committee, 1951, p. 34.

51) Sigerist, Henry, (Chairman), Report of the Health Services Survey Commission, Regina, Sask: King's Printer, 1944.

municipalities and improvement districts.(52) Although health regions may be established and boundaries determined at the discretion of the Minister of Public Health, provisions for local consent are set out in provincial regulations. Health regions are constituted only after requests for inclusion are received from at least 10 municipalities and/or improvement districts. Following notice in the Saskatchewan Gazette, 60 days are allowed for petitions opposing inclusion. When deemed advisable by the Minister of Public Health, a vote may be ordered in the municipalities concerned if opposing petitions are received from at least 6 contiguous municipal councils or 20 percent of the electors of such municipalities; if opposing petitions are received from the councils or 20 percent of the electors of at least 10 municipalities, a vote may be ordered throughout the entire proposed region. However, even if the vote is unfavourable in one part of a proposed region, it may still be included in the region if the overall majority vote is favourable.(53)

The 8 full-time health regions established up to the end of 1952 are administered through regional boards of health with joint administrative and financial participation by the provincial health department and the contained municipalities. In addition to providing full-time public health services,

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(52) S.S. 1950, c. 82.

(53) Sask O/C 2026/48 as amended by Sask. O/C 1760/49, Sask. O/C 2138/49 and Sask. O/C 2851/52.

Regional boards are empowered to introduce tax-supported dental care for children, hospital out-patient services, radiological services and general medical care services, subject to the approval of the Minister of Public Health.(52)

Both within and outside health regions, municipal councils are required to act as municipal boards of health while each municipal council outside a health region is required to appoint a medical health officer.(54) In 1950, approximately 200 physicians served as part-time health officers for municipalities outside health regions, their work being largely confined to communicable disease and sanitary control measures.(55) To supplement rural municipal health services outside health regions the provincial health department employed a number of district public health nurses and sanitary inspectors.

Alberta: The province of Alberta had 14 full-time local health units and 2 full-time city health departments serving 72.1 percent of the population at the end of 1952. In addition, partial local services were provided through 2 "one-nurse" health units, 33 "municipal" nursing districts, several provincial sanitary inspection areas and numerous municipal boards of health in rural areas outside health units.(56)

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54) S.S. 1950, c. 81.

55) Saskatchewan, Health Survey Committee, Op. Cit., p.85.

56) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by Alberta Department of Public Health.

The establishment of full-time health units in Alberta is simply one among several recent developments designed to create larger units of local administration.(57) In 1952 the province was organized into 7 cities, 69 towns, 140 villages, 54 rural municipalities known as municipal districts and 3 counties.(58) Through consolidation, rural municipal districts have been reduced in number from 143 to 54 over the past ten years, while the counties were set up in 1951 on an experimental basis. In the educational field, about 3,591 independent local school administrative units which existed in 1936, have been largely replaced by 56 school divisions. In addition, there are more than 60 hospital districts organized to provide hospital facilities and services; they are not municipal subdivisions but are special areas usually smaller than municipal districts and school divisions.(57)

Statutory authority for the formation of full-time health districts in Alberta was first provided through an amendment to the Public Health Act in 1929, which authorized the Minister of Health to establish public health districts, either at his own discretion without local consent or following submission of a scheme to the various municipalities for their

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57) Hanson, E.J. "Local Government Reorganization in Alberta", in Can. J. Econ. and Pol.Sci., Vol. 16, No. 1, pp.53-62.

58) Dominion Bureau of Statistics, The Canada Year Book, 1952-53, Ottawa: Queen's Printer, 1953, p. 80.

approval.[59] As outlined in subsequent amendments[60] a full-time unit could be constituted after a scheme had been approved by councils representing 60 percent or more of the residents of the proposed health unit. Two experimental units were set up in 1931, and up to 1948, six more had been established.[61] In 1951, following the enactment of a separate Health Unit Act, the existing units were enlarged, and a number of new units set up.

Although the formation of health units is in practice entirely voluntary, under the new Health Unit Act the provincial government retains discretionary power to constitute, alter or disestablish health unit districts by order-in-council. By statute, health units may include towns, villages, municipal districts, improvement districts, special areas, and cities with a population not exceeding 50,000. Units are set up following requests from municipal councils, and boundaries are altered at the request of a health unit board or any contributing municipal council.[62]

Outside the full-time health units, comprehensive full-time city health departments are independently operated by the cities of Edmonton and Calgary. Elsewhere, municipal health organization is limited to the minimal framework required by the Alberta Public Health Act. Every municipal

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(59) Statutes of Alberta, 1929, c. 36.

(60) Statutes of Alberta, 1932, c. 37; 1945, c.51.

(61) Alberta, Health Survey Committee, A Survey of Alberta's Health, Edmonton, Alta: Department of Public Health, 1950, p. 26.

(62) Statutes of Alberta, 1951, c.23.

corporation is required to have a board of health, while cities and towns are required to appoint at least a part-time medical officer of health.(63)

Additional limited services in rural areas outside health units are provided through "one-nurse" health units and "municipal" nursing districts. "One-nurse" health units are designed to provide generalized nursing services until a full-time health unit can be organized. Based on enlarged school divisions and administered through local school boards, the nine units originally set up in 1944 have been almost entirely replaced by full-time local health units.

Since 1919 the provincial Department of Public Health has operated a district nursing service in outlying communities situated at some distance from medical and hospital services. As this service was originally available only in provincially administered improvement districts, new legislation became necessary in 1950 to retain the service in communities increasingly being incorporated into enlarged municipal districts. The Nursing Service Act authorizes the Minister of Public Health to enter into agreements for the provision of nursing services with the councils of villages, rural municipalities or with the Department of Municipal Affairs on behalf of improvement districts; special districts are set up known as "municipal" nursing districts.(64)

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(63) Revised Statutes of Alberta, 1942, c. 183.

(64) Alberta, Health Survey Committee, Op. Cit., pp. 26-29.

British Columbia: At the end of 1952 in British Columbia, full-time local public health services serving 95.5 percent of the population were made available through 15 local health units and 2 metropolitan health departments; outside these areas partial services were provided through 5 public health nursing districts, 2 sanitary inspection areas, 16 part-time municipal medical health officers and 21 part-time school district medical inspectors.(65)

As in the other western provinces the development of local health units in British Columbia is part of a general trend towards larger special purpose units of local administration. Seventy-six school districts have replaced 650 school units that existed prior to 1946,(66) while a number of welfare regions have been organized by the Welfare Branch of the Department of Health and Welfare.(67) Municipal governments included 35 cities, 41 villages and 28 district municipalities in 1952,(68) although 20 to 25 percent of the population was still served by provincially administered improvement districts.(66)

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(65) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by British Columbia Department of Health and Welfare.

(66) Brittain, Horace L. Local Government in Canada, Toronto: Ryerson Press, 1951, pp, 189-193.

(67) British Columbia: Department of Health and Welfare (Welfare Branch), Seventh Annual Report, 1952. Victoria, B.C: Queen's Printer, 1953.

(68) Dominion Bureau of Statistics, The Canada Year Book, 1952-53, p. 80.

In earlier days, responsibility for local public health affairs was divided between three distinct authorities. School boards were required to provide school health services, municipal councils were responsible for general public health services in their jurisdiction, and the provincial government was responsible for all services in municipally unorganized territory. Since, with the exception of the large cities, each school district included both municipally organized and unorganized territory, there were three health authorities operating in most districts.

Full time health unit services provided through union health districts were first authorized by amendment to the Public Health Act in 1936.(69) Union health districts administered through union boards of health are composed of one or more school districts and any group of cities, villages, municipal districts and provincial improvement districts. While the provincial health department recommends and encourages the formation of districts, they are nevertheless set up entirely on a voluntary basis following the passage of concurrent by-laws by two or more participating municipalities; school boards are permitted to transfer responsibility for school health services to the union board subject to the approval of the Lieutenent-Governor-in-Council. Any municipal council or school board is free to withdraw from the union health district if six months notice is given.

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(69) R.S.B.C., 1936, c. 114.

The joint provision of public health services in Greater Vancouver is unique in large Canadian metropolitan areas. Since 1936, various suburban municipalities have consolidated with the city of Vancouver to organize a large metropolitan health department through the Metropolitan Health Committee of Greater Vancouver. The cities of Victoria and Esquimalt also amalgamated their health services in 1946 under a Union Board of Health.(70)

In the few remaining non-health unit areas a number of public health nursing districts are located, the vestiges of a system started in 1944. Originally made up of groups of school districts, the nursing districts were reorganized in 1946 to coincide with the new enlarged school districts. Through public health nursing committees, limited school nursing services were expanded to become generalized public health nursing services; sanitary inspection services were added as an intermediate step prior to the organization of full-time local health unit services.(71)

In these areas, all municipalites are required to have boards of health; cities are required to appoint a medical officer while villages and district municipalities are required

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(70) Goldenberg, H. Carl, Provincial-Municipal Relations in British Columbia, Victoria, B.C: King's Printer, 1947, p. 28.

(71) British Columbia: Dept. of Health and Welfare (Health Branch), Fifth Annual Report, 1950, Victoria, B.C: King's Printer, 1951, p. 39.

to do so when considered necessary by the Lieutenant-Governor-in-Council.[72] A feature unique to British Columbia is that local school boards are required to arrange for the provision of "adequate" school health services.[73] Outside health unit and metropolitan health department areas, school boards employ part-time school medical inspectors while school nursing services are provided through public health nursing districts. In municipally unorganized areas the provincial government is responsible for all services.

(72) R.S.B.C. 1948, c. 141.

(73) R.S.B.C. 1948, c. 297.

CHAPTER III

SIZE OF HEALTH UNITS

"he integration of associated local public health functions into a unified organization must be based on an administrative unit of adequate size. The determination of the appropriate size involves the balancing of geographic area, population and public health functions. Considerations of technical efficiency, however, may require modification in order to facilitate participation and control by local citizens. Moreover, in the broadest sense, efficiency implies political and administrative arrangements which make local services responsive to local needs. As with municipal government, "A unit that is geographically too large ceases to be an area of local government for it lacks cohesive forces. One that is too small in point of population ceases to be a suitable unit for governmental purposes".[1)]

Determination of Health Unit Boundaries

The problem of health unit size has been studied by a special committee of the American Public Health Association. In a report published in 1945, it was recommended that most health unit areas should contain at least 50,000 people; exceptions were recognized, of course, depending upon wealth,

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1) Callard, K., "The Present System of Local Government in Canada: Some Problems of Status, Area, Population and Resources", in Can. J. Econ. and Pol.Sci., Vol. XVII, No.2. p.209.

density of population, health problems and geography. The report suggested that for adequate basic public health services a community of 50,000 persons would need one full-time professionally trained and experienced medical officer of health, a full-time public health or sanitary engineer and a sanitarian of non-professional grade, ten public health nurses, one of whom would be of supervisory grade, and three persons for clerical work.(2)

In Canada, there is considerable variation between provinces, but apart from city health departments based on city boundaries, certain standards may be discerned which appear to determine the general size of full-time health units. General policy considerations in the plan of health unit districts in each province are of course affected or modified by various local factors.

Smaller units of considerably less than 50,000 population are stressed in some provinces as a means of enabling health units to be responsive to local needs and wishes. In such units the medical health officer may maintain close contact with the public by directly undertaking most clinical services such as immunizations, child health clinics and school medical examinations. In many areas this system is made necessary by the general reluctance of the practicing physician to assist through the part-time provision of clinical services. One

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(2) Emerson, Haven, Local Health Units for the Nation, New York: The Commonwealth Fund, 1945, p. 2.

official report attributes this reluctance to such factors as lack of time in a busy practice, low financial inducement, reluctance to see and advise another doctor's patients in a public clinic, lack of knowledge of public health practice, and perhaps an underlying suspicion of all government health plans, be they preventive or curative.(3)

Generally, outside Canada's larger cities small health units have been favoured by the existence of low population densities,(4) and the large number of small municipal units.(5) Sparsity of population imposes administrative limitations on size due to the distance factor and travel costs, both direct and through time spent on travelling, while political limitations may arise from the refusal of outlying municipalities to participate if the unit is too large. Except where provincial health districts are set up, consideration must be given to local consent for the inclusion of particular communities.

Despite the importance of local consent and participation, the advantages arising from the economies of large scale organization have tended to encourage the develop-

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(3) Manitoba, Advisory Health Survey Committee, An Abridgement of the Manitoba Health Survey Report, Winnipeg: Queen's Printer, 1953, p.35.

(4) The average density of population per square mile in all provinces in 1951 was 6.5 varying from 45.1 in Prince Edward Island to 2.4 in Newfoundland (Dominion Bureau of Statistics, The Canada Year Book,1952-53, Ottawa: Queen's Printer, 1953, p. 129.)

(5) Local municipalities in Canada numbered 4020 in 1942 (Dominion Bureau of Statistics, The Canada Year Book 1952-53, Ottawa: Queen's Printer, 1953, p. 80.)

ment of large units over 50,000 population. The most important factor favouring larger units has been a continuing shortage of professionally trained medical health officers. If large population groups are included, more units can be established, and medical health officers can be more readily attracted to employment by the greater scope and responsibilities. In a large health unit, the medical health officer assumes extensive administrative responsibilities, which means that many direct services must be provided by private physicians hired on a part-time basis; such arrangements are commonly regarded as promoting coordination and mutual understanding between public health and medical practice. At least one province (Saskatchewan) also regards large units as necessary from the point of view of developing regional prepaid medical care administration and co-ordination with enlarged hospital service districts.

In any province, regardless of general policies, the local pattern of population distribution dominates the determination of boundaries. Units made up of cities consolidated for health purposes with surrounding rural areas are large in population and small in area, while units serving thinly populated rural territory are small in population and large in area.

Various other specific considerations will affect the size of any particular unit. As stated in an official report: "Many factors such as natural boundaries, available transportation, existing health facilities, social and economic

conditions and the wishes of the local area must be considered when fixing the boundaries of any health region."(6) Another report points out that, "The boundaries of a health unit should coincide with those of a normal trading area with a good town as its logical centre in order that the office may be as accessible as possible to all members of the community."(7)

Finally, of course, the existing boundaries of municipalities or special purpose units of administration will affect health unit boundaries. Health units may be composed of groups of municipalities, groups of school districts, or groups of hospital districts. In some provinces a single county or groups of counties may compose a unit. Although the boundaries of such units are likely to reflect fundamental geographic and economic factors, their existence may modify the ideal administrative unit for public health functions.

Distribution of Full-Time Health Units by Size

At the end of 1952, Canada maintained 152 full-time health units or districts, exclusive of full-time city health departments. The mean population per unit was approximately 70,000. Table VI below, which shows the range of population and area of health units in seven provinces, indicates the wide variation in size within provinces as well as between provinces in 1952. The mean population per unit varied from about 22,000

6) Saskatchewan, Health Survey Committee, Saskatchewan Health Survey Report I, Health Programs and Personnel, Regina, Sask: The Committee, 1951, p. 34.

7) Alberta, Health Survey Committee, A Survey of Alberta's Health, Edmonton, Alta: Department of Public Health, 1950, p. 28.

TABLE VI RANGE OF POPULATION AND AREA OF FULL-TIME HEALTH UNITS AND DISTRICTS BY PROVINCE DECEMBER 31, 1952(1)

Province	Number of Units	Mean Population Per Unit	Median Population Per Unit	Population of Largest and Smallest Unit		Mean Area Per Unit in Square Miles	Median Area Per Unit in Square Miles	Area of Largest and Smallest Unit in Square Miles	
				Largest	Smallest			Largest	Smallest
ritish Columbia	15	37,023	33,545	61,789	12,774	11,184	4,881	50,603	298
lberta	14	27,758	23,454	44,970	19,310	4,084	3,528	7,984	1,540
askatchewan	8	47,203	52,452	77,944	11,800	9,256	8,892	15,030	5,544
anitoba	13	21,920	18,146	50,000	12,591	2,000	1,100	10,048	9
ntario	27	47,556	45,000	97,721	16,000	894	901	2,200	7
uebec	67	38,394	35,264	90,000	10,000	3,152	780	75,225	8
ova Scotia	8	69,624	74,572	90,874	47,710	2,592	(2)	(2)	
anada	152	39,604	(3)	97,721	10,000	3,823	(3)	75,225	7

(1) Based on unpublished material showing area and population of each health unit supplied to Research Division, Department of National Health and Welfare by provincial health departments. Full-time urban health departments are not included.
(2) Information not available.
(3) Not calculated.

in Manitoba to about 70,000 in Nova Scotia; the mean area varied from 11,200 square miles in British Columbia to 900 square miles in Ontario. The smallest unit, located in the Magdalen Islands, Quebec, contained 10,000 persons, while the largest, in Simcoe County, Ontario, had a population of 97,721. With respect to area one joint unit in Ontario contained 7 square miles of territory while in Quebec there was a unit covering 75,225 square miles.

Since the mean population or area of all health units in a province is significantly affected by the number of units in remote areas or the number containing sizeable cities, provincial policies in determining boundaries can only be analyzed by isolating rural units with roughly similar population densities. In Table VII rural health units with population densities exceeding 3 per square mile are separated from sparsely populated units with less than 3 persons per square mile, and from combined rural-urban units containing one or more incorporated cities, towns or villages of more than 10,000 population. This table shows that 12 sparsely populated rural units had a mean population of about 26,000; 93 rural units with a population density exceeding 3 per square mile had a mean population over 34,000; the mean population of combined rural-urban health units was 55,000 persons.

Analysis of 93 rural health units with densities exceeding 3 per square mile reveals distinct differences in size of units between provinces. In 1952, as shown in Table VII,

TABLE VII MEAN POPULATION OF FULL-TIME HEALTH UNITS AND DISTRICTS GROUPED BY POPULATION DENSITY AND BY PROVINCE, DECEMBER 31, 1952(1)

Province	All Health Units		Rural Health Units with Population Density Less than 3 per square mile		Rural Health Units with Population Density Exceeding 3 per square mile		Rural-Urban Health Units Containing Incorporated City, Town or Village with 10,000 or more population	
	Number of Units	Mean Population Per Unit	Number of Units	Mean Population Per Unit	Number of Units	Mean Population Per Unit	Number of Units	Mean Population Per Unit
ritish Columbia	15	37,023	5	24,554	7	40,845	3	44,898
lberta	14	27,758	1	21,601	12	27,773	1	33,730
askatchewan	8	47,203	1	11,800	5	54,226	2	48,455
anitoba	13	21,920	2	17,217	9	23,833	2	23,250
ntario	27	47,556	0	-	15	36,792	12	65,392
uebec	67	38,394	3	40,977	41	30,911	23	51,439
ova Scotia	8	69,624	0	-	4	62,568	4	76,681
anada	152	39,604	12	26,128	93	34,132	47	55,029

(1) Based on unpublished material showing area and population of each health unit supplied to Research Division, Department of National Health and Welfare by provincial health departments. Full-time urban health departments are not included.

Health units in Alberta and Manitoba were relatively small in size, averaging less than 30,000 persons per unit. In British Columbia, Ontario and Quebec the mean population was between 30,000 and 50,000. Larger districts or regions in rural Saskatchewan and Nova Scotia exceeded 50,000 in mean population per unit.

Table VIII following indicates a trend towards larger health units between 1948 and 1952. While some of the population increase arises from natural growth, some arises from the addition of territory to existing units or the formation of new larger units.

Provinces With Small Size Health Units

The two largely rural provinces of Alberta and Manitoba have experimented with relatively small health units averaging less than 30,000 persons per unit. While the maintenance of small units was recommended in the 1950 Alberta Health Survey Report,(8) somewhat larger units have been developed since 1951. In Manitoba, on the other hand, larger units were recommended by a Health Survey Committee,(9) but so far there has been no substantial increase in size.

Alberta: The development of enlarged rural municipal districts and enlarged school divisions has affected the determination of health unit boundaries in Alberta. Prior to 1951,

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8) Alberta, Health Survey Committee, Op. Cit., p. 28.

9) Manitoba, Advisory Health Survey Committee, Op. Cit. p.32.

TABLE VIII MEAN POPULATION AND AREA OF FULL-TIME HEALTH UNITS AND DISTRICTS BY PROVINCE 1948 AND 1952(1)

Province	Number of Units		Mean Population Per Unit		Mean Area Per Unit in Square Miles	
	1948	1952	1948	1952	1948	1952
ritish Columbia	8	15	30,398	37,023	16,530	11,184
lberta	9	14	17,245	27,758	1,860	4,084
askatchewan	6	8	42,638	47,203	8,550	9,256
anitoba	13	13	18,190	21,920	1,980	2,000
ntario	24	27	44,792	47,556	550	894
uebec	65	67	35,036	38,394	3,240	3,152
ova Scotia	7	8	79,140	69,624	2,960	2,592
anada	132	152	36,393	39,604	3,550	3,823

(1) 1948 data based on Provincial Health Survey Reports, Reporting Form D.
1952 data based on unpublished material supplied to Research Division, Department of National Health and Welfare by provincial health departments. Full-time urban health departments are not included.

boundaries of health units were usually based on one or two rural municipal districts or one or two school divisions containing from 15,000 to 20,000 persons; full-time units numbered nine. The Alberta Health Survey Committee in 1950 recommended the development of 24 rural health units averaging 22,600 population. As stated by the Committee, "...It was felt that the size of a standard health unit should be such that all medical work entailed could be handled by the health officer in charge so that he may maintain a direct personal contact with the public and a first hand knowledge of local problems".(10)

Following the 1951 Health Unit Act existing units were enlarged and new units were established. It is clear from Table VIII that the increase in mean unit population from about 17,000 persons in 1948 to 28,000 in 1952 was caused mainly by extension of area rather than natural population growth. Existing health units are composed of larger groups of municipal districts than before. According to the Health Unit Act they may include any combination of towns, villages, municipal districts, improvement districts, special area or cities with a population under 50,000.(11) These are rural units; only one of 14 contains an incorporated city, town or village of 10,000 or more population.

Manitoba: The relatively small size of health units in Manitoba seems to arise from recommendations contained

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(10) Alberta, Health Survey Committee, Op. Cit., pp. 28-29.

(11) Statutes of Alberta, 1951, c. 23.

n a special study of Public Health in Manitoba made in 1941; 3 units with an average population of 15,000 were recommended.(12) While three early units before 1941 were all ocated in urban and suburban areas, after that time new nits were developed in rural territory. In 1948, the mean opulation of 13 health units was 18,200 persons.

n a new health unit plan developed a ppart of the anitoba Health Survey Report, 15 enlarged units were recommended in 1950. with an average unit population of 31,000 ersons.(13) Under this plan, each proposed health unit area was made up of varying numbers of local hospital districts. t was further recommended that funds be made available to ermit the part-time employment of practising physicians no would assist in performing certain clinical services.(13)

t the end of 1952 the total number of health nits in Manitoba was still 13 while the mean population er unit had increased to 21,900 persons. Most of the increase arose from the normal expansion of population rather han the addition of new territory to existing units.

rovinces with Medium Size Health Units

he three highly industrialized provinces of ritish Columbia. Ontario,and Quebec each have a number of ombined urban-rural health units, with large populations.

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12) Buck, Carl E., Public Health in Manitoba 1941, Report f a Study made by the American Public Health Association, ew York: The Association. 1941, pp. 101-103.

13) Manitoba,Advisory Health Survey Committee, Op. Cit., p. 32-34 and Appendix III.

For rural units with population densities in excess of 3 per square mile, the mean population has varied between 30,000 and 50,000 persons per unit. Health unit boundaries are mainly based on existing special purpose or general purpose units of government. In British Columbia, health units are usually made up of two or three enlarged school districts. Most health units in Quebec and Ontario are single county, multi-county, or city-county units. In these provinces there is no definite policy on the employment of private physicians to assist in performing clinical services on a part-time basis.

British Columbia: In British Columbia, provincial plans for health units are designed to cover the province with 18 units serving populated areas outside Greater Vancouver and Greater Victoria.(14) This development is governed to a considerable extent by geographical and topographical factors, since the population is scattered and dispersed with much of the area of the province uninhabited and uninhabitable. The planned units are mainly modelled on groups of enlarged school districts carefully organized on the basis of the 1946 Cameron Report. The general policy is that health units should contain from 30,000 to 40,000 population.

The method of planning health unit boundaries has been outlined in the 1951 Annual Report of the Provincial Health Branch as follows:

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14) British Columbia: Department of Health and Welfare (Health Branch), Sixth Annual Report, 1951. Victoria, B.C: Queen's Printer, 1952, p. 11.

"In the original planning of health units, division of the Province into potential health unit areas was designed on the basis of such factors as population distribution, school district boundaries, geographical contours, distances of travel and road conditions. With these factors in mind the units were organized around at least one main centre of population, but including a number of communities or municipalities and a number of school districts for which it was felt efficient service could be provided by a staff localized and resident throughout the area. In the beginning, it was not always possible to commence the unit with the provision of service to the entire area, and often the unit in its initial stages included only a part of the proposed area on the principle that expansion to include the ultimate area would take place as the organization became consolidated." (15)

Between 1948 and 1952 the number of health units increased from 8 to 15. As shown in Table VIII the mean population per unit increased from 30,400 to 37,000 over this period. Three of the units in 1952 were combined rural-urban units, while 5 others were rural units with very low population densities. Table VII shows that in the 7 rural units with population density in excess of 3 per square mile, the mean population was 40,845.

Ontario: The two-tier organization of municipal government in Ontario has permitted the organization of health

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15) British Columbia: Dept. of Health and Welfare (Health Branch), Sixth Annual Report, 1951. Victoria, B.C: Queen's Printer, 1952, p. 37.

nits based on county boundaries. Of 27 health units existing at the end of 1952, 22 were located at least partly in Southern ntario counties, while 5 units in Northern Ontario formed part of territorial districts. Eighteen units included entire counties, while 4 were limited to part of a county. Not all hese health units were rural in nature. Twelve units included cities or towns containing 10,000 or more population.(16)

Since cities and "separated" towns are included in many Ontario health units the mean population per unit is high. If, however, only rural units with a population density exceeding 3 per square mile are considered, Table VII shows a mean population per unit of 36,800. No attempt has yet been made to establish multi-county health units except where counties are already united for municipal purposes.

Quebec: Of 67 Quebec health units in 1952, 57 were county units, 2 served half a county each, and 8 were multi-county units. Twenty-three health units included cities or towns over 10,000 population. Of these, 3 included 3 cities over 10,000 population plus rural areas, 18 included a single city and rural territory, while 2 consisted of cities only.(17) The mean population of rural-urban units was 51,500.

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16) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by Ontario Department of Health.

17) Based on Quebec, Ministere de la Sante, L'Enquete sur les Services de Sante de la Province de Quebec. III. Services de Sante Provinciaux. Quebec: Ministere 1951.pp.84-169, and Dominion Bureau of Statistics, Incorporated Cities, Towns and Villages, Population Bulletin: 1-9. Ottawa: Queen's Printer, 1952.

almost the entire rural area of the province was covered by health units. Most of the 41 rural units with a population density exceeding 3 per square mile were based on single counties. Since many Quebec counties are rather small, the mean population of these 41 units was only 30,900 in 1952.

To facilitate provincial administration, the Quebec Health Survey Report of 1951 recommended the grouping of health units into 24 health districts each composed of 3 or 4 health units and including about 100,000 inhabitants.(18). This suggested system of enlarged health districts is discussed further in Chapter IV.

Provinces With Large Size Health Units

The two primarily rural provinces of Saskatchewan and Nova Scotia have developed larger rural health units than the other provinces. In both provinces great emphasis is placed on the importance of administrative efficiency. The medical health officer administers a wide area, and many personal health services are provided by private practitioners. In health planning, as indicated in provincial health survey reports, public health districts are almost coterminous with planned hospital districts. Nevertheless, the reasons for and the thinking behind the development of these districts has differed greatly between the two provinces.

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18) Quebec, Ministere de la Sante, L'Enquete sur Les Services de Sante de la Province de Quebec. I. Presentation et Synthese du Rapport, Quebec: Ministere, 1951, pp.14-15.

Saskatchewan: In Saskatchewan, health units are termed "health regions", and concepts of regional planning dominate thinking in this province. Health region authorities are empowered to introduce regional medical care insurance, and health regions are considered as potential units of medical care administration as well as public health administration.(19) Under this system, the functions of the regional medical health officer are primarily administrative and efforts are made to have school medical examinations and clinics done by local physicians, while immunizations are done by public health nurses.

The Saskatchewan Health Survey Report of 1951 recommended the division of the province into 12 health regions coinciding with planned hospital service areas, or alternatively 14 health regions.(20) As stated in the report, "For Saskatchewan, an area of 7,500 to 10,000 square miles with a population of 50,000 to 65,000 is considered to be the most suitable size for a public health region, although many factors such as natural boundaries, available transportation, existing health facilities, social and economic conditions, and the wishes of the local area must be considered when fixing the boundaries of any health region."(21)

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(19) Only one region, the Swift Current Health Region, has introduced a public medical care insurance program. This pilot scheme has been in operation since 1946.

(20) Saskatchewan, Health Survey Committee, Saskatchewan Health Survey Report. I. Health Programs and Personnel, Regina, Sask: The Committee, pp.36-39.

(21) Saskatchewan, Health Survey Committee, Op. Cit., p. 34.

By the end of 1952, 8 health regions had been set up. Of the rural regions with a population density exceeding 3 per square mile, the mean population per region was 54,200. Although the cities of Regina and Saskatoon have not participated in health regions, 2 of the 8 regions contained cities of more than 10,000 population.

Nova Scotia: In Nova Scotia, health districts, which are termed "health divisions", are simply field service areas of the provincial health department. In contrast to Saskatchewan where regions are established only when fairly complete staff can be provided, the entire province of Nova Scotia, exclusive of the city of Halifax, is included in the health divisions. The number and boundaries of the health divisions are changed from time to time depending on the number of medical health officers available. Since local consent is not a factor in the establishment of provincial divisions, relatively large areas may be included. At the same time, part-time municipal medical health officers continue to undertake minor functions, thus relieving divisional medical health officers from directly providing certain services.

The system of large districts was supported in the 1950 Nova Scotia Health Survey Report as follows: "Many of the counties are too small in area or too low in population to serve as individual health or hospital units... However, it is fortunate that groups of counties or municipalities are so separated by natural barriers that the province is

readily divided into nine regions. These are relatively distinct geographic units which are of a suitable size and population to serve as administrative units for health services, and presumably also for hospital and medical care services, if such are organized at any future date".(22)

In 1952, eight health divisions exclusive of the city of Halifax had a mean population of 69,600 persons.

Provinces Lacking Full-Time Units or Districts

Less complete local public health services are available through health districts in New Brunswick, Prince Edward Island and Newfoundland. Recommendations not yet implemented have been made in provincial health survey reports for the development of full-time services in New Brunswick and Prince Edward Island. Newfoundland's health survey report has not yet been completed.

New Brunswick: The size of New Brunswick's provincial health districts has usually depended on the number of medical health officers available. In 1952 there were 6 districts serving the entire province, with a mean population per district fo 86,000 persons. Included within the 6 provincial districts were 16 sub-districts based on county boundaries as described in Chapter II.

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22) Nova Scotia, Health Survey Committee, Report on the Survey of Health Facilities and Services in Nova Scotia 1949-50. By Stewart, C.B., Halifax: The Committee, 1950. p. 37.

The New Brunswick Health Survey Report recommended the reorganization of local health services through nine health districts to replace both provincial districts and local sub-districts. Three of the recommended districts coincided with counties while the others included several counties or parts of counties. In each district would be provided a unified local public health service including public health nurses, sanitary inspectors, and clerks under the direction of a full-time medical health officer.(23)

Prince Edward Island: In 1948, Prince Edward Island was demarcated for purposes of health administration and public health nursing services into six areas of which one was a full county, and the remaining five were parts of counties.(24) The province's three counties are simply geographic subdivisions and not units of local government.(25)

In planning the reorganization of more suitable nursing units of smaller size, the Prince Edward Island Health Survey Report selected the approximately 480 school districts as blocks of territory. It was recommended that 20 health districts be established for nursing administration, each containing 20 to 30 school districts and from 4,000 to 7,000

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(23) New Brunswick, Health Survey Committee, Report of the Health Survey Committee, Fredericton, N.B: The Committee, 1951, pp. 323-330.

(24) Prince Edward Island, Provincial Health Planning Commission, A Report Prepared by the Provincial Health Planning Commission for Presentation to the Government of the Province of Prince Edward Island, Charlottetown: The Commission, n.d., p. 16.

(25) MacKinnon, Frank, The Goverment of Prince Edward Island, Toronto: University of Toronto Press, 1951, p. 274.

persons. In addition, two health areas each under the jurisdiction of a full-time medical health officer were recommended, with each health area containing 10 health districts. All districts and areas were to be administered and served by the provincial health department.(26)

In 1952, as mentioned in Chapter II, ten provincial public health nursing districts were in operation but no medical health officers had yet been appointed to the two health areas.

Newfoundland: Newfoundland's 17 cottage hospital districts contained 152,654 persons in 1952, so that the mean population per district was less than 10,000. These districts were all located along the province's sparsely populated coastline, and were concerned mainly with the provision of medical and hospital care. As mentioned in Chapter II, the only full-time local public health organization in the province was the provincially operated service for the city of St. John's population.

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(26) Prince Edward Island, Provincial Health Planning Commission, Op. Cit., pp.16-26.

CHAPTER IV

ADMINISTRATIVE STRUCTURE AND RELATIONSHIPS

While the establishment of enlarged public health units permits the extension of full-time local public health services to rural areas, it does not necessarily guarantee local control and participation in the operation of these services. Specialization of equipment, knowledge and personnel has led to increasing participation by higher-level government in the actual operation of local programs. When services are developed and financed from local funds as in the larger cities, a minimum of provincial control is required. However, when joint-municipal units are promoted and financially supported by a province, it becomes a matter of provincial concern to see that the program is being carried out at least at the standard of performance which provincial authorities consider essential. Centralized provincial control for purposes of efficiency may then seriously jeopardize local interest and participation. As stated by one authority "One of the most perplexing problems of administration is the proper relationship between administrative levels or units which enjoy a certain degree of autonomy".(1)

To understand the administrative structure and relationships of local health organizations it is necessary to consider both the executive and policy-making levels of organization. In each local jurisdiction, the chief executive

(1) Pfiffner, John M., Public Administration, Revised Edition, New York: Ronald Press Co., 1946, p. 129.

s the medical health officer, while determination of policy s theoretically, if not in practice, the function of a local oard of health representing local residents. Provincial oncern for the maintenance of minimum standards is reflected n both spheres of organization. In addition to general egislation defining local organization, duties and powers, ach provincial government, through its health department, main- ains some degree of administrative supervision over local perations and participates in the determination of policy.

ome General Features of Local Internal Administrative Structure

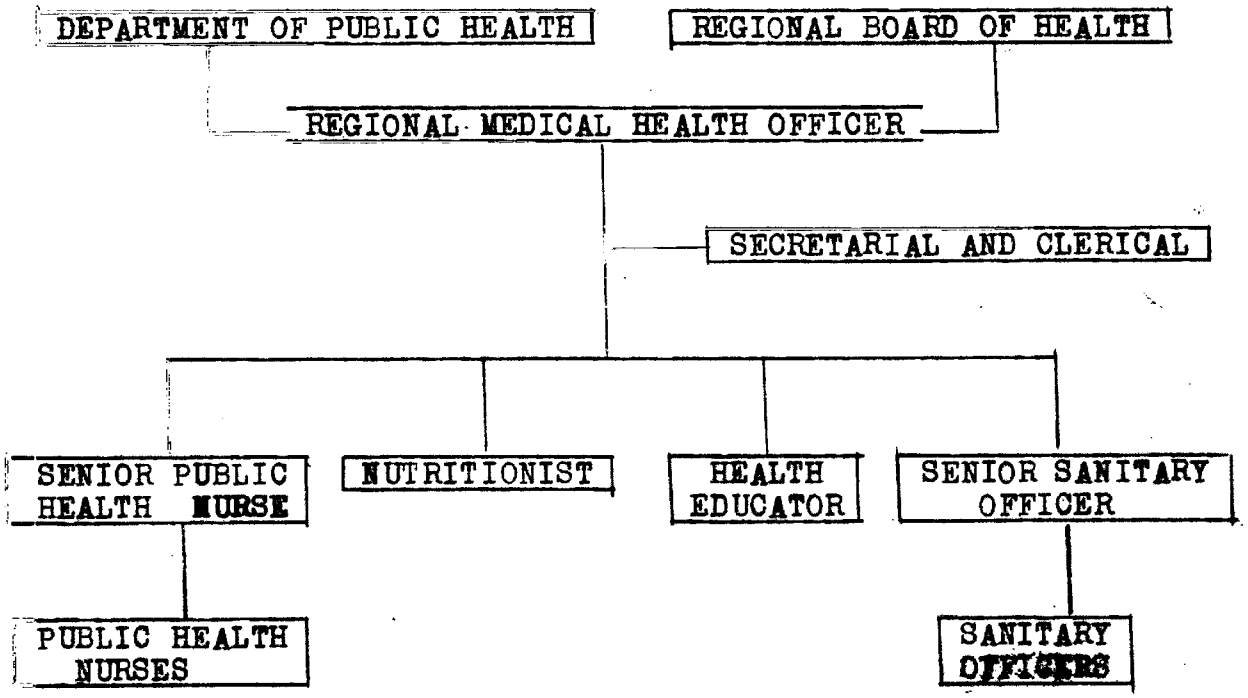
he internal administrative structure has been argely standardized in all full-time health units or health epartments. Associated local public health activities are ntegrated under the unified administrative direction of a edical health officer. Together with his local health staff he medical health officer is responsible for the administra- ion of statutes, regulations and by-laws and the provision f public health services. In addition to public health urses, sanitary inspectors and clerical staff, other pecialists such as nutritionists, health educators, labora- ory technicians, dental officers, psychiatrists and sanitary ngineers may be employed.

ural Health Units: Under the medical health officer he principal sub-divisions of the work are differentiated on he basis of major purpose or function. Within each functional

group, the work organization is further subdivided on the basis of geographic areas. The organization chart of a large rural health unit is shown in Figure I below.

FIGURE I

ORGANIZATION OF A SASKATCHEWAN HEALTH REGION(1)



1) Based on Saskatchewan, Health Survey Committee, Saskatchewan Health Survey Report.I. Health Programs and Personnel. Regina, Sask: The Committee, 1951, p. 35.

The role of the health unit medical health officer varies between provinces, but generally he is limited to preventive and promotional activities. A typical example is the health officer in Manitoba whose duties are set out in the Manitoba Manual of Procedures and Duties for the Personnel of Local Health Units as follows:

"The medical director shall

(1) be the medical officer of health for each municipality, or part of a municipality, which forms a part of the local health unit of which he is appointed the medical director, and as such, he shall be responsible for the enforcement of:

(a) THE PUBLIC HEALTH ACT and regulations made thereunder;

(b) the health provisions of any other provincial Act and regulations made thereunder,

(c) any by-law pertaining to the health of the people within the boundaries of the local health unit which has been passed by a municipal council of any municipality, or part of a municipality, which forms a part of the local health unit; Providing that such by-law is not inconsistent with the provisions of The Public Health Act and regulations made thereunder, or the health provisions of any other statute of the Province of Manitoba and regulations made thereunder.

(2) be responsible for the carrying out of policies as laid down for the operation of the local health unit by

(a) the minister

(b) the board

(3) act as the secretary-treasurer of the board of the local health unit, but shall not be a member of the board with power to vote.

(4) be responsible for the organization, supervision, performance and reporting of all work done by all members of the staff of the local health unit.

(5) develop the preventive field in prenatal and maternal hygiene and where conditions in the local health unit indicate that it is desirable, arrange for the establishment of prenatal and post-natal clinics.

(6) develop a child hygiene service, and establish well-baby and pre-school clinics where deemed desirable.

(7) organize school health programmes and carry out, as often as circumstances permit, periodic physical examinations of school children: Reporting any discovery of defects to the parents or guardians and encouraging the early correction of same.

(8) carry out a full immunization programme against those diseases which can be so controlled and offer immunization to all children requiring it at well-baby and pre-school clinics as well as at the periodic school examination.

(9) keep available at all times a supply of those biologics supplied by the Department for free use by the physicians.

(10) be responsible for the control of venereal disease within his jurisdiction and, at the request of the director, conduct, facilitate, or cause to be conducted, venereal disease clinics.

(11) facilitate all measures for the control of tuberculosis within his local health unit area, and co-operate with the travelling tuberculosis clinic and the local medical profession in this regard.

(12) be responsible for the control of all other communicable diseases within his local health unit area, and for the enforcement of regulations hereto made under The Public Health Act: And act as consultant to any practising physician in the district when so requested.

(13) facilitate, or cause to be conducted, with the aid of those having special knowledge and training in this field, a mental health programme.

(14) be responsible for, or cause to be carried out, a sustained programme for general health education.

(15) endeavour to keep in readily available form all statistics relating to the health of the community; including preventive services rendered by private physicians or institutions.

(16) be responsible for the inspection and supervision of maternity homes, child caring homes, and institutions and homes for the care of the aged and infirm, within the area of the unit; and insure they operated under permit issued under regulations of The Public Health Act.

(17) co-operate with other agencies in regard to the health and well-being of the people.

(18) attend conferences at the time and place designated by the minister.

(19) prepare, each month, for the month immediately preceding:

(a) a full report on the work of the members of the staff on forms specified by the minister,

(b) a financial statement on forms specified by the minister;

Five copies of the above report shall be prepared and distributed as follows:

(a) one copy shall be presented to the board.

(b) three copies shall be forwarded to the director; one for the commission, one for the minister and one for the department files.

(c) one copy shall be kept for the records of the unit.

(20) prepare, or cause to be prepared, at the end of each calendar year, a report on the operation of the unit on forms specified by the minister, and forward four copies of same to the director not later than the thirty-first day of January of the next succeeding year.*(2)

Urban Health Departments: In the larger urban health departments, the internal administrative structure becomes more complex, and functions are sub-divided into a larger number of divisions. Thus, for example, in 1952 the Montreal City Health Department included the following

(2) Manitoba, Department of Health and Public Welfare, Manual of Procedures and Duties for the Personnel of Local Health Units, n.d., (mimeo.), pp. 3-4.

divisions:health education. demography, sanitary inspection, venereal disease, communicable diseases, child hygiene including pre-natal and pre-school hygiene, school medical inspection, dental hygiene, mental hygiene and nutrition, medical control, tuberculosis, food inspection,laboratories and health districts.(3)

A further development has been the decentralization of certain activities on the basis of geographical areas, in order to localize certain public health services in health districts. Under this arrangement, direct services such as well-baby clinics, public health nursing and school health services are under the unified direction of a full-time district medical health officer. General supervision is exercised by the senior municipal medical health officer, and specialist consultant services are provided by the various health divisions in the same manner as provincial health departments assist local health units. Thus, for example, the metropolitan area of Greater Vancouver is divided into 6 health units each staffed with a public health physician as director, a supervisor of nurses, public health nurses and clerical staff.(4) The City of Montreal is divided into 9 health

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3) City of Montreal, Dept. of Health, 1952 Annual Report, Montreal: The City, p. 7.

4) British Columbia, Dept. of Health and Welfare, Survey of Health Services and Facilities in British Columbia, By Elliott, G.R.F., Victoria, B.C: Queen's Printer, p. 41.

districts each with a full-time medical health officer, other full or part-time physicians, one supervisory nurse, 5 to 20 public health nurses and a clerk.[5)]

Local Boards of Health

The agency legally responsible for the local administration of public health services is usually a local board of health with jurisdiction either within the boundaries of a single municipality or in a special purpose district covering a number of municipalities. Local boards are responsible for the local administration and enforcement of provincial statutes and regulations relating to public health, as well as municipal public health by-laws. Policy making powers, however, are usually limited to details. Where services are provided on a municipal basis, general policy determination is largely a function of the municipal legislative body. In intermunicipal health units, local boards in some provinces have been delegated extensive policy making powers, while in others their role is essentially advisory to the provincial health department.

Although most local boards are appointed by or consist of municipal councillors, it is likely that they were originally conceived as a device to remove public health from local politics. As stated by one authority, " ... in

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5) Quebec, Ministere de la Sante, L'Enquete sur Les Services de Sante de la Province de Quebec. IV. Services de Sante Municipaux, Quebec, Ministere, 1951, pp. 34-36.

imitation of Great Britain and the United States, such special bodies were frequently provided for in Canadian municipal systems which were developing at the time when the British and the United States policy favoured decentralization within the municipal structure."(6) In the nineteenth century, when the first municipal boards of health were established, provincial governments probably considered that such boards would be more amenable to provincial guidance than municipal councils. More recently, the development of health unit boards of health has served as a useful device for representing various municipalities and citizen groups.

Municipal Health Boards: Municipal boards of health are usually composed of members of the municipal council. In provinces where other persons may be appointed, municipal councils retain control over appointment. Some provinces make provision for the medical health officer to be an ex officio member of the board.

Table IX shows the consititution of municipal boards of health as specified in provincial Public Health Acts. Although the three provinces of Manitoba, Quebec and Newfoundland make no specific provision for municipal boards, municipal councils in these provinces may exercise similar functions under the broad provisions of municipal acts. For some cities, particularly in Quebec and Nova Scotia,

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(6) Crawford, K.Grant, Local Government in Canada, Queen's University, (mimeo.), p. 105.

TABLE IX COMPOSITION OF MUNICIPAL BOARDS OF HEALTH AS SPECIFIED IN PROVINCIAL PUBLIC HEALTH ACTS

Province	Municipal Unit	Membership of Board of Health	
		Ex Officio Members	Members Appointed by Municipal Council
British Columbia	Cities, Villages, District Municipalities	Municipal Councillors	
Alberta	Cities, Towns	Mayor, Municipal Engineer, Medical Health Officer	Three Ratepayers
	Villages, Municipal Districts	Municipal Councillors Medical Health Officer	
Saskatchewan	Cities, Towns, Villages, Rural Municipalities	Municipal Councillors or alternatively in cities a Committee of Municipal Council	
Ontario	Cities and Towns Over 4,000 Population	Mayor, Medical Health Officer	Three Resident Ratepayers (In cities over 100,000 population, council may appoint five resident ratepayers two of which must not be councillors)
	Other Towns, Villages, Townships	Head of Municipality, Medical Health Officer	One Resident Ratepayer
New Brunswick	Counties	Medical Health Officer	One appointed by Provincial Government; four appointed by County Municipality; one appointed by Cities and Towns between 2,000 and 10,000 population; two appointed by Cities and Towns between 10,000 and 20,000 population; three appointed by Cities over 20,000 population.
Nova Scotia	Towns	Municipal Councillors, Medical Health Officer	
	Rural Municipalities	Medical Health Officer	As specified by Provincial Government
Prince Edward Island	Cities, Towns	Municipal Councillors	

city charters specify that the city council or a health committee of the council shall act as the board of health.

Of special interest is the fact that Alberta and Ontario provide for representation of ratepayers who are not necessarily members of the municipal council; the medical health officer is also an ex officio member of the board. Alberta is the only province to specify three year overlapping terms for appointed members.(7) Ontario is the only province that requires several meetings a year - at least four, and the only province that authorizes payment of board members - up to $4 per meeting plus travelling expenses.(8) It may also be noted that in Alberta each municipal council "shall in each year vote such sums as in the opinion of the local board are necessary for the carrying on of the work ... within its boundaries",(7) while in Ontario, "the treasurer of the municipality shall forthwith upon demand pay the account of any services performed under the direction of the board..."(8) As indicated later, these efforts to strengthen municipal boards of health are paralleled by a strong emphasis on local responsibility for health unit services in these two provinces.

New Brunswick differs from the other provinces in authorizing "Sub-District" boards of health at the county

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7) Revised Statutes of Alberta, 1942, c. 183.

8) Revised Statutes of Ontario, 1950, c. 306.

level to replace city, town and rural municipal boards.(9) These are joint boards composed of representatives appointed by contained cities and towns as well as by county councils and the provincial government. While each county council appoints four members, the number of additional members from cities and towns is in proportion to population with a maximum of three representatives for a city over 20,000 population. The provincial government appoints one other member in addition to the provincial district medical health officer who is ex officio chairman of the board.

Metropolitan Health Committee of Greater Vancouver: Although the advantages of efficient administration, common standards, and avoidance of duplication through the joint provision of services in large metropolitan areas are evident, such an amalgamation of public health services has taken place only in the metropolitan area of Greater Vancouver.(10) This consolidation of local health services in 1936 was particularly significant because it was the first of its kind in all North America.

The Metropolitan Health Committee of Greater Vancouver, which corresponds to a municipal board of health, is composed of representatives from municipal councils and

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(9) While Ontario also has some county boards of health, these are used as a means of providing full-time health unit services. Full-time services in New Brunswick are provided through provincial health districts.

(10) The new Greater Toronto metropolitan authority does not yet have any jurisdiction over public health services.

school boards in the area. The 20 Committee members include 8 from the City of Vancouver, 4 from the City and District Municipality of North Vancouver, 2 each from the District Municipalities of West Vancouver, Richmond and Burnaby, one from the University of British Columbia Area and one from District Lot No. 172.

By agreement the formula for union does not provide for a totally integrated department. General policies and procedure are determined centrally, and administrative control rests with the Senior Medical Health Officer of Vancouver who is responsible to the Committee. However, each local authority maintains its own budget and employs its own staff.(11)

Health Unit Boards of Health: Health unit boards serve to co-ordinate local public health services through a single local authority. Such boards usually assume the powers and duties of each contained municipal board of health and undertake responsibility for school health services. In some cases, as in Saskatchewan, intermunicipal boards may also be empowered to develop medical care services.

A primary purpose of health unit boards is to give participating municipalities a voice in health unit administration. This raises the problem of making the boards large enough to give adequate local representation while keeping them small enough for efficient and effective deliberation. Each municipality wants representation primarily to ensure

11) Murray, Stewart, "Administration of the Greater Vancouver Metropolitan Health Services", in Can. J. Pub. Health, Vol. 43, No.5, pp. 202-208.

that it receives what it considers a fair share of the service in return for payment of a fair share of the cost. Municipal representatives tend to consider themselves as "delegates" and look at health unit problems through the coloured glasses of their own municipality. The need for board members with an overall viewpoint can be partly met by having some members appointed by the provincial government. A further aid to efficiency is to have the medical health officer serve as secretary-treasurer, and to have technical representation from the medical profession. Another device to preserve continuity of approach while obtaining new viewpoints is to have rotation of membership with overlapping terms.

Some features of health unit boards of health in five provinces are presented in tabular form in Table X. In the provinces of Ontario and Alberta where boards have been delegated extensive administrative powers, boards are relatively small in size and their constitution is generally designed to facilitate efficient operation. In Manitoba, Saskatchewan and British Columbia the role of health unit boards is largely advisory and a primary function is liaison with the general public. Consequently, these boards tend to be larger with wide-spread representation from participating municipalities. In Quebec where the control of health units is highly centralized, no provision is made for local boards of health.

In Ontario and Alberta, as indicated in Table X,

health unit boards average five or six members. Small boards are facilitated in Ontario by the fact that most health units are composed partly of counties. This means that representation of counties replaces the need for representation from each municipality contained in the county. Where units include cities or "separated" towns combined with a county, or are formed outside county areas, the number of members usually exceeds six.(12)

In Alberta, small boards have been arranged through the device of dividing each health unit into health wards - usually five in number. Each ward is represented by one board member who is appointed by the municipality having the largest population within the ward.(13) Strict control of the size of health unit boards in Alberta probably is the result of experience prior to the 1951 Health Unit Act when the boards were much more unwieldy bodies than they are today. Board members were nominated by participating municipal councils, school boards and any other interested groups; usually all nominations were approved by the Minister of Public Health who fixed the representation. Since each municipality, regardless of size, demanded at least one representative, some of the boards had as many as 30 members.

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12) Based on Ontario Consolidated Regulations 335/50.

13) Statutes of Alberta, 1951, c. 23.

Municipal and county councils in Alberta and Ontario maintain continuous control over their representatives since appointments are at the pleasure of the appointing council, in some Ontario units, however, appointments may be rotated annually between a number of municipalities. Ontario also provides for one appointment in each unit by the provincial government. It is noteworthy that these two provinces provide for the highest maximum remuneration of board members for attendance at meetings.

Manitoba, Saskatchewan and British Columbia vary greatly in the method of appointment of board members, but generally the boards are larger in size than in Ontario and Alberta, reflecting a preoccupation with widespread local representation. Saskatchewan and Manitoba, however, have made an effort to have boards composed of members with an overall viewpoint, rather than having simply a group of municipal delegates.

In Manitoba each municipality has one or more representatives on the board, but in addition, the Minister of Health and Public Welfare appoints citizen representatives from among local residents numbering at least two in a five-member board and at least three in a larger board; ministerial appointments must include one local physician and may not in total constitute a majority of all board members. Further provincial control is exercised, however, through the power

of the Minister to fix the number of representatives from each municipality, and to approve appointments made by municipal councils.(14)

Saskatchewan has maintained local appointment, but has established a two-tier structure to assure local participation while bringing in board members with a wider than municipal point of view. Every health region is divided into a number of health districts, each with a health council composed of representatives from all constituent municipalities and improvement districts; each municipal council and improvement district appoints one member. While district councils are intended to serve as forums for discussion and consultation, their main function is to elect representatives to the Regional Board of Health. The number of representatives from each health district is determined by the Minister of Public Health on a population basis.(15) Members hold office for three years, membership being on a rotating basis with one-third reappointed or replaced each year. Usually in Saskatchewan there is about one board member per 5,000 population. Although regional boards are fairly large, averaging nine members, this is mainly because of the relatively large size of health regions.

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14) S.M. 1945, c. 22 and Manitoba Regulation 36/48.

15) Saskatchewan O.C. 2026/48.

In British Columbia, where the role of union boards is essentially advisory and educational, the province exercises no control over the composition of the boards, and there is complete local self-determination with regard to organization and procedure. Each union board consists of representatives from participating municipal councils, school boards and other official bodies as mutually agreed upon.(16) The number of members varies from 6 to 20. Meetings are held quarterly to review the work of the health unit and to convey to the director opinions as to policy and work which should be done in their communities. Remuneration and travelling expenses of Board members are considered a municipal responsibility, which means that they are not paid for their work.

Provincial - Local Relations

Provincial governments are inevitably concerned with assuring minimum standards of performance in the provision of local public health services, which are of wider than local concern even though appropriate for administration through local units. While part of the means towards higher standards involves larger units and financial support, control and supervision of organization and activities is also necessary to promote efficiency.

In the legal and constitutional sense, provincial

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(16) R.S.B.C. 1948 c. 141.

control of local health services is absolute, for the legislative power of the provincial legislatures within the local sphere is exclusive and supreme. However, in all provinces responsibility has been decentralized through the delegation of subordinate powers to various local authorities. These powers are exercised within a framework circumscribed by provincial legislation, regulations, orders and direct administrative supervision.

Statutory control and administrative supervision are least extensive where public health services are still a municipal responsibility. Generally, each municipality is required to have a board of health and a medical health officer responsible for the local enforcement of provincial public health statutes and regulations. Since the medical health officer is the key to local health activity, some provinces specify standards of qualification and provincial approval of municipal appointments. In the provinces of Ontario and Manitoba, appointment is during good behaviour, and the incumbent cannot be removed from office except by a two-thirds majority vote of the whole council together with the consent of the Minister of Health who may require cause to be shown for dismissal.(17) Aside from such statutory require-

17) Statutory provisions for security of tenure are designed to protect medical health officers from local pressure groups. While responsible to the courts for enforcement of provincial statutes and regulations, the medical health officer is also the employee of the municipal council, which may order conflicting policies. As long as tenure of office and rate of pay rest entirely with the municipal council, the medical health officer is likely to follow council instructions regardless of provincial enactments.

ments. provincial supervision is usually limited to the provision of advisory and consultative services together with certain specialized direct services such as public health laboratories.

Intermunicipal health units involving provincial financial support represent a form of joint administration necessitating increased provincial control over standards and expenditures. In Ontario and Alberta, nevertheless, the degree of local autonomy in health units approaches that of municipal public health services. Health unit personnel are employed and paid by local boards of health, subject to provincial approval. Some provincial controls are exercised over standards and expenditures in relation to grants in aid, but administrative authority is placed in local hands and the administrative role of the province is mainly consultative.

In Manitoba, Saskatchewan, British Columbia and Quebec, basic health unit policies are determined by provincial health authorities, while health unit boards have mainly advisory functions; Quebec does not even have advisory boards. Provincial control extends to the appointment of medical health officers and other staff, the preparation and approval of local budgets, and administrative supervision of standards.

The Atlantic provinces have provincial health districts entirely administered and financed by provincial departments. Nova Scotia and New Brunswick also have locally

appointed boards with minor public health functions, while Prince Edward Island and Newfoundland provide for provincially appointed local advisory boards to present community viewpoints.

Administrative supervision, whether limited to advice and information, or extending to the direct operation of services, is centred in provincial health departments. In provinces with largely autonomous local health units, a provincial division of health units is responsible for promotional work and grant administration; technical consultative services in such fields as public health nursing, dental health, tuberculosis control, mental health, nutrition, sanitary engineering, industrial hygiene, maternal and child health, venereal diseases and epidemiology are made available separately by specialized divisions. In other provinces with greater central control of health units, provincial supervisory services are co-ordinated more closely through branches or bureaux of local health services. The smaller Atlantic provinces supervise provincial health districts through the central offices of the Deputy Ministers of Health.

Ontario and Alberta: The emphasis on the principle of local responsibility for public health services in Ontario and Alberta probably reflects the vigour of local government institutions in these provinces. In health units as well as municipal health departments policies are locally determined,

personnel are locally appointed, budgets are locally prepared and funds are locally controlled. Aside from advice and persuasion, provincial control over standards depends on certain statutory requirements and other conditions attached to provincial grants in aid.

The advantages of decentralizing responsibility to local health authorities are discussed in Chapter VII. It may be noted here, however, that local administration opens the way to wider participation by local citizens which strengthens public support for public health services. Although there are likely to be greater variations in policy to take account of differences in local conditions, minimum standards can be maintained through provincial regulatory control.

In Ontario, minimum service and staff requirements are specified as conditions for provincial grants to local health units, and minimum qualifications are required for locally appointed personnel. Minimum standards of service are determined separately for each health unit by the Minister of Health on the basis of a staff establishment considered sufficient to provide basic services. Formal qualification requirements for the appointment of medical health officers, public health nurses and sanitary inspectors are set out in provincial regulations.(18) Further regulations provide for approval of health unit staff appointments and salaries by the Minister of Health; moreover, the medical officer of

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(18) O. Reg. 16/44.

health may not be dismissed from office without the approval of a majority of board members and the consent of the Minister of Health.(19) In addition, there is mandatory statutory provision for an annual conference of all medical officers of health.(20)

Actually, provincial statutory control of municipal public health services is almost as extensive as the control of health units. Municipal public health officers must meet the same formal qualification requirements, must attend an annual conference and can be appointed only with the approval of the Minister of Health. A notable provision mentioned previously, is a measure which provides employment security for the municipal medical health officer; appointment is during good behaviour and the medical health officer cannot be removed from office except by a two-thirds vote of the whole municipal council, and with the consent and approval of the Minister of Public Health who may require cause to be shown for dismissal.(20)

In Alberta, provincial control of local health unit activities relates only to services for which provincial grants are payable. Thus, while local boards employ all staff including the medical health officer, staff appointments of

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(19) O. Reg. 57/45.

(20) Revised Statutes of Ontario, 1950, c. 306.

certain approved classes within a maximum staff entitlement for which salary costs are assisted by provincial grants, are subject to approval by the Minister of Public Health.(21) Similarly, a budget relating to expenditures for which provincial grants are payable must be approved by the Minister. Each board, however, may appoint additional staff outside approved classes or in excess of its maximum entitlement for grant purposes, and may pay salaries in excess of the provincial salary schedule.(22)

The provincial health department further controls standards of service by requiring each local board to draft a schedule of services to be provided as a basis for grant payments. Quarterly and annual reports are required from each board. Technical advice and consultative services are provided through various provincial specialized divisions, particularly the Division of Communicable Disease Control and Health Units. This division encourages the formation of additional units, assists in securing staff, and convenes periodic meetings of health unit medical health officers.(23)

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(21) Further details on staff entitlement provisions relating to provincial grants are set out in Chapter V.

(22) Statutes of Alberta, 1951, c. 23.

(23) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by Alberta Department of Public Health.

Manitoba, Saskatchewan, British Columbia and Quebec:

In three western provinces and Quebec, greater emphasis is placed on central direction to secure uniformity of standards and efficiency of operation. This is achieved primarily through provincial employment of personnel and direct supervision of local programs. To a considerable extent, in practice if not in theory, health unit boards serve as administrative agents of the provincial health department.

Direct provincial administrative supervision promotes close co-ordination and unity of effort. Uniformity of policy, approach and methods may enable higher standards of efficiency. Perhaps the main advantage arises in the recruitment of personnel. Provincial employment makes it easier to hire suitably trained persons when the position offers opportunities for promotion, transfer and specialization. Furthermore, it offers uniform salary schedules with regular increment, paid holidays and sick-leave privileges, and a superannuation scheme. Staff members may also be kept up to date by regular staff meetings, refresher courses and in-service training.

In Manitoba, health units are jointly operated by the provincial government and health unit boards, but staff are employed and allocated to the units by the provincial Department of Health and Public Welfare.(24) The staff carry

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24) Manitoba Advisory Health Survey Committee, An Abridgement of the Manitoba Health Survey Report, Winnipeg, Queen's Printer, 1953, p. 15.

out of the general programs and policies outlined by the provincial department and specified in the provincial Manual of Procedures and Duties for Personnel of Local Health Units.(25) Through its various bureaux and sections, the provincial department provides broad field supervisory services which are co-ordinated through the Bureau of Local Health Services.(26) Annual conferences and institutes are arranged for local health unit personnel. Recently, as recommended in the Manitoba Health Survey Report, a start has been made in adding a consultation-advisory field staff to the Bureau of Local Health Services to channel the plans and policies of the various specialized provincial divisions to local health units.(27)

Health unit boards of health in Manitoba are officially designed as "advisory", although they are also made responsible "for the local policies and activities of the unit relying on the advice of the local medical director",(28) The annual budget prepared by the unit Medical Director, who acts as secretary of the Board is subject to the approval of the Board except for salaries; all expenditures are authorized by the Board. Each Board may request replacement of

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(25) Manitoba, Advisory Health Survey Committee, Op. Cit., Appendix VI.

(26) Manitoba, Advisory Health Survey Committee, Op. Cit.,p.35.

(27) Manitoba: Department of Health and Public Welfare, 1952 Annual Report. Winnipeg, Queen's Printer, 1935, p. 115.

(28) Manitoba,Advisory Health Survey Committee, Op. Cit., Appendix V.

or transfer of staff and may recommend improvement of services and extension of activities. It is evident, however, that the main function of the board from the provincial point of view is "to act as liaison between the health unit and the public".(28)

In Saskatchewan, where regional health boards are empowered to introduce prepaid medical and dental services, the relationship of the provincial government to the administration of curative services differs markedly from the relationship in public health services. As described by Mott in connection with curative services: "The Regional Board has almost complete freedom of action and responsibility, subject to the approval of the Provincial Government. The members of the Board look to the Health Officer for advice, but they administer the medical care program through their own Secretary-Treasurer and staff."(29)

Public health services, on the other hand are provided by the regional medical health officer and his staff who are employees of the provincial Department of Public Health. The role of the regional boards is essentially advisory. As pointed out in an official report, "The regional board meets at least three or four times a year to review the programs,

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(28) Manitoba, Advisory Health Survey Committee, Op. Cit., Appendix V.

(29) Mott, F.D., "A Pattern of Local Services in the Saskatchewan Health Program", in Amer. J. Pub. Health, Vol. 39, No. 2, p. 2.

and to advise and consult with the regional medical health officer with respect to matters of policy in effect throughout the region".(30) Each board submits the regional budget to the Minister of Public Health, and may advise on the improvement of services and the extension of activities of the board.(31)

In addition to the appointment of regional public health personnel, the provincial health department approves regional budgets, controls public health expenditures, and determines general policies. Through the Regional Health Services Branch, programs are directly supervised to ensure minimum requirements and uniformity of standards, and technical consultative services are provided for field personnel.(32) Quarterly meetings of regional medical health officers are held, and an annual conference for all regional public health staff is convened.(33)

In British Columbia, the legislative theory described in Chapter II, which provides for administration of full-time local health units by union boards of health contrasts sharply with actual administrative practice. Prior to 1946

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30) Saskatchewan, Health Survey Committee, Saskatchewan Health Survey Report.I. Health Programs and Personnel, Regina, Sask: The Committee, 1951, p. 35.

31) S.S. 1950, c. 81.

32) Saskatchewan, Dept. of Public Health, Annual Report for the 15 months ending March 31, 1951, Regina, Sask: Queen's Printer, 1952, p. 19.

33) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by Saskatchewan Department of Public Health.

each union board of health employed its own personnel, made up its own budget, and was in full control of the administration of its health unit, while the Provincial Health Department served in an advisory capacity.(34) This system of direct local administration has been continued in the Greater Vancouver Metropolitan Health District and the Victoria-Esquimalt Union Health District.(35) However, elsewhere in other health units the administrative arrangement was completely reversed in 1946 leading to a high degree of centralized control.

According to provincial health department reports, the union board of health is "the legally qualified body responsible to Councils and School Boards for the administration of local health services."(36) local personnel "are responsible to their own local boards of health",(37) and "every effort is made to preserve local autonomy".(38) In practice, however, health unit staff are appointed and

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34) Murrell, John, "The Development of Health Units in British Columbia." in Can.J. Pub.Health, Vol.41, No.9, p.395.

35) British Columbia, Dept.of Health and Welfare. Survey of Health Services and Facilities in British Columbia, By Elliott. G.R.F., Victoria, B.C: Queen's Printer,1952, pp.40-42.

36) British Columbia: Dept. of Health and Welfare (Health Branch), Fifth Annual Report, 1950. Victoria, B.C: King's Printer, 1951, p. 28.

37) British Columbia: Dept. of Health and Welfare (Health Branch), Seventh Annual Report, 1952. Victoria, B.C: Queen's Printer, 1953, p. 13.

38) British Columbia: Dept. of Health and Welfare. Survey of Health Services and Facilities in British Columbia, By Elliott. G.R.F., Victoria, B.C: Queen's Printer, 1952, p. 42.

employed by the provincial health department, budgets are drawn up by the local medical health officer and approved by the central office, and general policies are determined centrally. Union boards may advise on staff appointments and transfers, and make recommendations for the improvement of services and the extension of activities, but they have no control over the budget or expenditures.(39)

The provincial Bureau of Local Health Services provides the direct relationship between the technical divisions and services of the provincial Health Branch and local health units. Supervision of the local health staff and maintenance of standards are the primary functions. All information regarding policy or other matters of general interest are cleared to local health staff through the Bureau. Meetings are held at least twice a year for all full-time medical health officers, while public health nurses and sanitary inspectors employed in local areas meet at least once a year.(40) The local Health Services Council, composed of directors of provincial technical health divisions, is

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(39) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by the British Columbia Department of Health and Welfare.

(40) British Columbia: Dept. of Health and Welfare. Survey of Health Services and Facilities in British Columbia, By Elliott, G.R.F., Victoria, B.C: Queen's Printer, 1952, p. 23.

developing a Local Health Services Policy Manual designed to define functions and responsibilities of local boards and health unit staff.[41]

In Quebec, where no provision exists for health unit boards of health or advisory committees, health units are directly administered by the provincial department of health and personnel are appointed by the Lieutenant-Governor in Council. Although local municipalities make a financial contribution, budgets and expenditures are completely controlled by the provincial government. Technical and administrative supervision is co-ordinated through the provincial Division of Health Units.

No consideration was given to the problem of local participation in the recent Quebec Health Survey Report, but a scheme was drafted to improve administrative efficiency. The Report recommended a system of provincial health districts, each district to include several health units. District staff would include a district medical health officer, and specialists such as a tuberculosis clinician, dental public health officer, supervisory public health nurse, a health educator, a veterinarian, and a psychiatric nurse. The purpose would be to decentralize provincial specialized services in order to improve

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41) British Columbia: Dept. of Health and Welfare (Health Branch), Sixth Annual Report, 1951. Victoria, B.C: Queen's Printer, 1952, p. 36.

standards and maintain more effective supervision of local health unit staff.(42)

Atlantic Provinces: The transfer of administrative and financial responsibility for public health to provincial governments has advanced furthest in the Atlantic provinces. As mentioned in earlier chapters, practically all local public health services are provided through provincial districts, completely administered and financed by provincial governments. In Nova Scotia, New Brunswick, and urban areas of Prince Edward Island and Newfoundland, official or unofficial relationships are maintained with municipal or county boards of health which retain minor reponsibilities. In rural Prince Edward Island and Newfoundland provision is made for provincially appointed district boards of health, entirely advisory in nature.

Nova Scotia's dual system of provincial health divisions and municipal health boards does permit some local participation in minor public health matters of exclusively local concern. The activities of municipal units are subject to the approval of the Minister of Health, but there is no statutory relationship between provincial divisional medical health officers and the local boards or their part-time medical officers of health. In most areas, however, the Divisional Medical Health Officer co-operates with local

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42) Quebec, Ministere de la Sante, L'Enquete sur les Services de Sante de la Province de Quebec. III. Services de Sante Provinciaux, Quebec: Ministere, 1951. pp.77-78.

authorities and acts as unofficial advisor and consultant. In addition, liaison and co-operation are stimulated by joint meetings of divisional medical health officers and part-time municipal health officers convened annually by the provincial health department. To increase "grass-roots" participation in local public health programs, the 1950 Nova Scotia Health Survey Report recommended the establishment of advisory health committees in each of the provincial health divisions.(43)

In New Brunswick, where county sub-district boards of health have replaced municipal health boards, a closer relationship exists with provincial district medical health officers, the only local medical health officers in the province. It is true that all medical health officers and most public health nurses are provincially employed while sanitary inspectors and other personnel are locally appointed. However, by statute, the district medical health officer is both member and chairman of each sub-district board of health within his jurisdiction. In addition, he is legally responsible for the administrative supervision of public health staff employed by the local boards(44) In this way some degree of unified administrative direction is obtained, and liaison is maintained with local authorities in the development of policy.

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(43) Nova Scotia, Health Survey Committee, Report on the Survey of Health Facilities and Services in Nova Scotia 1949-50, By Stewart, C.B., Halifax: The Committee, 1950, pp.60-68.

(44) Revised Statutes of New Brunswick, 1952, c. 102.

Prince Edward Island provides local public health services through the provincial health department, but local boards of health exist in incorporated cities and towns. In addition, statutory provision has recently been made for boards of health in provincial public health nursing districts serving other areas of the province. These health unit boards, however, consisting of not more than five members each, are composed of members directly appointed by the provincial government. Evidently, their main function is advisory.(45)

Newfoundland also has provincially appointed local boards of health in cottage hospital districts. In practice, they serve as liaison between the community and cottage hospital and have only advisory functions. Otherwise, medical, hospital and public health services in cottage hospital districts are administered by the provincial Department of Health.(46)

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45) Statutes of Prince Edward Island, 1949, c. 18.

46) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by Newfoundland Department of Health.

CHAPTER V

FINANCING LOCAL PUBLIC HEALTH SERVICES

The development of full-time local public health services requires a strong and stable revenue base as well as public recognition of the desirability or need for the necessary expenditures. Both these factors have tended to shift the sources of financial support from the municipalities to higher-level governments. Various cost-sharing arrangements have evolved which now include the federal government as well as provincial and municipal governments.

In urban communities of heavy population concentration where public health problems are obvious, services have been developed over many years from local funds. Crowded urban living has created public health problems of greater complexity and variety than in rural areas. However, although urban expenditure requirements per capita are relatively high, the concentration of wealth and assessable property tends to be correspondingly high. Local fiscal capacity in relation to preventive public health services is not a serious problem in most large cities since such services involve only a small portion of the total muncipal budget.

In small communities and rural areas, quite apart from the small size of many municipal units, there has been a definite unwillingness to co-operate in the development of locally tax-supported public health services. Of course it

is true that the volume of wealth and assessable property tends to be lower in rural areas. Perhaps more significant, however, is the "benefit" theory of public finance traditionally linked with the taxation of real property. The rural ratepayer who wishes to receive something directly beneficial to his property in return for his tax can muster little enthusiasm for public health services designed primarily to benefit persons rather than property. Furthermore, although services may be less extensive than in cities, travelling costs both direct and through time spent in travelling are greater for similar services. For these reasons the development of full-time services has been largely dependent upon the promise of financial assistance from outside sources.

When full-time health units were in the experimental stage, the initial financial stimulus was provided by grants in aid from the Rockefeller Foundation. In time, as the value of these units was demonstrated, provincial governments assumed responsibility for financial support. Generally, provincial assistance has been designed to absorb the additional cost of new services, while the municipalities are expected to contribute a share not less than the cost of earlier part-time services. In other words, the purpose of provincial financial participation has been to stimulate the development of services of an approved standard in areas lacking them, rather than to relieve the existing burden on local ratepayers.

More recently, the burden of financial support for undeveloped service has been shifted to the federal government. In 1948, federal assistance for the expansion of existing local services and the development of new services was made available from the General Public Health Grant as part of a new National Health Grants Program.(1) This grant was distributed to the provinces on the basis of 35 cents per capita in 1948, but was increased by 5 cents each year until it reached its maximum of 50 cents per capita.

Inter-Governmental Distribution of Costs

In broad summary it can be said that the cost of services developed up to about twenty years ago, is still carried mainly by the municipalitis. The cost of additional services introduced between 1930 and 1948 has largely been assumed by provincial governments. New local services developed since 1948 are financed to a considerable extent from federal funds. There is no uniform pattern, however; the distribution of costs varies considerably between provinces and urban and rural areas.

Municipal Share: In urban areas where full-time services of a relatively high standard have existed for many years, municipally operated health departments are still financed almost completely from general municipal funds. This situation

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(1) The federal General Public Health Grant may also be allocated to general provincial health programs including the training of personnel and the conduct of surveys and studies. (P.C. 1953-471).

continues despite the fact that per capita expenditure requirements in the larger cities are generally greater than requirements in less densely populated areas. In 1951 public health expenditures in seven large Canadian cities shown in Table XI below averaged $2.07 per capita.

TABLE XI PUBLIC HEALTH EXPENDITURES OF SEVEN FULL-TIME CITY HEALTH DEPARTMENTS, 1951(1)

City	Total Expenditure	Per Capita Expenditure
Calgary	$ 156,421	$ 1.21
Edmonton	149,937	.94
Halifax	153,774	1.80
Montreal	2,017,043	1.97
Toronto	2,120,759	3.24
Greater Vancouver	863,492	1.85
Winnipeg	299,935	1.25
Total	5,761,361	2.07

(1) Based on the 1951 Annual Reports of Municipal Departments of Health in the cities specified.

In 144 local health units in six provinces, as shown in Table XII, total expenditure was $6,663,349, or $1.22 per capita for the covered population in the fiscal year 1952-53. The local contribution was $1,865,883 or 28 percent of the total cost. The municipal share was about 50 percent in the provinces of Ontario and Alberta, where administrative responsibility is mainly decentralized to health unit boards of health. In British Columbia, Saskatchewan, Manitoba and Quebec, the municipalities contributed less than one-third of

TABLE XII

ESTIMATED TOTAL EXPENDITURE, PER CAPITA EXPENDITURE AND PERCENTAGE DISTRIBUTION ON TOTAL EXPENDITURE BY FEDERAL PROVINCIAL AND MUNICIPAL GOVERNMENTS ON LOCAL HEALTH UNIT SERVICES IN SIX PROVINCES FOR FISCAL YEAR 1952-53

Province	Total Expenditure				Per Capita Expenditure for Covered Population				Percentage Distribution of Total Expenditure			
	Total	Federal (1)	Provincial (2)	Municipal (3)	Total	Federal	Provincial	Municipal	Total	Federal	Provincial	Municipal
	$	$	$	$								
British Col.	986,340	203,338	623,705	159,297	1.78	0.37	1.12	0.29	100	21	63	16
Alberta	581,162	109,796	178,901	292,465	1.49	0.28	0.46	0.75	100	19	31	50
Saskatchewan	442,683	38,303	282,173	122,207	1.17	0.10	0.75	0.32	100	9	64	27
Manitoba	410,066	82,859	210,304	116,903	1.44	0.29	0.74	0.41	100	20	51	29
Ontario	1,828,238	357,150	602,985	868,103	1.42	0.28	0.47	0.67	100	19	33	48
Quebec	2,414,860	117,105	1,990,847	306,908	0.94	0.05	0.77	0.12	100	5	83	13
Total	6,663,349	908,551	3,888,915	1,865,883	1.22	0.17	0.71	0.34	100	14	58	28

(1) Based on health grant records for fiscal year 1952-53, Directorate of Health Insurance Studies, Department of National Health and Welfare.

(2) Based on provincial Public Accounts for the fiscal year 1952-53.

(3) Based on provincial Public Accounts for the fiscal year 1952-53 for the provinces of British Columbia, Saskatchewan, Manitoba and Quebec. The estimate for Alberta is based on the formula by which federal and provincial grants cover 60 percent of the cost of approved local expenditures. Since the federal-provincial share is $288,697, the total approved cost is $481,162, and the local share $192,465. Additional non-approved local expenditures are roughly estimated at $100,000 making a total estimated local contribution of $292,465. The estimate for Ontario is based on audited statements of expenditure for the calendar year 1952 submitted to the Ontario Department of Health by all health units.

the total cost of operation. The apportionment of the local share between participating municipalities has usually been based on the population factor.

In the Atlantic provinces, the municipalities within provincial districts make no financial contribution to provincial district services, but have continued to finance certain supplementary services of their own.

Provincial Share: As previously indicated, provincial financial support is mainly designed to extend full-time local services to new areas. Although the equalization of relative local tax burdens is not the primary aim, a rough measure of equalization is achieved by withholding financial assistance to the larger and wealthier municipalities which have already developed full-time services. Alberta is the only province that provides substantial grant assistance to its full-time city health departments. In British Columbia, the Greater Vancouver Metropolitan Health District and the Victoria-Esquimalt Union Health District receive provincial grants, but although urban these districts are co-operative intermunicipal endeavours. Similarly, in other provinces, cities which co-operate with surrounding areas in the formation of joint health units, benefit from provincial aid although in some cases they may be required to raise a higher proportion of the cost than the surrounding municipalities.

n intermunicipal health units, provincial governments paid 58 percent of the total cost in the fiscal year 1952-53 as shown in Table XII. The provinces of Alberta and Ontario provide assistance through percentage grants in aid for approved services. More direct responsibility for financing is assumed by the provincial governments of British Columbia, Saskatchewan, Manitoba and Quebec. Local governments are charged or assessed some portion of the cost in these provinces, while the province pays the balance. In the Atlantic provinces, of course, the full cost of provincial district services is paid by provincial governments.

Federal Share: Federal public health grants are project grants allocated to projects submitted for approval by provincial health departments. The pattern of federal assistance in each province has depended upon provincial policy and the extent to which services had already been developed up to 1948. With the approval of provincial health departments, federal grants for special projects have been provided to city health departments in most provinces. More extensive assistance has been provided for the development of health unit and health district services; these grants have mainly replaced provincial rather than municipal expenditure. By the fiscal year 1952-53, as shown in Table XII, the federal share of total health unit expenditures had reached 14 percent.

Financial Arrangements in Ontario and Alberta

The provinces of Ontario and Alberta rely on percentage grants-in-aid to local authorities for the development of full-time services. Municipalities pay the remaining cost of approved services together with the full cost of any additional services provided. In this way greater local interest is maintained in so far as interest is proportionate to financial responsibility.

Ontario: Provincial grants for health units in Ontario were first introduced on a regular basis in 1944. They are allocated at the discretion of the Minister of Health and are roughly intended to equalize the burden of health unit costs between urban and rural municipalities. As outlined in an informal memorandum of the provincial health department, grants on behalf of cities over 25,000 population forming part of a health unit total 25 percent of the cost of services applicable to the city; cities under 25,000 population benefit to the amount of 33 1/3 percent; counties and all other municipalities not part of a county receive 50 percent.(2) Federal health grants replace the provincial share on new health units established since 1948, while federal grants for additional services in existing units replace both provincial and municipal expenditures. Municipal governments still directly financed 18 percent of health unit costs in the fiscal year 1952-53.

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2) Ontario, Health Survey Committee, Report of the Ontario Health Survey Committee. Toronto: The Committee, 1951, p. 404.

To qualify for provincial or federal grants, health units must provide a minimum basic service and employ a minimum basic staff; standards for each unit are determined by the Minister. Budgets are prepared by health unit boards and submitted to the provincial health department for approval. Provincial grants are paid quarterly on the basis of projected expenditure, with adjustments made at the end of the budget year.(2)

The distribution of the local share of the cost between municipalities is determined by mutual agreement. Where cities or separated towns are combined with counties, the allocation of cost between the two for provincial grant purposes is based on population. Within counties and in other cases where rural municipalities are grouped in health units, the local share is raised through uniform rates on equalized assessment.(3)

Outside health units, the provincial government makes special grants for school health programs, dental treatment services and venereal disease clinics. Approved county school health programs are subsidized by percentage grants amounting to one-third of the cost. Local dental programs for children are subsidized by percentage grants covering 20 percent of the cost in municipalities over 5,000 persons and 30 percent of the cost when the population is under 5,000 up

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(3) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by Ontario Department of Health.

to a maximum of $2,000 per municipality.(4) Grants for salaries, equipment and other items are made to assist locally operated venereal disease clinics.(5)

Alberta: Although Alberta has subsidized both local health units and city health departments since 1951, greater proportional assistance is extended to health units. In both cases, the provincial government pays 60 percent of certain approved costs, mainly salaries, but the statutory list of approved services is much more liberal for health units. Federal grants pay 60 percent of the cost of certain services established since 1948, the balance being raised by the municipalities.

Prior to 1949, both the provincial government and the participating municipalities each contributed 50 percent to the cost of operation of each health unit. However, under the authority of the Public Health Act, the Minister of Public Health was empowered to fix the total budget of each health unit.(6) In practice the budget for each unit was fixed at $18,000 regardless of size, and funds were directly controlled by the provincial government.(7)

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4) O. Reg. 44/44,

5) O. Reg. 62/44.

6) Revised Statutes of Alberta, 1942, c. 183.

7) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by Alberta Department of Public Health.

In 1949 the provincial contribution was increased to 60 percent and the fixed budget principle was altered to allow for differences in population between health units. Each budget was set up on the basis of $1.20 per capita of which the province paid up to 72 cents per capita, while the municipalities contributed up to 48 cents. As with the earlier system, contributions were paid into a provincial trust fund in quarterly instalments and at the end of each year any surplus remaining was refunded to both the province and the municipalities.(8)

With the new Health Unit Act in 1951, the control of health unit funds was transferred to the health unit boards. Under the new system, provincial grants cover 60 percent of local expenditures for equipment, salaries and other operating costs approved by the Minister of Public Health. All salary expenditures for which grants are paid must be based on a provincial statutory schedule of staff entitlement and the provincial salary schedule recommended from time to time by the salary survey committee of the provincial government.(9) However, since provincial standards for staff

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8) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by Alberta Department of Public Health.

9) In 1953 provincial grants were payable to each health unit board of health for the following staff:
   a) a full-time medical officer for a population of 30,000 or more;
   b) A part-time medical officer for a population less than 20,000;
   c) a full-time nurse for each 10,000 population within a town or city;

continued page 120)

and salaries are minimal, most boards have been willing to employ additional personnel and pay salaries in excess of the provincial schedule. The distribution of the local share of the cost between municipalities is based on population using figures from the latest quinquennial census of the western provinces.(10)

Grants for city health departments, authorized in 1951, apply only to limited categories of public health personnel, and are also based on a statutory schedule of staff entitlement and the provincial salary schedule.(11)

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9) Con'td from p.120.
   d) a full-time nurse for each 6,000 population outside a town or city;
   e) a full-time sanitary inspector for each 20,000 population;
   f) a student sanitary inspector for every 10,000 population in excess of 20,000 or any multiple thereof;
   g) a full-time stenographer-technician for each 20,000 population or major part thereof;
   h) a full-time or part-time secretary-treasurer;
   i) a full-time or part-time dentist to provide dental services for children of 16 years of age and under;
   j) a full-time or part-time dental assistant.

10) Statutes of Alberta, 1951, c. 38.

11) In 1953, provincial grants were payable to city health departments for the following staff:
   a) a medical officer for each 75,000 population or major portion thereof;
   b) a public health nurse for each 12,000 population or major portion thereof;
   c) a sanitary inspector for each 30,000 population or major portion thereof;
   d) a clerk for each 30,000 population or major portion thereof.

They are designed to cover a much smaller portion of actual costs than grants to health units.

In outlying areas of the province, where one or more municipalities and/or improvement districts employ a full-time public health nurse, the provincial government pays 60 percent of approved operating costs. The balance is shared between participating municipalities in proportion to population. This scheme, known as the municipal nursing service, replaced the provincial district nursing service in 1950.(12)

Financial Arrangements in Manitoba, Saskatchewan, British Columbia and Quebec

In the four provinces of Manitoba, Saskatchewan, British Columbia and Quebec where the administration of health units is primarily provincial, the municipalities in effect purchase services from the province at a rate far below cost. Since the policy of each provincial government is to promote intermunicipal health units, almost no financial assistance is extended to municipally operated city health departments. The only province to do so is British Columbia where locally operated services are jointly provided in the Greater Vancouver and Victoria-Esquimalt districts.

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12) Statutes of Alberta, 1950, c. 45 and Alberta O.C.1046-50.

In each of the four provinces, the municipalities contribute one-third or less of the total cost of healthy unit operations. Only in Manitoba is the municipal share completely linked to operating costs as a prescribed local percentage. In the other provinces limits which are unrelated to cost are imposed on the local contribution. Saskatchewan uses a fixed percentage of cost formula but a per capita maximum limit exists for individual municipalities. In British Columbia there is a fixed local per capita appropriation, while Quebec imposes a mandatory tax rate or millage for the local share. The result is that as costs increase in British Columbia and Saskatchewan, a larger percentage is paid by provincial governments. In Quebec, the same result occurs as long as real estate valuations are not raised. It is worth noting as indicated in Chapter IV that the degree of local interest and participation is low in provinces where the local share of the cost is low and financial responsibility is minimal.

Manitoba: Before the Health Services Act was brought into force in 1945, the province and the municipalities each contributed 50 percent of the cost of operation of health units in Manitoba.(13) Under the new Act, the provincial government share of operating costs was increased to two-thirds, while the full cost of new equipment was assumed

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(13) Manitoba, Advisory Health Survey Committee, An Abridgement of the Manitoba Health Survey Report. Winnipeg: Queen's Printer, 1953, p. 32.

by the province.(14) Each municipality pays its pro-rata share of one-third of the estimated operating cost in quarterly instalments; adjustments on the basis of actual expenditure are made at the end of each fiscal year.(15) The local share is distributed between municipalities on a population basis.(16)

Financial arrangements for diagnostic laboratory and x-ray units authorized under the Health Services Act are on a similar basis whether or not diagnostic units coincide with health units. Two-thirds of the operating cost is paid by the province, and one-third by the municipalities with the municipal share allocated in terms of population.(17) Dental services for children in rural areas, separately provided by the province, are provincially financed subject to a payment of $25 per clinic day by the local community served.(18)

Health services in the city of Winnipeg are entirely financed from local revenues except for certain new services developed with federal grants. Additional services in existing health units have also been financed from federal grants.

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(14) S. M. 1945, c. 22.

(15) Manitoba Regulation 36/48.

(16) Manitoba, Advisory Health Survey Committee, Op. Cit., p. 15.

(17) S.M. 1953, c. 24.

(18) Manitoba, Advisory Health Survey Committee, Op. Cit., p. 40.

Saskatchewan: As in Manitoba the government of Saskatchewan makes a sharp distinction between public health services provided through health regions and services provided elsewhere. In health regions the province pays about two-thirds of the cost of basic public health services, and makes grants in aid for additional special services. City health departments not included in health regions receive no financial assistance from the province.

The general policy on the division of regional public health costs, determined at the discretion of the Minister of Public Health,(19) is that the province pays two-thirds of operating expenditures. However, in any instance where a municipality is charged more than 50 cents per capita the excess is paid by the province. Moreover, in the northern Meadow Lake health region the entire cost is assumed by the province, while in cases where a city with a full-time health department is incorporated into a region, the province pays only one-half the cost applicable to the city as determined by the proportion of the city's population to that of the whole region.(20)

After the total local share has been determined in each health region, its distribution between participating municipalities is the discretionary responsibility of the

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(19) Statutes of Saskatchewan, 1950, c. 81.

(20) Saskatchewan, Health Survey Committee, Saskatchewan Health Survey Report.I. Health Programs and Personnel. Regina: The Committee, 1951, pp. 35-36.

Saskatchewan Local Government Board. In determining the apportionment, a measure of equalization is introduced by considering taxable assessment as well as population. After two separate calculations of the allocation have been made on the basis of population and taxable assessment respectively, a combined calculation is made which gives greater weight to assessment for villages and rural municipalities.(21)

Special services which are locally administered by health region boards, are assisted by the province on a grant-in-aid basis. Preventive dental services in four health regions receive provincial grants covering 50 percent of the cost up to a stated maxima.(22) In the Swift Current Region, the province pays a grant of 25 cents per capita towards the cost of prepaid medical care together with grants covering 50 percent of the cost of dental, hospital out-patient, and radiology services up the specified maxima.(23)

British Columbia: In British Columbia, where the administration of local health units is largely a provincial matter, only a relatively small financial contribution is made by the municipalities. Elsewhere in the metropolitan areas of Greater Vancouver and Greater Victoria, the local health departments receive substantial provincial and federal

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21) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by Saskatchewan Department of Public Health.

22) Saskatchewan, Health Survey Committee, Op. Cit., p. 82.

23) Saskatchewan, Health Survey Committee, Op. Cit., p. 206.

grants. Provincial financial assistance for specified public health services is also extended to areas where full-time units have not yet been set up.

Prior to 1946, when union boards of health were fully responsible for local health unit administration, municipal authorities financed the major portion of health unit costs. In municipally organized territory, the local area was responsible for 75 percent of the cost of the service to the population within municipal limits, while the Department of Municipal Affairs paid 25 percent of the cost of services for persons residing in unorganized territory. The remaining funds required were made available to the Union Board of Health through grants from the provincial health department.(24)

When the provincial government assumed the main administrative and financial responsibility in 1946, provision was made for the "purchase" of health unit services by local authorities at the fixed price of 30 cents per capita per annum. In this way the local contribution was stabilized, while the burden of increased costs and new services was carried by the province. Initially the local share was about 30 percent, but by 1952 this had been reduced to approximately 16 percent as shown in Table XII. Through agreement, the local contribution is paid to the provincial health

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24) British Columbia: Dept. of Health and Welfare (Health Branch), First Annual Report, 1946, Victoria, B.C.: King's Printer, 1947, p. 24.

department by the local school boards of the enlarged school districts making up health unit areas. Each school board requisitions contained municipalities and unorganized territory for the required amounts, the respective shares being in proportion to population.(25)

The same system of financing applies in areas where provincial public health nurses and sanitary inspectors are employed prior to the formation of a full-time health unit. The local school board is charged 30 cents per capita for whatever health services are provided on the understanding that there will be no additional cost to local government as personnel and facilities are increased. The only exception is that the provincial health department may impose a small additional charge for the introduction of dental health services whether within or outside local health units.(26)

In Greater Vancouver and Victoria-Esquimalt areas the services provided are financed mainly by the participating municipalities on the basis of needs and ability to pay. Thus, for example, by agreement the city of Vancouver pays for its own local services as well as the cost of specialized services such as mental hygiene and nutrition applicable to the whole area, while the suburban municipalities pay only for their own strictly local services such as public

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(25) Based on unpublished material supplied to Research Division, Department of National Health and Welfare by British Columbia Department of Health and Welfare.

(26) British Columbia, Dept. of Health and Welfare, Survey of Health Services and Facilities in British Columbia, By Elliott, G.R.F., Victoria, B.C: Queens Printer,1952, p.43.

health nursing and sanitary inspection. Provincial grants for urban public health services have been paid for a number of years. Together with federal grants for new services developed since 1948, they cover approximately 25 percent of the total cost.(27)

Quebec: The method of financing health unit services in Quebec has remained unchanged since the Health Unit Act of 1933. The local share of the cost is raised through a mandatory special property tax rate which varies slightly for urban and rural municipalities. Independent cities and towns over 4.000 population are required to contribute a share calculated on the basis of two cents per hundred dollars municipal assessment valuation, while counties together with towns under 4.000 population contribute a sum based on one and one-half cents per hundred dollars valuation.(28) This system has meant that the provincial government has assumed a steadily increasing proportion of the total cost which has generally risen faster than rural property valuations. By the fiscal year 1952-53 the municipalities paid only 13 percent of the total cost.

Independent city health departments are financed entirely from local funds without assistance from provincial or federal grants.

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27) Murray, Stewart, "Administration of the Greater Vancouver Metropolitan Health Services" in Can.J.Pub.Health, Vol.43. No.5, pp.202-208.

28) Statutes of Quebec, 23 Geo.V, c. 74.

Financial Arrangements in the Atlantic Provinces

Local public health services in the Atlantic provinces are dually financed and operated rather than jointly administered and financed.

In Nova Scotia, provincial district units undertake about 95 percent of the organized public health work outside the city of Halifax, which presumably involves about 95 percent of the total cost.(29) Various new district services introduced since 1948 are financed from federal funds. The municipalities pay for their locally operated part-time services, while Halifax pays the cost of a full-time health department.

In New Brunswick, where all cities as well as other municipalities are included in health sub-districts, local authorities contribute a substantial portion of total costs. In 1948, the latest year for which data are available, local boards employing secretaries, sanitary inspectors, vital statistics registrars etc., contributed about 45 percent of the total. The provincial health department employing full-time medical health officers and public health nurses paid 55 percent. The overall per capita cost, however, was only 36 cents.(30) Since 1948, federal health grants have paid for

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(29) Nova Scotia, Health Survey Committee, Report on the Survey of Health Facilities and Services in Nova Scotia 1949-50. By Stewart, C.B., Halifax: The Committee, 1950, Reporting Form D.

(30) New Brunswick, Health Survey Committee, Report of the Health Survey Committee. Fredericton, N.B: The Committee, 1951. Reporting Form D.

The employment of additional provincial public health nurses, and have paid 50 percent of the cost of employment of full-time sanitary inspectors by sub-district boards.

In Prince Edward Island and Newfoundland partial local public health services are made available and financed by provincial governments, with some assistance from federal grants. Local residents in Newfoundland make prepayment contributions to cover part of the cost of medical and hospital care in cottage hospital districts, but do not directly contribute to financing public health services.

CHAPTER VI

PROBLEM OF PERSONNEL

Undoubtedly the key to efficient local public health administration is the recruitment and maintenance of a well trained professional and technical staff. For adequate service both quantity and quality are necessary. In Canada the total demand for qualified full-time public health workers has long exceeded the available supply. Moreover, the fact that 25 percent of the population still lacks even minimal full-time services indicates that the total need continues to exceed the effective demand.

Staff Requirements

It is generally recognized that certain types of personnel are essential for the operation of a generalized public health program embracing minimum basic services. This personnel nucleus consists of one or more public health physicians, public health nurses, sanitary inspectors and clerical workers. Additional public health workers that may be employed include sanitary engineers, public health dentists, statisticians, nutritionists, veterinarians, health educators and psychiatrists.

Quantitative: The effective demand for public health workers is determined by the number of budgeted positions provided for by local health agencies. The demand, however, may exceed or be less than the actual need in terms of desirable

services of minimum standard of adequacy. Although staff needs may vary with the social and health characteristics of the community, they may be roughly related to the population of the area served.

Certain generally accepted minimum staffing requirements have been developed by public health authorities in the United States. These standards apply to physicians, nurses, sanitarians and clerks as follows:

1 public health physician for every 50,000 persons (or 1 for every local health unit, whichever is less);

1 public health nurse for every 5,000 persons;

1 sanitary engineer or sanitarian for every 15,000 persons;

1 clerk for every 15,000 persons.(1)

If applied to Canada's 1951 census population on an overall basis, these standards indicate a total need for 280 medical health officers, 2,800 public health nurses, 933 sanitary inspectors, and 933 clerks in local public health work.

Qualitative: Numbers mean little without adequate educational qualifications. Minimum educational standards have been developed by the Canadian Public Health Association, and are accepted as provincial health department policy in most provinces.

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(1) U.S.Department of Health, Education and Welfare, Greve, C.H. and Campbell, R.J. (editors), "Report of Local Public Health Resources, 1951," Public Health Service Publication No. 278, Washington: U.S.Government Printing Office, 1953, p. 17.

Generally, as outlined by the Canadian Public Health Association, all medical health officers should be physicians with a post-graduate Diploma in Public Health or its equivalent. Similarly, public health nurses should have at least one year's postgraduate training in public health nursing, as well as their regular nursing diploma. All sanitary inspectors should have obtained the Certificate in Sanitary Inspection (Canada) or its equivalent. Also, of course, other specialized personnel should be educationally qualified in their specialties.(2)

Shortage and Turnover of Personnel

While the staffing situation has improved in recent years, there remains a quantitative shortage and high rate of turnover of qualified personnel, particularly among public health nurses. The extent of the shortage for different categories of personnel may be illustrated by comparing the number of personnel actually employed by each local agency with the minimum staffing requirements mentioned above. Table XIII shows the number of full-time health units or districts and the number of full-time urban health departments having sufficient staff in the various major categories for the year 1948.(3) This table highlights the shortage of public health

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2) Canadian Public Health Association, Report of the Committee on Salaries and Qualifications of Public Health Personnel, Toronto: The Association, 1947.

3) 1948 was the latest year for which data on an agency basis were available to the writer. By applying minimum staffing requirements on an agency basis, areas having more than the required minimum do not compensate for areas having less.

TABLE XIII NUMBER OF FULL-TIME PUBLIC HEALTH AGENCIES BY PROVINCE HAVING SUFFICIENT MEDICAL HEALTH OFFICERS, PUBLIC HEALTH NURSES OR SANITARY INSPECTORS ACCORDING TO MINIMUM STAFFING REQUIREMENTS(1) DECEMBER 31, 1948.

Province	Full-Time Health Units or Districts				Full-Time Urban Health Departments			
	Total Number of Agencies	Agencies with Sufficient Medical Health Officers	Agencies with Sufficient Public Health Nurses	Agencies with Sufficient Sanitary Inspectors	Total Number of Agencies	Agencies with Sufficient Medical Health Officers	Agencies with Sufficient Public Health Nurses	Agencies with Sufficient Sanitary Inspectors
British Columbia	8	7	8	4	2	2	0	1
Alberta	9	7	1	0	2	0	0	2
Saskatchewan	6	5	3	5	2	2	1	2
Manitoba	13	10	7	11	1	0	1	1
Ontario	23	23	11	10	12	8	4	6
Quebec	65	63	3	12	5	3	0	3
Nova Scotia	7	5	0	0	1	1	1	1
Total	131	120	33	42	25	16	7	16

(1) Based on personnel data for each health agency contained in Provincial Health Survey Reports, Reporting Form D.

Minimum staffing requirements as follows:
- 1 public health physician for every 50,000 persons
  (or 1 for every local health agency, whichever is less)
- 1 public health nurse for every 5,000 persons
- 1 sanitary inspector for every 15,000 persons

nurses and sanitary inspectors. Of 156 full-time local public health agencies existing in 1948, 136 had a sufficient number of medical officers, but only 58 employed adequate numbers of sanitary inspectors while only 40 had sufficient public health nurses.

If appointments were limited to personnel with special public health training the shortage would be much worse. Table XIV below shows that in 1949, only 61.3 percent of the nurses employed by public health agencies had received special postgraduate training in public health. Similar data on public health physicians prepared by the Canadian Public Health Association in 1951 indicated that 138 of 716 positions for full-time public health physicians in federal, provincial and local agencies did not require special qualifications.(4)

The problem of the overall shortage is aggravated by the rapid turnover of personnel which breaks continuity of policy and impairs efficiency of operation. The two following examples illustrate the size of the problem.

The Manitoba Health Survey Report contains an appendix which includes a table showing graphically the month by month turnover of local health unit personnel in 1948. This table shows that only 6 of the 13 units had the

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4) Canadian Public Health Association, "Recommended Qualification Requirements and Minimum Salaries for Public Health Personnel in Canada, 1951," in Can. J. Pub. Health, Vol. 43, No.2, p. 84.

TABLE XIV TRAINING OF NURSES EMPLOYED BY OFFICIAL PUBLIC HEALTH AGENCIES IN CANADA, 1949 (1)

Province	Number of Nurses Employed	Percentage Trained in Public Health Nursing	Percentage Untrained in Public Health Nursing
British Columbia	182	96.1	3.9
Alberta	75	56.0	44.0
Saskatchewan	79	36.7	63.3
Manitoba	105	56.2	43.8
Ontario	658	83.7	16.3
Quebec	424	18.0	82.0
New Brunswick	17	64.7	35.3
Nova Scotia	53	62.3	37.7
Prince Edward Island	8	62.5	37.5
Total	1601	61.3	38.7

(1) Based on Canadian Public Health Association, Report of the Study Committee on Public Health Practice in Canada, Toronto: The Association, 1950, p. 75.

services of a public health trained doctor for the entire twelve months while only 4 retained the same nursing staff during this period.(5)

The staff turnover of public health nursing personnel is further illustrated in Table XV, which shows the turnover of public health nursing staff in British Columbia over a ten year period. Over these years, total staff turnover including appointments, resignations and transfers varied from 46 percent to 117 percent per annum of the number of positions established.

Factors Affecting Staff Recruitment and Maintenance

It is fairly obvious that the supply of qualified personnel depends upon adequate provisions for training, and attractive inducements for intelligent persons to enter and remain in the local public health services. These inducements include monetary inducements as well as less tangible factors relating to job satisfaction and the nature of the work. The importance of each factor, of course, varies between individuals and between different categories of public health personnel.

Provisions for Training: Postgraduate instruction in public health for physicians, dentists, veterinarians, engineers and other university graduates is provided at the School of Hygiene of the University of Toronto and the School

(5) Manitoba, Advisory Health Survey Committee, An Abridgement of the Manitoba Health Survey Report. Winnipeg: Queen's Printer, 1953, Reporting Form D.

TABLE XV PUBLIC HEALTH NURSING STAFF CHANGES IN BRITISH COLUMBIA, 1943-52 (1)

	1943	1944	1945	1946	1947	1948	1949	1950	1951	1952
Positions Established	52	56	64	77	98	111	115	121	123	129
New Appointments	17	13	22	42	37	24	41	33 (2)	45	38
Resignations	12	11	16	27	11	14	28	31 (3)	36	31
Transfers	8	9	10	19	17	14	25	17 (4)	17 (4)	14
Total Staff Changes (5)	37	33	48	88	65	52	94	81	98	83
Staff Turnover (percent)	71	59	75	117	65	46	82	67	76	64

(1) Based on British Columbia: Dept. of Health and Welfare (Health Branch), Seventh Annual Report, 1946, Victoria, B.C. Queen's Printer, 1953, p.39.

(2) Persons returning from university included.

(3) Persons leaving for university included.

(4) Exchanges included.

(5) Includes appointments, resignations and transfers.

of Hygiene of the University of Montreal. In addition, the various universities throughout Canada offer courses leading to Public Health diplomas for graduate nurses. With respect to inspectors, the Canadian Public Health Association conducts annual correspondence courses for the Certificate in Sanitary Inspection (Canada). Recently, the provincial health departments of Manitoba, Ontario and Quebec have introduced special training courses for sanitary inspectors combining lectures and field work. All these training courses in public health receive financial assistance from federal and provincial governments, voluntary agencies and charitable foundations.(6)

To persuade adequate numbers of persons to undergo appropriate professional training, financial assistance in the form of bursaries is necessary. Local authorities have rarely used funds to sponsor persons for special training. Prior to 1948, some provincial governments awarded training bursaries, but the number of trainees was very limited. To meet this problem, the federal government introduced a Professional Training Grant in 1948 and further supported training under various other health grants as part of the National Health Grants Program. Under the program assistance is given toward the establishment of special educational facilities, and training bursaries are awarded to persons selected by provincial authorities. At the end of the first five years

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(6) Ontario, Health Survey, Report of the Ontario Survey Committee. Toronto: The Committee, 1951, pp. 408-410.

up to March 31, 1953, persons trained or undergoing training included among others, 173 public health physicians, 721 public health nurses and 168 sanitary inspectors.(7)

Appointment by Merit: Because of the technical nature of public health functions it is generally recognized that employees should be selected and promoted on the basis of qualifications or merit; the merit system for public health employees is now widespread in Canada. Outside the city health departments, full-time local public health personnel are appointed by the provincial government in eight provinces. Most of these provinces have Civil Service Commissions responsible in varying degrees for the arrangement of job classifications, the establishment of salary ranges, and approval of appointments on a merit basis.(8) In addition, some provinces such as Ontario, control minimum qualifications of locally appointed personnel through provincial regulations.(9)

Patronage appointments still exist in some areas, particularly for sanitary inspectors and clerical personnel. Furthermore, part-time persons may often be hired on a patronage basis. Nevertheless, these practices appear to be diminishing.

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(7) Canada, Department of National Health and Welfare, 5 Year Report, National Health Program. Ottawa: The Department, 1953, pp. 22-27.

(8) Cole, Taylor, The Canadian Bureaucracy, Durham, N.C.: Duke University Press, 1949, pp.183-191.

(9) O. Reg. 16/44.

Salaries and Related Factors: A prominent public health official is reported to have stated that there are three problems in public health today, namely: (1) Salaries, (2) Salaries, (3) Salaries.(10) While this viewpoint reflects a universal human preoccupation, it is undoubtedly true that monetary inducements in public health are not very great for the professionally trained worker.

In its 1951 Report on Recommended Qualification Requirements and Minimum Salaries for Public Health Personnel in Canada, the Canadian Public Health Association grouped public health physicians by minimum and maximum salary intervals.(11) From these data it may be calculated that the 1951 median minimum annual salary of public health physicians in local health units and city health departments was $4918 in 1951 while the median maximum salary was $5857. By comparison, in the United States, the median salary interval of local health officers in April 1952 was $8400-$8599, while the median salary interval of other local public health physicians was $7000-$7199.(12) Consideration of the salaries of practising

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(10) British Columbia, Dept. of Health and Welfare, Survey of Health Services and Facilities in British Columbia, By Elliott, G.R.F. Victoria, B.C: Queen's Printer, 1952,p.55.

(11) Canadian Public Health Association, "Recommended Qualification Requirements and Minimum Salaries for Public Health Personnel in Canada, 1951" in Can.J. Pub. Health, Vol.43, No. 2, P.83.

(12) U.S. Federal Security Agency, "Salaries of Local Public Health Workers April 1952", Public Health Service Publication No. 237, Washington: U.S.Government Printing Office, 1952, p. 6.

physicians shows that the median net income of tax-paying Canadian physicians in 1951 was about $7721.(13)

The salary problem has been summarized by the Canadian Public Health Association as follows: "In nearly all groups the initial minimum salary is inadequate and it has become increasingly apparent that the small salary range of most positions is a major deterrent to professional people who contemplate public service. The small salary range, with increments usually confined to a period of a few years, not only affects recruitment but makes it very difficult to retain competent workers. Public health cannot compete successfully with other professional fields in Canada or the United States. For people already engaged in the practice of public health, there is little or no monetary incentive to advancement, and this is one of the main reasons why so many well-trained workers have left public health during the past few years."(14)

Other factors affecting income include superannuation provisions, holidays with pay and sick leave. The 1948 Survey by the Canadian Public Health Association showed that 121 out of 133 agencies had a joint employer-employee superannuation plan, all had holidays with pay of 2 weeks or more, and all had sick leave plans.(15)

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(13) Canada, Dept. of National Revenue, Taxation Statistics, 1953, Ottawa: Queen's Printer, 1953, p. 68.

(14) Canadian Public Health Association, "Recommended Qualification Requirements and Minimum Salaries for Public Health Personnel in Canada, 1951", in Can. J. Pub.Health, Vol.43, No. 2 pp. 60- 61

(15) Canadian Public Health Association, Report of the Committee on Salaries and Qualifications of Public Health Personnel, Toronto, The Association, 1947, pp. 8-10.

Job Satisfaction: Basic local public health functions which are preventive and promotional in nature, have become increasingly standardized in their application. Much of the medical health officer's work has an administrative content, and the medical aspects tend to be routine and uninteresting to the physician. This problem is changing as the scope of public health expands into the chronic diseases and medical care administration. Nevertheless, part of the trouble in local health work is dullness and routine. Although local public health work brings contact with individuals and their problems, it lacks the satisfaction which may be derived from employment at the provincial or federal level where wider areas of policy are involved.

The problem has been stated in a special report as follows: "In far too many cases, official agency programs are purely routine as a result of provincial policy, local precedent, or both. The ambitious public health worker is unable to derive adequate job satisfaction from working in a groove, and he is apt to lose initiative or else leave for other agency positions which he feels will provide better scope for his abilities. For job satisfaction there must be freedom to explore, initiate, carry through and analyze projects. Such freedom is, of course, dependent, in great part,

on the availability of sufficient money to provide facilities and staff to implement and supervise the desired program."(16)

Provincial versus Local Appointment

The problem of personnel has been a major cause of the increased higher-level government participation in local public health services. In addition to making more funds available for the training and employment of staff, this participation has greatly improved personnel policies. In eight provinces, apart from municipal health departments, local personnel are recruited and appointed by the provincial government. In Ontario and Alberta (the other two provinces), personnel are locally appointed, but provincial health departments exercise certain controls and assist in recruitment.

Direct provincial employment of local personnel offers many advantages. One advantage is that local personnel receive uniform treatment with regard to salary, working conditions and pension arrangements. Most provinces have job classification schemes, regular pay increments and provision for superannuation. Of equal importance are the opportunities for transfer, promotion and specialization which are available. When personnel can be shifted from one unit to another, in-service training is facilitated and job satisfaction may be

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16) Canadian Public Health Association, Report of the Study Committee on Public Health Practice in Canada, Toronto: The Association, 1950, p. 7.

increased through variety of experience. In a provincial system, capable persons may be promoted from smaller to larger units and from less interesting jobs to more interesting and important jobs. Finally, stimulation towards good work is provided by periodic conferences and field visits from provincial supervisors.

On the other hand, many of the advantages of provincial administration are consistent with local appointment which has, moreover, certain additional advantages. Local authorities may be able to pay salaries in excess of provincial salary schedules, which are often low to keep them in line with the salaries of other provincial professional workers. More important, however, is the opportunity available to the medical health officer to operate his own program without being tied down to province-wide uniformity. Job satisfaction is increased with local autonomy and scope for initiative. Some of the major advantages of provincial employment can be retained if the province specifies minimum qualifications and salaries, includes local personnel in the provincial superannuation scheme, and arranges periodic meetings and conferences.

CHAPTER VII

SUMMARY AND CONCLUSIONS

The impact of modern local public health functions on organizational structure in the various provinces has been analyzed in previous chapters. It has been pointed out that these functions can no longer be undertaken adequately without the employment of full-time professional personnel of various types. Efficient performance now requires the integration of associated public health functions in a unified organization, administrative units of adequate size, a broad basis of financial support, and measures to attract the necessary qualified personnel.

All the provinces have been faced with similar problems of imbalance between the municipal structure and local public health organization requirements. Large numbers of municipalities are too small for efficient administration and too financially weak to afford a desirable level of service. There has been general recognition of the desirability of enlarged units of administration.

Full-time intermunicipal special purpose public health units have been jointly developed by provincial and municipal governments in six provinces. In the four western provinces, these units represent part of a general trend toward consolidation of local areas along functional lines. There is less structural change in Ontario and Quebec where health units are based mainly on the county units of

or government. In the Maritime provinces provincial public health districts have been superimposed on the municipal public health structure, while in Newfoundland provincial health districts have been developed primarily to provide medical and hospital care.

Concurrent with the development of enlarged administrative units, there has been a great increase in provincial administrative and financial participation, leading in many provinces to a high degree of centralized control over local public health services. Centralized control is greatest in the Atlantic provinces and Quebec where health units or districts are provincially administered. Local participation in these provinces is limited to provincially appointed advisory boards in Newfoundland and Prince Edward Island, municipal health boards with minor functions in Nova Scotia and New Brunswick, and a local financial contribution in Quebec. In Manitoba, Saskatchewan and British Columbia health unit boards of health have been set up, but in varying degrees the major responsibility has been assumed by provincial governments while the public health powers of local boards have become largely advisory. More extensive powers have been delegated to local health unit boards in Ontario and Alberta.

Generally, enlarged units and increased provincial assistance and control have enabled the extension of full-time local services to small communities and rural areas, and have greatly improved quality of service and efficiency of performance.

However, as has been pointed out throughout this thesis, these trends may undermine local responsibility for and interest in public health services. While centralization raises the immediate problem of making local services responsive to local needs, it also has unfavourable implications for the preservation of genuine local self government through local administration of significant governmental functions.

In the following pages, the approach to these problems in each province is briefly evaluated and the degree of co-operation between provincial and local authorities is analyzed. Because of varying conditions within provinces and between provinces, it should be recognized, however, that no uniform pattern of organization can be strictly applied to varying circumstances.

Atlantic Provinces

While responsibility for the development of public health services has mainly been transferred to provincial governments in the Atlantic provinces, services are generally of a lower standard than elsewhere. The underlying reason, of course, is the relatively less favourable economic situation of the Atlantic region, evidenced by the fact that each of the Atlantic provinces has a lower average per capita personal income than any of the other Canadian provinces.(1) Further

1) Canada, Dominion Bureau of Statistics, National Accounts, Income and Expenditure 1926-50, Ottawa; Department of Trade and Commerce, pp. 60-61.

difficulties arise from the low share of provincial-municipal services financed by the municipalities, a situation caused by sociological as well as purely economic factors.

The preference for transferring responsibility rather than attempting fundamental change in local organization reflects the individualism of local communities deeply attached to the benefit theory of property taxation. Local communities appear to retain a strong feeling of independence and non-responsibility for the welfare of surrounding areas. Local boards of health have been largely inactive, and non-mandatory joint action has been negligible. The inevitable consequence has been substitute administration by provincial governments through large administrative units.

Newfoundland: The province of Newfoundland is particularly handicapped by low per capita income, and by the lack of development of municipal institutions reflecting a deep-rooted opposition to property taxation. A further problem is the scattered distribution of the population around 6,000 miles of coastline with attendant high expenditure requirements for satisfactory services.(2)

Under these conditions, with limited fiscal resources, the provincial government has concentrated attention on certain

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2) Powell, C.W., "Problems Arising from Lack of Organized Municipalities in Newfoundland", in 1949 Proceedings of the First Annual Conference of the Institute of Public Administration of Canada, ed. by Clark, P.T. Toronto: Institute of Public Administration, 1949, pp. 168-182.

critical problems such as tuberculosis and the provision of ordinary medical and hospital care. The cottage hospital system of prepaid medical and hospital care in rural areas is one of the most advanced schemes in operation anywhere. The immediate and urgent problem of treatment services is so large in relation to available personnel, that medical health officers and nurses simply lack time for adequate public health work.

The ultimate solution of the broader economic and social questions rests in Newfoundland's economic development program and the redistribution of the population in larger settlements. In the meantime it seems inevitable that public health services must be thinly spread around the coastline as an adjunct to the treatment program. The existing cottage hospital districts may serve as the framework through which public health services can be developed and integrated with curative services. Indeed, in the absence of municipal institutions, there might be some merit in using the hospital districts as suitable areas for enlarged rural municipal districts. To stimulate local interest and participation, existing cottage hospital advisory boards could be assigned broader areas of responsibility instead of being allowed to lapse into inactivity.

Prince Edward Island: Because of the small size of Prince Edward Island, it is logical that public health services should be almost entirely administered by the provincial government. Although full-time medical health officers have

not yet been appointed, public health nursing, sanitary inspection and other specialist services are provided. The system of advisory local boards of health in rural areas has been in existence for too short a time to assess their efficiency or the effectiveness of their co-operation with the provincial Department of Health and Welfare. However, the fact that members are provincially appointed rather than locally appointed or elected may jeopardize local interest and support.

Nova Scotia: A centralized system of administration and financing has enabled the extension of full-time provincial health districts throughout the province of Nova Scotia. While this system permits localization of the provincial health program it appears that considerable time and effort is diverted to the special problems of tuberculosis control and venereal disease control. Since the health districts are very large in relation to the number of staff employed, overall coverage is achieved to the detriment of concentrated public health sefvices in particular areas. The training and recruitment of additional personnel with the assistance of federal health grants has, however, increased the intensity and improved the quality of service over the past few years.

Additional minor services in provincial health districts areprovided by part-time municipal medical health officers and other municipally appointed personnel. Liaison and co-operation between these physicians and provincial medical health officers is stimulated by annual joint meetings convened

by the provincial health department. Informal co-operation, however, does not entirely obviate the difficulties of a legally dual organization which defies the principle of integration of associated public health functions in a unified organization.

A further problem is the lack of relationships between municipal boards of health and provincial health officials. Although the activities of local boards are subject to the approval of the Minister of Health there is no statutory relationship between these boards and the divisional medical health officers. Furthermore, the complete absence of local administrative and financial participation discourages local interest in provincial health district programs. While the appointment or election of advisory health committees might help, effective local support implies some measure of local financial contribution to the costs of operation of provincial health districts, together with integration of provincial and municipal services.

New Brunswick: Although New Brunswick was the first province in Canada to organize intermunicipal boards of health on a province-wide basis, full-time local services have not been developed through these county "sub-districts". In 1918, when sub-district boards were first planned on a mandatory basis, it was probably intended that all local services would be locally administered under the general supervision of provincial district inspectors. Through practical necessity,

however, the most important services were developed by the province; by 1949 the average per capita expenditure of 14 out of 16 local boards was less than it had been 20 years earlier.(3)

Provincial services are thinly spread through six health districts covering the whole province. The large size of these areas decreases the effectiveness of the work of medical health officers and nurses who are forced to spend a large amount of time on travel. On the other hand, some of the county sub-districts are undoubtedly too small to serve as full-time health units. Despite the dual structure, a considerable degree of unified direction is obtained by having the district medical health officer serve as chairman of each local board in his jurisdiction, and by having local staff legally under his administrative direction. Co-operation between the provincial health department and local boards is evidenced by a recent arrangement to replace inadequate part-time sanitary inspection services by full-time services financed on a 50:50 basis by local boards and the federal government through a health grant.

Quebec, British Columbia, Manitoba, Saskatchewan: In Quebec, British Columbia, Manitoba and Saskatchewan full-time local public health services outside the large cities are mainly administered by provincial governments. Unlike Nova Scotia and New Brunswick, however, services have been jointly developed and financed by provincial and municipal governments,

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(3) New Brunswick, Health Survey Committee, Report of the Health Survey Committee. Fredericton: The Committee, 1951, p. 26.

and are integrated in full-time intermunicipal health units. Local residents are represented on health unit boards in Manitoba, Saskatchewan and British Columbia; there is joint financing in Quebec but no provision is made for local health unit boards.

Centralized direction and control has permitted the development of health unit areas on the basis of an overall plan, selection and appointment of well qualified personnel by the province, direct supervision of standards of service, uniformity of policy and co-ordination of effort. The health unit boards is Manitoba, Saskatchewan and British Columbia enable local representation, but the limited advisory powers of these boards reduce their effectiveness. In Manitoba and Saskatchewan, however, local boards may be delegated additional powers over related health services which helps to stimulate board activity.

Health unit services are jointly financed by provincial and local authorities, but in each of the four provinces the municipal share is one-third or less of the total cost. Furthermore, in each province, except Manitoba, a fixed limit unrelated to cost is imposed on the municipal share. While this protects local authorities against excessive costs, it militates against local interest in health unit finances.

Quebec: It was Quebec which first developed full-time health units on a province-wide basis. Through vigorous provincial leadership almost the entire rural area of the

province has been covered with unified local health organizations. Furthermore, many urban communities have been combined with surrounding rural territory to form joint rural-urban health units. Almost all units are geographically set up on county boundaries. This is generally a satisfactory arrangement for rural-urban units, but many of the rural counties make rather small health units.

The system of administration and financing is highly centralized so that local units are the organic agents of the provincial health department. However, because of the large number of units, local medical health officers appear to have considerable autonomy in developing their own programs. Despite some progress co-ordination and direction from the centre is inadequate; there are 67 units but no regional offices serving groups of units. Other apparent problems are insufficient numbers of staff-particularly public health nurses, and inadequately trained staff- particularly sanitary inspectors. In addition, there is little participation by practising physicians in the preventive program.

While included municipalities are assessed a fixed millage rate for the support of each health unit, there is no provision for health unit boards of health or advisory committees. Nor do the municipalities undertake additional partial services as in Nova Scotia and New Brunswick; the health units provide all services. This perhaps reflects the

the weakness of Quebec counties which perform few functions and have few funds at their disposal. In most cases it appears that liaison between the health unit staff and the various municipal councils is practically non-existent since municipal governments are not particularly interested.

British Columbia: While full-time local health units have been jointly developed by provincial and local authorities in British Columbia, there has been a shift towards centralized direction and control since 1946. The formation of units remains dependent on local consent, but local agreement is readily obtained because of the system of financing. Since local authorities are assessed a fixed per capita contribution, all additions in cost are absorbed by the provincial or federal government. Many units have been set up on a limited basis and progressively extended to include the proposed health unit area as the consent of the municipalities is obtained. By now almost all settled parts of the province are covered by full-time services.

There is evidence of administrative vigour and strong leadership in the British Columbia Health Department. This is illustrated by the biannual conferences of medical health officers and the annual Public Health Institute attended by all local health personnel. At headquarters, the provincial Local Health Services Council meets frequently to discuss policy questions. Staff standards are high and local programs

appear to be well co-ordinated and supervised. Flexibility of administration is facilitated by the absence of detailed statutory or regulatory provisions. Policies may be changed in detail from time to time by the provincial minister and his officials, who likewise are free to make rulings at their discretion which may change the whole system of financing and administration.

It seems apparent that the factors mentioned above have had unfavourable effects on local participation in public health. Provision is made for local boards, and the municipalities and school boards have complete discretion over their composition. However, these boards have no control over budgets, personnel or program planning, meet infrequently, and are simply informed of developments periodically by local medical health officers. Since they are unable to develop any additional services they may want, board members are reduced to using board meetings as a means of agitating for extension or improvement of service in a particular local area.

Manitoba: In earlier days Manitoba made no provision for municipal boards of health, but with the development of health units detailed provision has been made for local participation in their operation. Since units are small, local boards are composed of at least one representative from each municipality, while there are also provincially appointed members leading to an overall point of view. Evidence of

board activity is indicated by the frequent number of board meetings; in 1952, the 13 advisory boards held 106 meetings, an average of more than 8 meetings a year.(4) The role and powers of the advisory boards are clearly delineated in provincial regulations, which attempt to delegate considerable responsibility. Furthermore, the development of diagnostic laboratory and x-ray units is co-ordinated with public health services through the local medical health officer and the local board. There appears to be a high degree of co-operation between the boards and the provincial health department.

Although advantageous from the point of view of local participation and intensive service the small units fail to utilize the services of medical health officers to best advantage. Practising physicians participate very little, and there is a shortage of medical health officers for new units. Despite local demands for service, a considerable part of rural Manitoba still lacks local health units. There does not seem to have been great success in combining rural and urban areas in health units.

The provincial health department pays two-thirds of operating costs, and appoints, transfers and supervises local personnel. Strong leadership and effective co-ordination through the provincial Bureau of Local Health Services is

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(4) Manitoba, Dept. of Health and Public Welfare, Annual Report for the Calendar Year 1952. Winnipeg: Queen's Printer, 1953.

apparent. The emphasis on efficiency is evidenced by the plan to develop a field technical service operating out of the central office in an advisory capacity. This type of service, the first in Canada, is designed to prevent duplication of effort and casual unproductive visits by the various provincial specialized divisional directors.

Saskatchewan: Saskatchewan has probably gone further than any other province in attempting to build up large size health regions, undertake extensive provincial control and supervision to provide a high standard service, and at the same time provide elaborate machinery to stimulate local interest and participation. Provincially planned health regions are designed for medical care administration as well as public health, and the provincial health department insists on a "sound" organization before any program is initiated. Insistence on nigh standards has slowed down the development of health regions across the province. On the one hand, it has been difficult to obtain sufficient numbers of specially qualified personnel such as medical health officers trained in medical care administration. On the other hand, an intensive job of salesmanship has been necessary to convince local residents of the large joint regions; on two occasions a provincial proposal for the formation of a health region has been turned down by local vote.

The structure of the regional boards is designed to give all local areas a voice in health region operations. Difficulties arise from the large size of the regions in relation to Saskatchewan's many tiny individualistic rural municipalities, and the lack of board powers over public health funds and personnel. Most of the boards meet only three or four times a year, and they are rather large for effective deliberation. The system of district councils within health regions assures democratic representation but they have little to do as long as the regions are concerned only with public health. They serve as advisors to the advisors, and usually meet only once a year to appoint their regional representative.

The delegation of powers to regional boards to develop medical and dental care services provides a useful framework for the integration of prevention and treatment. However, the fact that the regional medical health officer and his staff are provincial employees, while the staff for dental and medical care are locally appointed and controlled appears to impede provincial-local co-operation. Board members lack sufficient interest in public health, while the provincial health department may be dissatisfied with local medical and dental care policies.

Regional public health programs, nevertheless, appear to operate in a progressive manner. Large numbers of

well-trained public health nurses and sanitarians are employed, and interesting special programs in health education and mental health are being developed in some regions. Extensive utilization of practising physicians in regional public health programs is facilitated by the municipal doctor system prevalent in rural Saskatchewan; these salaried local physicians undertake certain public health functions as part of their municipal contract. Public health personnel attend frequent conferences, and there is a good in-service training program.

Ontario and Alberta

The development of health units in Ontario and Alberta represents an attempt to develop province-wide services on an efficient basis, while retaining a large degree of local responsibility for administration and financing. In both provinces there has been a reversal of the trend towards centralization of responsibility in public health administration. Funds are locally controlled and personnel are locally appointed. Through provincial grants accompanied by the imposition of standards and co-operative relationships, local authorities have been stimulated to provide high quality services through joint health units. Such an approach probably reflects the strength of local government in these two provinces.

Ontario: Ontario's local health units are set up by mutual agreement between local authorities, stimulated by the promise of financial assistance from the provincial

government. Although the province has formal powers of approval over these arrangements, the determination of boundaries is essentially a matter of local decision. This prevents the development of units in accordance with an overall plan, and the existence of counties interposes an element of inflexibility in determining ideal boundaries. Nevertheless, there are numerous instances of multi-county and county-city co-operation in the development of suitable large size units.

Provincial grants, on a percentage of cost basis, are designed to encourage the formation of suitable units. In general, local authorities continue to carry a major portion of the cost, and differential provincial grants exert a rough equalization effect in terms of municipal status. Minimum standards of service are required as a condition of provincial grants, as well as minimum standards of qualification for locally employed personnel. These conditions have brought about a high level of service, but the system has a weakness in that the amount of grant and the standard of service required in each unit may be arbitrarily determined by the Minister of Health and his departmental officials.

Ontario's long experience with county government has probably facilitated the efficient operation of local boards. Representation on each board is determined by provincial regulation, and in most instances there appears to have been provincial-local agreement to keep the board small

in size. Each board retains control over the local budget and the appointment of personnel, subject to provincial approval.

Evidence of provincial-local co-operation is indicated by the fact that the province has never refused the appointment of a medical health officer in a health unit. Both medical health officers and public health nurses are mainly recruited by the province on behalf of the local boards. Sanitary inspectors may be locally recruited, but through provincial-local agreement they undertake a special provincial training course. Local boards pay salaries in excess of the minima required by the province. Some local boards have superannuation plans, but there are evident disadvantages in the lack of uniform provision for superannuation, salaries, holidays and sick leave.

Alberta: The 1951 Alberta Health Unit Act was apparently initiated as a result of pressure from local authorities. The vigour of local government institutions is reflected in the provisions of the Act. Since this enactment there has been widespread development and expansion of health units, and it would seem that services are of a much higher standard than before 1951.

Health units have been planned to include groups of enlarged rural municipal districts. Boundaries may be determined at the discretion of the provincial health department, but local consent is always a dominant consideration. Provincial control is also exercised over the composition of

health unit boards; the division of health units into wards for purposes of representation overcomes the problem of representing each community and enables small boards. Although units are much larger than before 1951, they are small in size if compared to Saskatchewan.

By giving boards control over funds, appointment of personnel, and the development of policy, the province has delegated significant functions. At the same time, the system of grants in aid enables provincial control over minimum standards while giving local boards power to develop extra services as they see fit. The grant system stimulates the boards to provide the necessary minimum services by paying 60 percent of the cost of a minimum staff entitlement. To obtain grants boards must employ the necessary qualified staff, and yet the grants are based on a very low provincial salary schedule so that the boards must compete with each other in paying higher salaries out of local funds to obtain the necessary staff. This has the advantage, however, of making the service dependent on local initiative. Its success is evidenced by the rapid development of local services when funds were transferred from provincial to local control in 1951.

Special additional measures to attract the necessary personnel are included in the Alberta Health Unit Act. To counteract the disadvantages of local employment, health unit personnel are covered by the provincial superannuation

scheme. Personnel are mainly recruited by the province for the health units, and frequent meetings of personnel are held.

In summary, there is considerable provincial control over the local health structure, but little control over day-to-day operations. The local boards are displaying vigorous activity, and co-operative relationships with the provincial health department are apparently good.

Some Concluding Suggestions

While admitting that conditions vary considerably between provinces, it is submitted that decentralized administration of local public health services through local authorities is more desirable than provincial administration. This viewpoint harmonizes with the primary purpose of local public health services which is education. It is increasingly recognized that education is most effective when it involves participation. Local administration opens the way to participation in planning, policy formation and administration by a substantial number of citizens serving on local boards or special committees; this enhances public understanding and support for public health.

Various other advantages of local administration and control might be cited. But since adequate public health standards are of wider-than-local concern, the real problem is whether high quality service is compatible with local responsibility. Can the undoubted advantages of provincial administration in terms of operating efficiency be maintained

if control is vested in local authorities? The experience of Ontario and Alberta suggests an affirmative answer. Perhaps one can draw upon the systems in various provinces to suggest a few elements of an ideal arrangement.

The first necessity is integration of associated public health functions in administrative units of adequate size. This surely involves compulsory consolidation of municipalities for public health purposes. Only in this way can a provincial health department plan and develop the boundaries of health units along the lines most suitable for efficient administration with due regard to economic geographic and social factors. If intermunicipal health units remain continuously subject to local consent they may dissolve or be voted down any time as has happened once or twice in Saskatchewan. Compulsory consolidation has been tried in Alberta for the development of enlarged rural municipal units; it has surely strengthened rather than weakened local government in Alberta.

A second necessity is an efficiently constituted health unit board of health, representative of various participating communities. While the provincial government should define the composition of the board limiting the number of members as in Alberta, appointments should be made by local authorities with perhaps one or two provincially appointed

members as in Ontario and Manitoba. Further provision might well be made for an Advisory Council, representing various professional and community groups as well as municipal governments.

While each local board should prepare its own budget and control its own funds, provincial grants in aid are undoubtedly essential to stimulate adequate services. A straight percentage grant system for specified approved services such as in Alberta is probably the most satisfactory method. If approved services are defined mainly in terms of staff-population ratios, an element of equalization can be introduced by varying ratios in terms of population densities or other factors. However, it seems more logical that the equalization problem should be dealt with by general provincial grants to the municipalities; in any case public health services are not very expensive in terms of the total financial position of any municipality. The point of the public health grant system is that it permits a minimum standard of service, while enabling the local board to add additional services or pay higher salaries as it sees fit.

While staff are appointed and directed by the local board, provincial grants must be accompanied by standards and consultative supervision. The most important thing is standards of qualification for locally employed personnel. A schedule of services to be provided might also

be required for approval. Provincial specialist divisions would maintain a consultative relationship with local health personnel. Co-ordination and uniformity through education and persuasion would, of course, be facilitated by frequent meetings or conferences convened by the provincial health department.

Professional personnel might be attracted to locally administered health units by the autonomy and freedom from excessive supervision, and by salaries higher than the provincial salary schedule. However, to compensate for the loss of certain advantages of being in the provincial civil service, special measures might be necessary. By statute or regulation, local personnel could be included in the provincial superannuation scheme, and uniform holiday and sick leave provisions might be required of all local health units.

The exact needs of public health, of course, might have to be modified in the interests of integration with other related services, and in the interests of the effectiveness of local government as a whole. The integration and co-ordination of medical and hospital care with public health services on a regional or district basis would in itself enhance the efficiency of public health programs. Citizen interest and participation would also increase if the powers of local health boards were extended to include a wider range of functions. However, some modification of local jurisdictions

would be necessary since the ideal boundaries of medical and hospital care districts do not necessarily coincide with public health units.

The problem of balancing public health organizational needs with the general effectiveness of local government is not serious. Under the existing municipal structure most small municipal units are incapable of undertaking any worthwhile public health functions, so that the formation of health units does not deprive them of significant activities. A general reorganization of municipal areas by provincial governments might produce enlarged municipal units which could undertake effectively most desirable local functions including public health. In Ontario, many existing counties already serve this purpose, and in Alberta experimental counties have been set up with broad powers. Delegation of public health functions to these enlarged municipal units might require subordination of technical considerations as to ideal public health boundaries. However, in a flexible system of local government, intermunicipal boards could continue to function wherever municipalities remained too small for public health purposes.

The adaptation of local government structures in Canada to expanding public health functions is one aspect of the general problem of reconciling local self-government to the demand for efficiency in the provision of services

at the local level. Methods used in public health are not necessarily applicable to more general problems. Nevertheless, the various techniques of adjustment for public health purposes described in this thesis may suggest certain avenues of approach in relation to broader questions of local government organization.

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