THE SASKATCHEWAN ANTI-TUBERCULOSIS LEAGUE

A STUDY IN THE ORGANIZATION OF

PUBLIC HEALTH ACTIVITY

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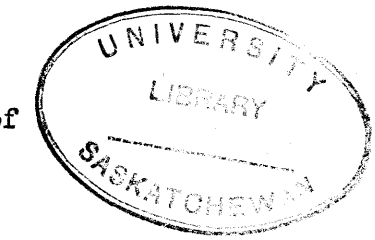

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FOREWARD

In the province of Saskatchewan the tuberculosis control program is entrusted to a non-official,but tax supported,health agency - the Saskatchewan Anti-Tuberculosis League. To the writer's knowledge, this organization represents a unique approach to the organization of public health activities. The following study is an attempt to investigate,from a bfoad social standpoint,the usefulness of this approach used in Saskatchewan.

Throughout the study it has been necessary to insert a substantial amount of descriptive material so as to acquaint the reader with some of the peculiarities of this organization. The compilation of this descriptive material had largely to be done from previously unexplored or inaccessible material.The writer is indebted to the Board of Directors of the Saskatchewan Anti-Tuberculosis League for permission to examine the Minutes of both the annual meetings of the League and of the quarterly meetings of the Board. Much material relating to the League's affairs was also provided by Mr.Frank Froh, Secretary to the League.

Dr.A.S. Acker and Mr.Lloyd Williams of the Saskatchewan Department of Public Health were instrumental in having the files of the Department made available and in

providing several helpful suggestions. Mr.G.Ferguson,Secretary to the Saskatchewan Association of Rural Municipalities provided valuable assistance by making available the minutes of the annual conventions of the Association.

The writer is particularly indebted to Dr.Lewis Thomas and the staff of the Saskatchewan Archives for the official assistance and personal kindnesses afforded him throughout the past year. In conclusion,acknowledgment is made of the continuous guidance and encouragement provided the writer by his supervisor,Mr.A.N. Reid.

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CHAPTER I

THE DISEASE AND THE PROBLEM CREATED BY IT

Like any disease, tuberculosis has certain distinguishing characteristics. Aside from their medical significance, however, these characteristics have peculiar social and economic implications. Because of this, the present chapter will be concerned with certain medical facts relating to tuberculosis, but only insofar as they are necessary to an understanding of its social and economic significance.

The Disease And The Terminology Associated With It

Tuberculosis is an infectious disease caused by a germ known as the Tubercle Bacillus. This germ enters the human body in most cases by way of the respiratory system following direct contact with an infected person. The term "infection" is used to denote the process by which the germ enters the body. Although it is possible for the germ to survive outside the human body and to be spread through contact with contaminated eating utensils and linen, for example, it is generally spread by direct personal contact.[1]

Although the bacillus may survive outside the body for considerable periods of time, it grows and multiplies

1. Ferguson, R.G., Studies in Tuberculosis, Toronto, University of Toronto Press, 1955, p.116)

only after it has entered the body. Once infection has taken place the bacillus lodges somewhere within the body and attempts to multiply. In about ninety per cent of the cases this takes place within the lungs which provide a peculiarly attractive environment for the bacillus.

If the infected individual lacks the capacity to resist the disease, the bacillus multiplies at the expense of the lung tissue, which deteriorates in the infected area. Under these circumstances the secretions of the infected area are free to circulate throughout the body and the individual begins to display the symptoms of the disease. The term "disease" is used to denote this condition. Loss of appetite, strength and weight are regarded as the earlier symptoms of disease. Once the local infection has grown sufficiently some of the increased secretion is passed into the air tubes of the lungs and causes the coughing and expectoration which characterize the later stages of disease.

When the individual has entered the later stages of disease with secretions passing into the air tubes he is capable of infecting other persons and for this reason is known as an "open" or "infectious" case.

It is not inevitable, however, that "infection" be followed by "disease". In fact, the bacillus causes many cases of infection without disease for every case

of infection with disease for which it is responsible.[2]

When the germ lodges in the body of a person with the ability to resist the disease a process takes place by which the cells in the infected area multiply to form a thick wall of tissue around the invading bacillus. This wall of protective tissue or "tubercle" isolates the germ and renders it inactive. When this takes place the case is described as being "closed" or "non-infectious" because no secretion from the infection is passed into the air tubes and the patient's sputum does not contain the tubercle bacillus.

The ability of the individual to overcome the infection depends upon two types of "resistance". If the individual has overcome a previous infection it is believed that his ability to withstand the disease will be increased. This is referred to as "specific" resistance. A vaccine known as BCG (Bacillus Calmette-Guerin) is available which artificially induces such specific resistance.

Even without specific resistance, however, the individual may overcome infection. Such "general" resistance is associated with the fitness of the individual and his ability to resist any type of infection.

2. Ioc.cit.

"Disease", then, results only when "infection" overcomes "resistance" (specific and general). The point at which this takes place and the individual begins to display symptoms of disease is denoted by the term "breakdown". If the individual will submit to treatment in time it is usually possible to strengthen his forces of resistance through rest and adequate nutrition thereby enabling him to resist further progress of the disease. If the forces of the body can be strengthened sufficiently that the infection is contained and the destroyed lung tissue healed, the patient is said to have realized a "cure". If, however, the patient suffers a second breakdown and requires further treatment the term "relapse" is applied to his condition.

Some Social And Economic Implications Of The Disease

Tuberculosis has certain characteristics which give it a real economic and social significance. Most important is the length of time required for treatment. If the treatment is to be successful it must be prompt, uninterrupted and followed by adequate convalescence and rehabilitation of the patient in "normal" life. The length of treatment and these other requirements imply a heavy financial burden upon the individual and the community.

Another characteristic of tuberculosis is its long observed correlation with social conditions. Hence, some attention must be given to poverty as a predisposing factor. Further social and economic implications of the disease appear when

the "incidence" of the disease is considered. Finally attention will be directed to the need for special institutions to provide treatment facilities.

The Length Of Treatment

Notwithstanding recent advances in pharmaceutical and surgical methods of speeding recovery from tuberculosis, there is still no specific cure for the disease. Although certain drugs, for example, greatly facilitate treatment of tuberculosis there is still no drug which is capable of "curing" the disease outright.

Rest remains the basic element in the treatment of tuberculosis. This often means that the individual is merely required to remain in bed and to relax, thereby minimizing the movement of the lungs and permitting the lesions caused by the disease to heal.

Often, however, more drastic methods are employed to rest the afflicted area. Temporary and sometimes permanent collapse of one lung is induced in some cases. Like the use of drugs, however, such surgical practices are still regarded as supplementary to bed rest which remains the basic form of treatment.

The length of time required for such treatment varies greatly from case to case. Cases discovered in the early stages may require only a few months of treatment, advanced cases may require years. The average length of treatment for patients discharged from Saskatchewan sanatoria in 1953

was 16.29 months.[3]

From this it may be concluded that tuberculosis is a disease which requires the afflicted individual to withdraw from all gainful employment, and indeed from all exertion of any kind, for rather long periods of time.

Economic Implications Of The Disease For The Individual

The length of treatment and the requirement that the individual give up his employment during the period of treatment have important implications related to the financial capacity of the individual.

Commenting upon this one Canadian authority on tuberculosis made the following statement.

> Very few patients have been able to pay the cost of hospitalization for a disease as long drawn out as tuberculosis..... The percentage who pay their way is so small that it would seem to be almost uneconomical to maintain collection departments.....4

While these remarks referred to the general situation in Canada they are clearly supported by the experience in Saskatchewan. In 1928, the last year in which individual patients were charged for treatment in Saskatchewan, less than 2.5 per cent of the total cost was actually collected from this source.

3. Annual Report of Medical Services 1953, Saskatchewan Anti-Tuberculosis League, mimeographed, p.3.

4. Wherrett, G.J., "Progress in Tuberculosis Control in Canada", Canadian Public Health Journal, Vol. 32, No.6, June 1941, p.290.

Even the few who did pay often appear to have been destitute upon discharge with the result that they frequently were unable to obtain the full benefit of treatment before going back to work.[5]

This was found to be at one time the principal cause of "relapse" (See terminology above) in Saskatchewan. A commission investigating the tuberculosis problem in Saskatchewan in 1922 found that 33.3 per cent of all relapses could be attributed to the patient finding it necessary to return to work before securing the maximum benefit from treatment.[6]

Because of this inability of the individual to withstand the financial crisis imposed upon him when tuberculosis strikes most states today assume the burden of financing treatment and to an increasing extent of rehabilitating the patient after discharge.

Poverty And Tuberculosis

Long before Robert Koch discovered that tuberculosis was caused by a germ (1882) the general relationship between tuberculosis and social conditions within the community was recognized.

5. Middleton, F.C., "Evolution of Tuberculosis Control in Saskatchewan", Canadian Public Health Journal, Vol.24, No.11, Nov.1933, pp.509-10.

6. Province of Saskatchewan, Report of the Saskatchewan Anti-Tuberculosis Commission, Regina, King's Printer, 1922, p.38.

Under certain circumstances poverty may be regarded as a factor predisposing to tuberculosis insofar as very low standards of living decrease the individual's resistance to the infection.

This factor was emphasized as early as 1901 by Dr. Adolphus Knopf, one of the early promoters of the anti-tuberculosis campaign in the United States, who wrote as follows:

> Let us always remember that tuberculosis as a disease of the masses has a large social aspect and that without improving the social conditions of the people, the disease tuberculosis will never be eradicated from our midst.7

How significant this living standard factor will be depends upon the nature of the tuberculosis problem confronting the particular community.[8] If a community has a high tuberculosis death rate indicating a large amount of infection, it will be almost inevitable that the individual will be infected at some time in his life. Under these circumstances it has been suggested that raising the standard of living might be a practical method of controlling the disease. Raising the standard of living could be expected

7. Knopf, Dr. A., "Tuberculosis as a Disease of the Masses and How to Combat it" in Cavins, H.M., National Health Agencie, A Survey With Especial Reference to Voluntary Organizations, Washington, D.C., Public Affairs Press, 1945, pp.76-77.

8. Ferguson, R.G., Studies in Tuberculosis, Toronto University of Toronto Press, 1955, p.5.

to increase the general resistance of the individual through improved nutrition, more healthful housing, greater opportunity for recreation and through other factors relating to the general health of the individual.

The other assumes, of course, that "the" standard of living is so low as to have a significant effect upon health. This would not seem to be the case in Saskatchewan today. During the decade of the 1930's, however, when Saskatchewan became a "depressed area" the truth of the relationship between living standards and the extent of tuberculosis was demonstrated. As early as 1930 the General Superintendent of the Saskatchewan Anti-Tuberculosis League wrote that -

> In this year of depression with its losses and financial embarrassment for those working for themselves and unemployment worries for those who work for hire, and lowered standards of living in the province generally, the responsibility resting upon the...League is perhaps the greatest since its formation.9

Raising the standard of living does not seem to be an appropriate policy in a situation where the tuberculosis death rate is low and where it is not inevitable that the individual become infected. Under these conditions the most appropriate policy would seem to be one aimed at preventing infection rather than the more cumbersome attempt to increase

9. Saskatchewan Anti-Tuberculosis League, "Annual Report 1930" in Valley Echo, Vol.XII, No. 8, Aug. 1931, p.32.

general resistance by raising the standard of living.

The Incidence Of The Disease

The economic significance of the disease both from the standpoint of the individual and the society is made even more apparent when the incidence of the disease is considered. Tuberculosis is still one of the major threats to the health of the labor force.

A recently published study showed that tuberculosis remains the "most serious infectious disease of the prime of life". In Canada in 1952 Tuberculosis caused more deaths in the age group between fifteen and forty than "all other endemic and infectious diseases combined...".[10]

So far as the individual is concerned then, tuberculosis is apt to interrupt his life during the income earning years with serious consequences for the financial condition of himself and his family. From the standpoint of the society tuberculosis is a particular threat to the productive age groups.

The Need For Specialized Institutions

While most other serious illnesses of a physical nature are treated in general hospitals, tuberculosis has long been distinguished from other illnesses by the specialized nature of the sanatorium. The most concise explanation of the reasons for the encouragement of such a policy of specialization in Saskatchewan is contained in

10. Ferguson, R.G., Studies in Tuberculosis, Toronto, University of Toronto Press, 1955, p.4.

the Report of the Anti-Tuberculosis Commission of 1922. This commission found that -

> ...it was the concensus of opinion that tuberculosis should not be treated in general hospitals. It was pointed out that the location and surroundings of a building intended for tubercular patients were of importance. General hospitals were invariably situated in large cities, and in this country usually planned to occupy the least possible space. The danger of cross infection was one of the most important objections raised. Usually a hospital patient is one whose resistance to infection is lowered, therefore, the danger of infection from a tubercular patient is notably increased. The absence in general hospitals of the attention needed, such as specialized nursing and medical services, and of the necessary facilities for successfully treating the disease, were among the points discussed.11

It is seen from this that the main reason for treating tuberculosis in specialized institutions is the infectious nature of the disease. In addition to providing treatment facilities the sanatoria are also places of isolation.

Tuberculosis In Saskatchewan

The organization of the tuberculosis control program in Saskatchewan is unusual and conflicts with certain principles esteemed elsewhere. Before the nature of this unusual form of organization can be examined some account must be taken of the peculiarities of the tuberculosis problem as encountered in this province. This section will evaluate the significance of the climate, the settlement process, the predominantly rural environment and the presence

11. Province of Saskatchewan, Report of the Saskatchewan Anti-Tuberculosis Commission, Regina, King's Printer, 1922, p.13.

of an aboriginal population in the province.

The Climate

There is no evidence to suggest that the climate of Saskatchewan predisposes to more or less tuberculosis.[12] Nor is there any evidence that any particular climate hinders or facilitates recovery from the disease. While it may be suggested that winter conditions hinder some aspects of the preventive program, this is not a problem peculiar to this province.

The Predominantly Rural Environment

Perhaps the most apparent peculiarity of this province is the fact that its population is largely rural. It is difficult, however, to estimate the net effect of this upon the problem of combating tuberculosis.

At first sight it would appear that a community founded upon extensive agriculture would enjoy certain advantages over urban areas in combating an infectious disease such as tuberculosis. The relative infrequency of personal contact where population is sparse is obviously a factor which could be expected to reduce the spread of infection. It would also be expected that the level of general resistance would be higher where most of the population is engaged in outdoor occupations and living in spacious surroundings relative to those found in industrial areas for example.

12. Ferguson, R.G., Studies in Tuberculosis, Toronto, University of Toronto Press, 1955, p.4.

In practice, however, these "natural" advantages of the rural environment are offset by the difficulty of organizing a tuberculosis control program in an area where the population is scattered so thinly as in Saskatchewan.

> The great difficulty with rural tuberculosis work has always been the scattered or sparse population which makes it so difficult to organize from a community standpoint.13

There are many reasons for this disadvantage. Remoteness from medical advice discourages early discovery of cases, finding cases requires more time and expense, following up ex-patients is more difficult and educational programs can be less easily carried out in a sparsly populated area than in one where the population is dense.

In Saskatchewan, once an active control program was instituted, it was found that the "natural" advantages of the rural environment were more than offset by its organizational disadvantage. In 1923, for example, the death rate in the cities was 47.0, in the towns 60.6 and in the villages 63.1 per 100,000 of population.[14]

During the period before 1941 the death rate from tuberculosis was reduced in the urban areas as much as in the rural.[15] Apparently the relative ease of encouraging early

13. Holbach, Dr.J.H., "Story of the Hamilton Health Association", in Canadian Tuberculosis Association, T.B. Papers, Ottawa, 1923, p.77.

14. Union of Saskatchewan Municipalities, Report of the Annual Convention 1923, p.46.

15. Ferguson, R.G., Studies in Tuberculosis, Toronto, University of Toronto Press, 1955, p.29.

diagnosis and isolation of tubercular persons in the cities was serving to offset the natural advantage of the rural areas in the province.

Since 1941, however, the difficulty of conducting the control program in rural areas has largely been offset by technological advance in case-finding procedures. With the introduction of mobile photofluorographic equipment it has been possible to extend preventive services to rural areas relatively cheaply. The effect of this has been to shift the balance in favor of the rural areas. Since it is now economically possible to provide comparable preventive service to both rural and urban areas the "natural" advantage of the former has reasserted itself.[16]

The Indian Problem

The tuberculosis control program in Saskatchewan has been complicated by the presence of an aboriginal population which has little resistance to the disease. Dr. Ferguson's study of tuberculosis among the Indians of the Qu'Appelle Valley demonstrated "the difference in the level of susceptibility between primitive people recently exposed and the white race exposed for centuries".[17]

With the coming of the white man to the prairies tuberculosis appears to have spread steadily among the Indian population. Even so it did not reach epidemic proportions until the 1880's when the Indians were established on the

16. Ibid., p.29

17. Ibid., p.9

reserves. Dr. Ferguson explains the resulting devastation in the following manner.

> The obvious conditions facilitating the progress of the epidemic and the spread of infection at this time were the concentration of the Indians in fixed residences on the reserves, lack of sanitation, their contact with the surrounding white settlers, and the concentration of the children in boarding schools for education. Under these conditions tuberculosis infection spread quickly.18

By 1939, although the Indians comprised only about two per cent of the population of the province, they suffered about twenty-five per cent of all the deaths from tuberculosis in the province.[19]

The infusion of white blood into the Indian population apparently increases resistance to the disease.[20] Even so, the Metis themselves pose a problem. The Metis comprise about two per cent of the non-Indian population of the province, but out of 110 non-Indian deaths in Saskatchewan during 1949, twenty-two were Metis. Hence, about twenty per cent of the non-Indian deaths occur in a group which comprises only two per cent of the non-Indian population.[21]

While the factor of racial susceptibility is emphasized by persons primarily concerned with the medical aspects of

18. Ibid.,p.6

19. Saskatchewan Urban Municipalities Association, Annual Convention 1939, p.25.

20. See Ferguson, R.G., Studies in Tuberculosis, Toronto, University of Toronto Press, 1955, p.9.

21. Saskatchewan Anti-Tuberculosis League"Annual Report" 1950 in Valley Echo, Vol.XXXII, No. 8, Aug.,1951,pp.9-10.

the Indian problem, the social and economic factors described earlier in this chapter must not be forgotten. These are summarized by D.A. Stewart in his

Red Man And The White Plague

> ...There is no doubt that a great part of the Indian's lack of resistance to tuberculosis is due to his abject poverty. Like most other social problems this one is less medical than economic and educational. It is true of course that this poverty is accentuated by his own mismanagement, indolence and improvidence and that these are sometimes gross... [But] the most energetic and resourceful white man, if put where some Indians are and under their limitations in employment chances, would likely not do much better than the Indians have done. Race, carelessness and ignorance handicap the Indian in his fight - if he does fight - against tuberculosis, but his poverty also presents great difficulties.22

There appears to be little doubt that these same factors account for the prevalence of the disease among the Metis. In spite of the infusion of white blood, the living conditions, employment opportunities and attitude toward the white man's way of life predispose this group to disease.

The "Indian Problem" is made even more complex by the fact that while it poses a threat to the overall tuberculosis control program in the province, its solution is constitutionally made the responsibility of the federal government.

Immigration And Tuberculosis In Saskatchewan

There appears to have been a tendency, dating from a

22. Stewart, D.A., The Red Man and the White Plague Ninette, Manitoba, 1939, p.3.

time before any tuberculosis control program began, to blame the tuberculosis problem in the province upon immigration. In 1910 the Commissioner of Public Health wrote to the Premier as follows.

> You will see that, in accordance with our population, our death rate from this disease is particularly high. This is not from any local cause, either climatic or otherwise, but is accounted for by many from other countries coming here while affected by the disease...23

When the Saskatchewan Anti-Tuberculosis League began operating the first sanatorium in the province it was found that only a small proportion of those admitted for treatment were of "native" origin, that is, very few of the patients had been born in the province. In its second annual report the League announced that out of a total of 380 patients discharged in 1919, 169 were Canadian born (39 being born in Saskatchewan), whereas 116 had been born in the British Isles, 35 in the United States and 54 in Europe.[24] The League concluded from this that since "tuberculosis infection occurs largely in childhood, it is plainly seen that most of this infection is imported into Saskatchewan from other provinces and countries."[25] This, in itself, was to be expected, however, in view of the fact that the entire settlement process had depended upon immigration. Because of this, at any given

23. Scott Papers, Correspondence dated Jan.18, 1910, Public Health-General, 1905-1911, Archives of Saskatchewan, Saskatoon, Saskatchewan.

24. Saskatchewan Anti-Tuberculosis League, Annual Report 1919, p.6.

25. Loc.cit.

time, the total number of persons classed as immigrants must have been much greater than the total number of persons born in the province.

Successive immigration was more significant even though it was relatively meagre, for once the population of the province had become established, the possibility of persons coming in from more highly tuberculerized areas posed a real threat to the health of the established population. Recently published studies of this problem have been interpreted to show that immigration from 1929 to 1932 affected the provincial tuberculosis death rate in the age groups under twenty and over forty. The mortality in the groups studied was one and one-half times higher than the death rate for the province.[26]

In spite of the deleterious effect upon the provincial tuberculosis situation in the age groups mentioned above it must be remembered that most of our immigration has been "selective". In general the majority of the immigrants to this country were relatively young and vigorous. This has led Dr. Ferguson to conclude that selective immigration from the United States and Western Europe has on the whole over the years been beneficial in its net effect upon the "tuberculosis rate" (cases of tuberculosis per 100,000 of population).[27] This does not say, however, that it has not increased the absolute

26. Ferguson, R.G., Studies in Tuberculosis, Toronto, University of Toronto Press, 1955, p.33

27. Ibid. p.35

amount of tuberculosis in the province.

The study referred to also claims that immigrants from a relatively highly tuberculerized region who have about the same natural resistance to the disease as the "native" population "quickly adopt the standards of sanitation and knowledge of preventive measures of their new neighbors, and in one or two generations incidence among them falls to the rate prevailing in the general population."[28]

It may be concluded then, that during the years when the tuberculosis control program was being organized in Saskatchewan the continued influx of immigrants served to increase the absolute amount of tuberculosis in the province. But because of the rapidity with which the immigrants have been assimilated into the general population and because "immigration in small proportions has a minor effect on a tuberculosis epidemic"[29] immigration has not been of particular significance over most of the period since the first sanatorium was opened in 1917. In the 1930's, however, it is interesting to notice that Saskatchewan lost an important part of its most resistant population. The emigration of young job-seekers from this province to Ontario and British Columbia caused an increase in the amount of tuberculosis in proportion to our population in Saskatchewan and had the opposite effect upon the situation in Ontario and British Columbia.[30]

28. Loc.cit.

29. Ibid.,p.34

30. Ibid., p.35

SUMMARY AND CONCLUSIONS

Tuberculosis has certain characteristics which make it a real economic and social problem. Notwithstanding medical advance in diagnosis and treatment there is still no specific cure for the disease. This means that lengthy rest remains the basic form of treatment. Such rest must be as complete as possible - with the result that the individual must abstain from gainful employment for considerable periods of time. This results, in many cases, in financial crisis for the individual and a real economic loss to the community.

Tuberculosis is an infectious disease spread by direct physical contact by a person with an infected person or object. Because of this the control of the disease becomes a community responsibility. The prevalence of the disease within the community will depend, in part, upon the ease with which infection is spread. This will be influenced by the extent of personal contact between individuals, sanitation and the hygienic standards of the community.

The prevalence of the disease will also depend upon the ability of the individuals within the community to resist infection when it is encountered. This in turn will depend upon the specific resistance acquired naturally by previous infection or artificially by vaccination with B.C.G., and upon the non-specific resistance associated with the general health of the individuals in the community. It is the latter factor which, in conjunction with the hygienic factors mentioned in the above paragraph, gives rise to the observable relationship

between the prevalence of tuberculosis and the standard of living.

Special institutions are constructed to make possible the provision of specialized treatment facilities, the isolation of the tuberculous sick from the rest of the population and to avoid bringing them into contact with persons with weakened resistance in general hospitals.

In Canada tuberculosis is the foremost cause of death from infectious disease between the ages of 15 and 40. Because of this it must be regarded as having special economic significance for the community insofar as it poses a particular threat to the age groups comprising the working force. From the standpoint of the individual and the family it is significant financially because it endangers the individual in his income earning years.

Tuberculosis In Saskatchewan

There is no evidence that the climate of Saskatchewan predisposes to more or less tuberculosis.

The net effect of the predominantly rural way of life in Saskatchewan is difficult to estimate. Because the sparse population associated with extensive agricultural operations would suggest an advantage over more densly populated areas in controlling an infectious disease, this "natural" advantage is offset by the difficulty of organizing and operating a tuberculosis control program under such conditions. Succeeding chapters will show that the organization and operations of the program in Saskatchewan have been entrusted to a unique authority,

the structure and policies of which have been designed to minimize this disadvantage.

The presence of an aboriginal population displaying greatly inferior resistance to disease has complicated the tuberculosis control problem in Saskatchewan. Too often, however, racial susceptibility is emphasized to such an extent that the inferior social and economic position of the Indian and Metis population is overlooked as a predisposing factor to tuberculosis.

The immigration associated with the settlement process in Saskatchewan was still in its last extensive phase when the tuberculosis control program was conceived in the province. During this period (1910-1917) the absolute amount of tuberculosis in the province appears to have been increased by the influx of tuberculous immigrants who escaped the screening of the federal immigration authorities. Insofar as the incidence of the disease expressed in cases per capita is concerned, however, studies suggest that immigration to Saskatchewan from the United States and Western Europe has not been a significant difficulty from the standpoint of tuberculosis control.

CHAPTER II

THE ORGANIZATION OF THE PROGRAM IN SASKATCHEWAN

The tuberculosis control program in Saskatchewan is planned and carried out by the Saskatchewan Anti-Tuberculosis League. Most of the revenues necessary for the program are, however, provided by governments. Because of this peculiar situation, the League is best referred to as a non-official health agency so as to avoid confusion with the purely voluntary organizations operating in the other provinces. Here the League not only performs the educational and preventative functions characteristic of the purely voluntary health agencies, but also manages the curative or treatment program. Except for its preventive program, which is financed by voluntary public contributions, however, the League derives most of its revenue from the provincial government and the municipalities of the province.

The Constitution Of The League

Although local anti-tuberculosis organizations existed earlier, the movement was first organized on a provincial basis in 1911. On February 17 of that year the Saskatchewan Anti-Tuberculosis League was formed as a voluntary health agency with an original membership of sixty prominent citizens of the province. This organization was incorporated by statute on March 23, 1911 by an act which set out the form, objects and powers of the Saskatchewan Anti-Tuberculosis League.

The following year, in 1912, the Board of Directors passed a bylaw defining the membership of the League as "those whose names are mentioned in the Act of Incorporation, and such others as may be added from time to time, by resolution of the League...". This early bylaw also stipulated that "the Commissioner of Public Health shall be ex officio a member of the executive or board of directors."[1]

The statutory provisions for membership in the League were revised in 1923. The act of that year provided that the membership of the League would consist of all persons who were members when the act came into force, "the mayors of all cities and towns in Saskatchewan, the overseers of villages and the reeves of rural municipalities during their respective terms of office and such other persons as may be admitted to membership under the bylaws, rules or regulations of the League."[2] In the following year, 1924, the Board of Directors passed a bylaw to the effect that any resident of the province who was over twenty-one years of age and a British subject could become a member of the League upon payment of one dollar and approval by the Board of Directors.[3]

1. Official Minutes of the Board of Directors of the Saskatchewan Anti-Tuberculosis League, June 18,1912. (Hereafter referred to as Minutes of the Board).

2. Statutes of Saskatchewan,13 Geo.V,c.59,s.4. (Hereafter Statutes).

3. Minutes of the Board, June 11, 1924.

The members of the League are eligible to attend an annual meeting at which they hear, discuss and approve the annual reports of the President and the various executive officials. The meeting then elects the League's representatives to the Board of Directors.

The Board of Directors

The Board of Directors which governs the activities of the League both in its preventive and curative functions was originally appointed by the membership of the League at its annual meeting. The fifteen directors so elected were to "hold office until the next annual meeting, or until their successors are elected". The procedure by which they were to be elected was by nomination and ballot.[4]

The first significant alteration in the composition of the Board came in 1920 as a result of the financial difficulties being encountered by the League at that time. This change in the composition of the Board was designed to provide representation on the Board for the provincial government "as an alternative to placing the Sanatorium under direct government control in the event of funds required for the institution being raised by taxation..."[5] Consequently, the Act of Incorporation was amended in 1920 to provide that the affairs of the League were to be managed by a board of directors, twelve of whom were to be

4. Minutes of the Board, June 18, 1912.

5. Correspondence dated October 13, 1920, bound in Minutes of the Board, 1920.

elected by the League's membership as before and "additional directors, not exceeding three in number" who were to be appointed by the provincial government "for such respective periods as may be named in the order-in-council appointing them".[6]

The composition of the Board remained unchanged until 1927. During this time the Board had itself considered adding representatives from the municipalities, the Saskatchewan Medical Association, the I.O.D.E. and other organizations in the province.[7] It should also be noted here that it was in these years that the municipalities of the province became involved in the League's finances.

In 1927 the Act of 1923 was amended so as to reduce to six the number of directors elected by the membership of the League. As before, these were to be elected at the annual meeting, but now the terms of office were "staggered" so that two directors would be elected annually to hold office for three years. Each year three directors were to be elected at the annual convention of the Saskatchewan Association of Rural Municipalities, two others by the Union of Saskatchewan Municipalities and one by the Saskatchewan Medical Association. As in the past, three directors were to be

6. Statutes, 11 Geo.V,c.6,s.2.

7. Minutes of the Board, June 11,1924.

appointed to the Board by the provincial government, thereby making up a board with a total of fifteen directors.[8]

The number of directors elected by a membership of the League itself was further decreased in 1929 when the Sanatorium Act of 1923 was replaced by a new act. This act provided for five directors to be appointed by the provincial government to hold office for two years, five by the Saskatchewan Association of Rural Municipalities for one year, two by the Union of Saskatchewan Municipalities for one year, one by the provincial government to represent the local improvement districts of the province for one year, and one by the Saskatchewan Medical Association. This left only one of the fifteen directors to be elected by the membership of the League. As before, this representative of the League was to be chosen at the annual meeting. It should be noticed, however, that this act excluded from voting those members of the League who were members by virtue of their offices as mayors, overseers or reeves of municipalities.[9]

The composition of the Board remained unchanged from 1929 until 1948. At that time the number of directors appointed by the League was increased to two. The purpose of this, however, was merely to enable the League to give

8. Statutes, 17 Geo.V,c.68,s.7.

9. Statutes, 19 Geo.V,c.61,s.6.

representation on the Board to the Associated Canadian Travellers. It was understood at the time that the additional director would, in fact, be the choice of that organization which has "aided the League very materially in its program".[10]

In 1948 then, the Board of Directors was increased to sixteen members. Two years later provision was made whereby an additional director would be appointed by the provincial government so as to give representation to the Northern Administration District.

Since then the Board has again been enlarged to increase from two to four the directors appointed by the Saskatchewan Urban Municipalities Association. At present then, the Board consists of nineteen directors. One of these represents the membership of the League, seven are appointed by the provincial government, nine by the municipalities of the province, one by the Saskatchewan Medical Association and one is appointed by the League to represent the Association of Canadian Travellers.

This Board meets every three months to direct the business of the League. The original bylaws of the League provided that the meetings of the Board would be open to all members of the League although they would be excluded from participation in the proceedings. The Board is permitted by statute to pay its members for their

10. Province of Saskatchewan, Annual Report of the Department of Public Health 1948, Regina, King's Printer, 1949, p.9.

attendence at Board meetings.[11]

The original bylaws of the League provided that "at any meeting of the Board, committees may be appointed to consist of either members of the Board or of the League..."[12] At present the Board appoints eight standing committees.[13]

The continuity in the actual direction of the League, in spite of the changes in the method of selection outlined above, is perhaps the outstanding characteristic of the Board. This is particularly noticeable in the office of president. Three men have held this post for forty-three of the League's forty-four years of existence. Peter McAra held office in 1911 and then from July 1930 until July 1945. A. B. Cook was president from December 1913 until June 1930 and E. G. Hingley from July 1945 to the present.

> Although the Directors are elected or appointed by various representative bodies, the League has had, since its origin, a remarkable degree of continuity of direction by men who have grown up with the organization and are thoroughly familiar with its problems and objective.[14]

The implications of this will be examined in Chapter Five.

11. Statutes, 19 Geo.V,c.61,s.23.

12. Minutes of the Board, June 18, 1912.

13. See Chart, Chapter V.

14. Submission by the Saskatchewan Anti-Tuberculosis League to the Select Special Committee on Social Welfare, Government of the Province of Saskatchewan, March 31, 1943, mimeographed, p.6. (Hereafter referred to as "Submission 1943").

The Executive Staff Of The League

The executive staff of the League is appointed by the Board of Directors in accordance with the provisions of the Act.[15] In practice, the Board usually makes such key appointments as to the positions of General Superintendent and Director of Medical Services and of Medical Superintendent while other appointments are usually made by the General Superintendent and Director of Medical Services subject to the approval of the Board. One noticeable characteristic of the League, however, has been the long tenure of such "key" personnel. Two of the three Medical Superintendents, for example, have held this position for twenty-five and thirty years respectively. In its forty-four years of operation the League has had only three General Superintendents, one of whom served for thirty-two consecutive years.

There has been little alteration in the organization of the executive staff over the years. Prior to 1922 the office of executive secretary served as the channel of communication between the Board and the general administration of the League. In that year, however, this office was abolished and a permanent managing director was appointed by the Board, "not so much for supervising the running of the Sanatorium which was operating very smoothly and satisfactorily, but that the general work of the League

15. Revised Statutes of Saskatchewan, 1953, c.235,s.15.

throughout the Province might be given more attention".[16] Originally this position was combined with that of President of the League and was filled by a member of the Board. After 1930, however, the duties of general administration were given to a medical employee of the League whose office was designated as that of "General Superintendent and Director of Medical Services".

It appears from personal inquiries and a study of the Board's minutes, however, that such arrangements were as much determined by the availability of individuals possessing particular administrative talents as by the Board's opinions relating to administrative organization.

The Functions Of The League

The functions of the League have been the same throughout its history and are implied in the following formal definition of the "objects of the League".

> The objects of the League shall be the care, conduct and management of Sanatoria and hospitals for the treatment of tuberculosis, the establishment, either independently or in cooperation with municipal, hospital or other authorities, of clinics for examination and diagnosis, and the adoption of such measures and the promotion of works and undertakings in its opinion necessary or desirable for preventing the development and spread of tuberculosis in Saskatchewan. 17

16. Minutes of the Board, April 18,1922.

17. R.S.S., op.cit., s.3.

It is apparent from this that the League's functions may be broken down into two types, the curative and the preventive.

The early activities of the League were chiefly devoted to establishing its curative program. From its incorporation in 1911 until treatment was made free in 1929, the League worked toward the establishment of "adequate" treatment facilities and an adequate financial structure for operating them. While by far the greatest part of the League's expenditures, even today, is on treatment account, after 1930 the preventive function of the League became relatively more important.

When the League shifted its emphasis from the curative to the preventive program in 1929 the General Superintendent described the change as follows.

> The year 1929 marks the effective opening of the preventive program of the League. At this date preventive effort has outstripped curative in the campaign to control tuberculosis. Having provided curative treatment for the sick and care for the dying, the League has moved on to attack the contagion at its source...In short, tuberculosis is now being dealt with not merely as a serious illness but as a serious infectious disease....18

Because provision was never made for financing preventive services out of taxes, the League had recourse

18. Saskatchewan Anti-Tuberculosis League (hereafter S.A.T.L.) "Annual Report 1929", in Valley Echo, Vol.XI, No.8, August 1930, p.31.

to voluntary contributions as the source of revenue on preventive account. In 1928 the Christmas Seal campaign was first used by the League. This campaign has been conducted each year since and the annual gross revenues from it have increased from $12,130. in 1928 to $152,637. in 1953.[19] Total returns from the campaign totalled $1,585,207.84 at the end of 1953.

In 1934 the League obtained an additional source of revenue for its preventive program when the Association of Canadian Travellers became interested in its work. Returns from this source have also grown, being $1,639.60 in 1934 and $83,929.81 in 1953. Total returns since 1934 amounted to $720,359.29 in 1953.

While these two sources, the Christmas Seal Campaign and the A.C.T. contributions account for the bulk of the preventive revenues raised by the League, there are several other sources. In 1938, for example, the League introduced the sale of "Health Bonds". These were certificates issued in various denominations from five to five hundred dollars in an attempt to encourage individuals and organizations to make larger contributions to the League's Preventive Fund. The "bonds" were also expected to have a publicity and educational value when displayed.[20]

19. S.A.T.L., "Annual Report of the Christmas Seal Committee for 1954" mimeographed, p.3.

20. S.A.T.L., "Annual Report of the Christmas Seal Committee for 1938", in Valley Echo, Vol.XX,No.8 August 1939, p.20.

The following year the Rural Municipal Secretaries undertook to sell seals in the Rural Municipalities. In the campaign of 1949-50 this group raised $2,324 for the preventive work of the League.[21]

In summary, the preventive work of the League is at present financed through funds received from the Christmas Seal Campaign, the sale of Health Bonds, the A.C.T., the Rural Secretaries and, occasionally, from special canvasses.

The nature of the preventive work done by the League has changed to some extent since 1929. To a large extent this has been the result of technological advances in the x-ray equipment used for diagnosis and case finding. Late in the 1930's the technique of photofluorography was developed and in 1941 the League pioneered in the use of such equipment for mass surveys of the apparently well population. Since then, using improved equipment, the League has completed three mass surveys of the province.

Since the 1940's then the emphasis in the preventive program has been on the mass x-ray surveys. Before then the emphasis was on stationary clinics and a travelling consultant service which in 1926 was considered "the most important part of the work being done by the League as far as prevention is concerned".[22]

21. S.A.T.L., "Annual Report of the Christmas Seal Committee for 1949-50", in Valley Echo Vol.XXXII, No.8, August 1950, p.22.

22. Minutes of the Board, December 21, 1926.

The stationary clinics and travelling consultant service are still important elements in the case finding program. It might be pointed out here that these methods emphasize the close relationship between the League and the private practitioners of the province. This relationship has been a significant characteristic of the organization of the program in Saskatchewan.

> The medical profession and particularly the family physicians are the keystone in the case finding campaign. Seventy-five per cent of new cases are diagnosed or suspected by the family doctor, and referred direct to sanatoria or clinics.23

Some understanding of the extent of the League's preventive program and of the relative emphasis placed upon its various elements may be gained from the following summary of preventive services for 1952.[24]

TABLE I

PREVENTIVE SERVICE	NO. OF EXAMINATIONS
Diagnosis at Sanatoria	5,340
Other stationary clinics	6,286
Travelling consultant service	247
Miniature x-ray surveys	225,631
Special x-ray surveys	2,500
Contacts examined by family doctor	849
Examination of nurses in hospitals	2,529
Indian survey-Treaty Indians	8,702
Non-treaty persons	1,888
Staff of Indian institutions	259
Miscellaneous surveys	868

Just as the effectiveness of the clinic and consultative service depends upon the informal cooperation

23."Submission 1943", p.10.

24. S.A.T.L., "Annual Report of Medical Services for 1952", in Valley Echo, Vol.XXXIV, No.8, August 1953, p.17.

of the physicians in the province, the preventive work of the League in general is so organized as to require the cooperation of many other groups and organizations including the clergy, press and teachers of the province; women's organizations such as the I.O.D.E., Homemaker's Clubs and Local Council of Women; fraternal groups such as the Canadian Legion and the councils of the various municipalities in the province.

The Part Played By The Provincial Government In The Tuberculosis Control Program

Like the preventive program, the curative program in Saskatchewan is planned and carried out by the League. The funds for the curative program, however, are raised by other governing bodies to meet the League's expenditures on treatment account. In addition to this, the plant which the League operates in carrying out the curative functions is owned by the Provincial Government. It is obvious then that the Provincial Government is indirectly involved in the anti-tuberculosis program in this province although its actual influence upon the direction of the program seems to be limited to its representation on the Board of Directors of the League.

The provincial government has been involved in the League's activities ever since the League was formed in 1911.

> The first meeting (of the League) was held in 1911, and one of their first moves was to interview the Government pointing out the necessity for a sanatorium, and inasmuch as this League

> represented a large proportion of the people of the province, through their local Leagues, the Committee interviewing the Government was able to demonstrate to the Government that the need for a sanatorium was genuine and that the public at large was really behind the movement, and would readily endorse any expenditure made by the Provincial Government for such purpose. In other words, this League was instrumental in creating the necessary public opinion in favor of having the money spent by the Provincial Government for a sanatorium. 25

The League originally asked the government for $50,000[26] but of this amount the government would promise only $25,000 and that only if the League could raise an equal amount by voluntary subscription. Apparently the government put somewhat less faith in the League's public prestige than is implied in the above statement.

This original provincial grant was made only after the government had investigated the League's position rather carefully - as is evidenced by the following extract from the report of the Secretary in 1911.

> The government would like to have submitted a statement of our proposed plans and the length of time intended for their completion, along with an estimate of the cost of maintenance, as well as our

25. Correspondence, Acting Deputy Minister of Public Health to the National Tuberculosis Association, New York, March 14,1929, Saskatchewan Department of Public Health Central Files, File No. 497.

26. F.C. Middleton, "Evolution of Tuberculosis Control in Saskatchewan", Canadian Public Health Journal Vol. XXIV, No. 11, November 1933, p.505.

prospective sources of revenue. [27]

By November 1911 the League had succeeded in raising its $25,000 share and in obtaining the provincial grant. The League immediately requested additional provincial aid, so as "to enable us to build a suitable infirmary for advanced cases of tuberculosis...". [28] Since no response was received to this request, the following year (1912) the League requested that the sum of $75,000 be granted to the Board, "being a revote of the $25,000 from last year and the sum of $50,000 to assist in the erection of a hospital for advanced cases". [29]

The following year, in 1913, the government promised to donate $60,000 to the League "on the condition that the League furnish $40,000 by public subscription." [30] This was later altered to increase the government grant to $90,000 if the League could raise $60,000.

In the meantime the League had purchased a site at Fort Qu'Appelle after a delegation from that district had "made an offer of $3,000 to be paid to the Trustees of the Saskatchewan Anti-Tuberculosis League in consideration of the selection of the Miller property

27. Minutes of the Board, November 17,1911.

28. Loc.cit.

29. Minutes of the Board, March 14,1912.

30. Loc.cit.

near Fort Qu'Appelle being made the site for the Sanatorium".[31] The construction of the institution was undertaken in the summer of 1913 with the funds received from the government supplemented by the voluntary funds raised by the League.

Up to the outbreak of war in 1914 the provincial government had actually advanced $104,125.81 to the League.[32] The League had raised the sum of $97,000 during the same period by voluntary subscription.[33] By July 1914, however, these funds had been exhausted and the League once again petitioned the provincial government for assistance, this time in the form of a loan. The requested loan was for $95,000, "the same to be repaid in eight annual instalments with interest at the rate of 5% per annum." An order in council was passed approving the loan, "in consideration of the great beneficial effects to the public by the early completion of the Sanatorium".[34] An agreement was then entered into between the League and the government outlining the previously described terms. With the outbreak of war, however, this agreement was suspended and the League, its funds exhausted,

31. Minutes of the Board, March 14,1912.

32. Report of the Building Committee, Minutes of the Board, September 12,1916.

33. "Submission 1943", p.2.

34. Correspondence from Deputy Provincial Treasurer, bound in Minutes of the Board, July 11,1914.

ceased work on the Sanatorium.[35]

It was only after the provincial government once again came to the League's assistance that the construction was completed. In 1916 the President of the League reported that he had the assurance of the government that -

> In the event of the League appointing a thoroughly competent committee of five members to conduct and complete the building operations of the Sanatorium... the necessary funds would be provided....[36]

Subsequently, in 1917, the province loaned the League $150,000 "for the purpose of capital expenditure of the League, to be secured by first mortgage upon the property of the League...."[37] As a result of this provincial assistance, the League was able to open its original institution, with a capacity of sixty patients, on October 10, 1917.

The following period was one in which the League expanded its facilities and every time it did so, the provincial government became more deeply involved in the League's capital financing. In 1918, the League made an agreement with the Dominion government for the treatment of tuberculous veterans. In order to fulfill its committments by this agreement the League had once again

35. Report of the Building Committee, Minutes of the Board, September 12, 1916.

36. Minutes of the Annual meeting of the S.A.T.L. August 19, 1916.

37. Minutes of the Board, February 15, 1917.

to solicit the provincial government for assistance. In 1918 it obtained a loan of $150,000 from the province to expand its treatment facilities.[38] This loan was secured by a second mortgage on the League's property.

This resume of events from 1911 to 1918 demonstrates the almost complete dependence of the League upon the provincial government for the acquisition of its capital facilities. In fact, then, provincial responsibility for providing such facilities, directly or indirectly, appears to have been generally accepted in this province since the initiation of the program. Official recognition of this is suggested in the following:

> The attitude of the Government from the commencement of the League is that the work must go on, and, if voluntary contributions from the public are not forthcoming to meet any of the League's financial obligations, that the government must come to the rescue. There is no question in my judgement, that this policy must be adopted by any Government. 39

It should occasion no surprise then to find that when the Anti-Tuberculosis Commission of 1922 inquired into the question of responsibility for capital facilities it reported as follows:

38. Report of the S.A.T.L. for the Years 1920-1924, p.5.

39. Correspondence between Provincial Treasurer and the Dominion Department of Soldier's Civil Re-establishment, June 26, 1918, Scott Papers, Public Health-General, 1905-1911, Archives of Saskatchewan.

> There were no two opinions expressed with respect to this question. The opinion of all may be summed up in the following resolution passed by the Hospital Board of Regina.... The cost of buildings and equipment, we believe, should be borne by the Province at large. These should be sufficiently equipped to care for all tubercular patients within the province who might require to go there. We consider that there is ample justification for taxing all the people for this in the fact that it is not only the patient, but his family and the community who will be benefited by him receiving treatment within an institution, and the danger of spreading infection to others being lessened. 40

The commission also found in favor of additional facilities being constructed for treatment of the disease. In preparation for this, and in recognition of the apparently clear case for provincial responsibility for capital expenditure, a new act was passed. This act, The Tuberculosis Sanatoria and Hospitals Act, 1923, recognized the fact of previous provincial responsibility for the League's capital facilities by providing for the transfer of the title of all property owned by the League to the Crown. Since most of this property was already heavily mortgaged to the province, the following provision was included.

> In consideration of the transfer of the property of the League to His Majesty, the province shall pay to the League the sum of sixty thousand dollars and shall release the League

40. Province of Saskatchewan, Report of the Saskatchewan Anti-Tuberculosis Commission, Regina, King's Printer, 1922, p.38. (Hereafter Commission 1922).

> from liability under any mortgage or other security held by the province for advances made to the Trustees of the.....League. 41

The same act, however, provided that the "care, control, conduct and management of all tuberculosis sanatoria and hospitals owned by the province" was to be entrusted to the League. 42

Following the Commission's report, the government then undertook the construction of a Sanatorium at Saskatoon. This institution opened in 1925 with a capacity of 135 patients (which was later increased to 175) and was duly turned over to the League for operation and management. Similarly the third sanatorium was constructed by the provincial government in Prince Albert, opened and turned over to the League in 1930. These three sanatoria, all in effect built with provincial funds, comprise the present plant of the League.

The part played by the provincial government in the curative program itself has not been limited to the provision of capital facilities. It has also accepted partial responsibility for subsidizing the League's operations on current account. When the original Sanatorium began operations in 1917, the provincial government paid a hospital grant to the League of fifty cents per day for each patient receiving treatment. This was merely an

41. Statutes, 14 GeoV,C.59,s.16.

42. Statutes, 14 Geo.V,c.59,s.17.

extension of the general provincial grant to all hospitals operating in the province to the specialized institutions for the treatment of tuberculosis. The basis for this grant is to be found in An Act to Regulate Public Aid to Hospitals, Revised Statutes of Saskatchewan, 1909, Cap.27,s.3. In addition to this grant, however, the province was also asked for loans on treatment account as a "means of financing the current operations of the League until such time as the institution was on a paying basis".[43] In 1917 the League borrowed $16,500,00 from the Province for this purpose.[44]

The provincial grant to the League on treatment account has continued to this day, and while it has undergone some alteration as to amount, these changes have not been large enough to suggest an alteration in the principles involved. Even with the introduction of free treatment in 1929 the province continued to accept only a partial responsibility for financing treatment. The fifty cent per day grant of 1917 was raised to $1.00 per day in 1923. It remained at that amount from 1923 to 1950 when it was raised to $1.50.[45] In 1949 the $1.00 per day grant paid about 17 per cent of the operating costs of the Sanatoria. With the increase in the grant in 1950

43. Minutes of the Board, October 22,1917.

44. Minutes of the Board, December 12,1917.

45. Statutes, 14 Geo.VI, c.98.

the province was in effect paying about one quarter of the current operating costs of the League.[46] The following year, in 1951, the government acted upon the finding of the Committee on Provincial-Municipal Relations and raised the per diem grant to $2.00.[47]

The Part Played By The Municipal Government In The Tuberculosis Control Program

The part played by the municipalities in the tuberculosis control program in this province has also been, on the surface at least, a financial one. When the League was incorporated in 1911 it was expected that its treatments costs would be met by charges made on the patients themselves.

> Charges for the support of such of the inmates of the sanatoria and hospitals as are of sufficient ability to pay for the same or have persons or kindred bound by law to maintain them and able to do so shall be paid by such inmates, such persons or such kindred at a rate to be determined by the said trustees. 48

As the wording of this provision suggests, however, it was recognized that there would be indigent patients. The same act provided that such patients might be admitted

46. Saskatchewan Urban Municipalities Association, Proceedings of the Annual Convention, 1950, p.61

47. See Province of Saskatchewan, Report of the Committee on Provincial-Municipal Relations, 1950. Regina, King's Printer, 1951, p.61

48. Statutes, 1 Geo.V, c.10, s.8.

"upon the request of the mayor of the incorporated city or town or the overseer of any village, the reeve of the rural municipality or the chairman of the local improvement district....".[49] The charges for such patients were to be "paid by the municipality".

With the opening of the Sanatorium, however, it became immediately apparent that such financial arrangements were quite inadequate. The League thereupon sought to find sources of revenue to supplement earnings from patients (indigent and otherwise) and the provincial grant. At the annual meeting held in January, 1918 a motion was adopted urging "an annual levy ... upon each municipality sufficient to carry on the work of the institution.....".[50] The League approached the municipalities and the provincial government and in 1920 the Saskatchewan Association of Rural Municipalities resolved that it was "in favor of adequate support being given to the sanatorium for Tubercular [sic] patients at Fort Qu'Appelle...".[51]

The same year the Rural Municipalities Act was amended to provide that "the council of every municipality shall make an annual grant of at least $100. for the benefit

49. Statutes, I, Geo.V, c.10, s.9.

50. S.A.T.L., Minutes of the Annual Meeting, January 19, 1918.

51. Saskatchewan Association of Rural Municipalities, "Minutes of the Annual Convention, 1920", p.7. (hereafter S.A.R.M.)

of the sanatorium for the treatment of cases of tuberculosis at Fort Qu'Appelle, and may make an annual grant of a greater sum not to exceed $500."[52] There were 301 Rural Municipalities during this period and, since annual collections made under this section of the Act never exceeded $30,100, it is concluded that all municipalities contributed only the minimum amount.

The unequal distribution of the indigent tuberculous sick among the municipalities and the inequality in their financial capacities, however, led to considerable discontent with this arrangement. In an effort to improve the situation, the League and certain rural municipalities formulated a "pooling" agreement to come into effect January first, 1923. This "rural pool", as it came to be called, represented an attempt to broaden the municipal base by having as many municipalities as possible "pool" their responsibility for the indigent tuberculous sick. According to the agreement, the funds of the pool were to be made up of "the total of the grants payable under... section 201a of the Rural Municipalities Act".[53]

The costs of treating patients admitted from rural municipalities which were members of the pool were charged against the capital fund created out of the $100 per annum compulsory contribution of all rural municipalities whether

52. Statutes, II Geo.V, c.37,s.201a.

53. Memorandum of Agreement bound with Minutes of the Board, 1923.

members of the pool or not. If in any year the total charges against the pool were greater than the funds put into it, the deficit was to be charged against the agreeing rural municipalities according to their assessments for taxation purposes.

The operations of the pool were handled by the "Rural Pool Trustee" and were "entirely beyond the control of the League".[54] The Trustees were appointed directly by the Saskatchewan Association of Rural Municipalities.

Two years after the initiation of the Rural Pool a similar pool was created by the urban municipalities. This pool was a purely voluntary one comprising those urban municipalities which desired to enter into an agreement with the League for combining their responsibility for tuberculous indigents. Unlike the fund of the rural pool, however, the urban pool fund as originally organized was not created by compulsory levies upon all urban municipalities. The rural municipalities of the province all had to contribute to the fund of the rural pool whether they were members of it or not because of the provisions of section 201a in the Rural Municipalities Act. In the urban pool, however, only the members made the initial contribution out of which the pool's fund was created.

54. Correspondence between the President of the League and the Department of Public Health, September 3, 1925, Saskatchewan Department of Public Health Central Files, File No. 742.

This was set by the League, acting under authority of the city, town and village acts as amended in 1923, at ten cents per capita for each agreeing urban municipality.[55] Then, if the charges made against the pool exceeded this fund in any year, "the balance necessary to meet the costs of the patients sent by the contracting municipalities themselves" was to be apportioned "on a per capita basis among the municipalities forming the pool".[56]

While membership in the urban pool remained voluntary, as did membership in the rural pool, all urban municipalities were required in 1927 to pay the ten cent per capita amount to the pool.[57]

These pools continued to function until 1929. In 1928 the urban pool provided for all persons resident in cities, about half those residing in towns and about one-third of those residing in the villages of the province.[58] About two-thirds of the rural municipalities had joined the rural pool.[59]

55. Minutes of the Board, January 13, 1925.

56. A.B. Cook, The Urban Municipal Pool, Pamphlet distributed to the urban municipalities of Saskatchewan, 1924.

57. Statutes, 17 Geo.V, c.22, c.23 and c.24.

58. Union of Saskatchewan Municipalities, Proceedings of the Annual Convention, 1929, Final Report of the Urban Pool Trustees.

59. "Submission 1943", p.7.

With the institution of free treatment in 1929 the principle of municipal responsibility was retained although its association with indigency disappeared. The basis for the present part played by the municipalities in the tuberculosis control program is to be found in the Tuberculosis Sanatoria and Hospitals Act 1929, which provided that all bona fide residents of the province would be entitled "to receive care and treatment at the expense of the League".[60] The same act required the Board of Directors each year to estimate the cost of treatment for the succeeding year, subtract from it the provincial grant and then to apportion the balance among "all the municipalities in the province both urban and rural, on the basis of their total equalized assessments for the preceding year..."[61]

This arrangement was protested immediately by the rural municipalities, apparently because they felt that "the legislation was not quite equalized and they felt that they were paying a little more than their share".[62] As a result of this discontent, the new legislation was amended the following year to provide that -

> The proportion of the net estimated expenditure to be borne by the urban

60. Statutes, 19 Geo.V, c.61, s.40.

61. Statutes, 19 Geo.V, c.61, s.25.

62. Union of Saskatchewan Municipalities, Proceedings of the Annual Convention, 1929, p.20.

> municipalities shall be forty per cent.. and the proportion to be borne by the rural municipalities shall be sixty per cent. 63

The actual allocation of the burden within each class of municipality was to be based upon the total equalized assessment of each municipality for the preceding year. 64

This organization of municipal responsibility for tuberculosis control survived from 1930 until 1952 when the method of apportioning the municipal share was changed. During this period there was considerable dissatisfaction expressed by the municipalities regarding the responsibility which had been placed upon them. There were two fundamental reasons for this dissatisfaction. Most significant was their complaint that the municipal share of the total treatment costs was proportionately greater than was considered just. As previously described the provincial grant remained unchanged (at $1.00 per day) from 1923 to 1950. During this time, however, there was a generally upward trend in treatment costs. Consequently the balance of the cost after the provincial grant was deducted tended to rise thereby increasing the burden on the municipalities. Throughout the 1930's the province contributed about forty per cent of the annual treatment costs incurred by the League. By 1949 the provincial share had fallen to about eighteen per

63. Statutes, 20 Geo.V,c.84,s.25.

64. Loc.cit.

cent of the total.[65] In 1950 Dominion Bureau of Statistics releases indicate that while the municipalities of Saskatchewan contributed about fifty-four per cent of the League's total revenue, the province contributed 23.5 per cent.

The second complaint of the municipalities was that the method of allocating the total municipal burden as between rural and urban municipalities was unfair. It was in an effort to settle the lengthy dispute over this point that the present formula was adopted. One third of the net estimated expenditure after deducting the provincial grant is now apportioned between the urban and the rural municipalities on a population basis, one third according to the total equalized assessment of each type of municipality and one third on the basis of the total number of treatment days received by residents of each type of municipality in the preceding year.[66]

Municipal Participation In The Preventive Program

In contrast to the official participation by the municipalities in the curative program of the League is their informal participation in its preventive program. Such a distinction is more apparent than real, however, because of the belief held by the creators of the program

65. Province of Saskatchewan, Report of the Committee on Provincial-Municipal Relations, 1950, Regina, King's Printer, 1951, p.65.

66. Statutes, I Elizabeth II, c.108, s.3.

that the best way to ensure municipal support of the program in general was to involve them in it financially.

> The request for the legislation which was put through this year (1929) was more or less from the municipal conventions. In this country, at least, the more you can get such work as this before the public, giving them an equal share and interest in the expense, attains much better results than having such matters entirely governmental. 67

Because of the obvious fact that the surest way to reduce the expenditure upon treatment is to eliminate the need for treatment, it is clearly in the interest of the municipalities to cooperate in the preventive program. Hence, the mass case finding program instituted in 1941 has been organized on a municipal basis and relies to a large extent upon the voluntary assistance of both paid and elected municipal officials.

The Part Played By The Dominion Government In The Tuberculosis Control Program

Just as the provincial and local governments in Saskatchewan have become involved in the support of the League's program, so has the Dominion government. Federal aid has been significant to both the curative and the preventive programs of the League in this province.

67. Correspondence, Acting Deputy Minister of Public Health to the National Tuberculosis Association, New York, March 14, 1929. Saskatchewan Department of Public Health, Central Files, File No. 497.

The curative aspect of the tuberculosis control program in Saskatchewan has received federal financial support both on capital and on current or treatment account. The earliest suggestion of Federal involvement in the program appears in 1915 when the League found itself unable to complete the original unit at Fort Qu'Appelle.

> This matter was thoroughly discussed by the Directors, it being the opinion of the majority that probably the Dominion Government could probably be induced to advance or donate sufficient money to complete the Sanatorium, providing the Directors turned over the building to them for hospital purposes. 68

A committee was set up to investigate this possibility. As previously described, however, the League was also negotiating a loan from the province. The result was a joint agreement between the League, the provincial and the Federal governments dated March 18, 1918. In addition to the $150,000 provincial loan made at this time, the Dominion loaned to the League "on a repayment less depreciation basis" $306,000.00 and donated sufficient equipment for the buildings which the League proposed to erect.

The agreement of 1918 was superseded by others. In 1924 it was replaced by a new agreement which cancelled the repayment provisions in the 1918 agreement in consideration of the League reserving forty beds for Indians. The cost of

68. Memorandum of Agreement bound in Minutes of the Board, 1950.

treatment of these Indian patients was to be paid by the Dominion Department of Indian Affairs. The same agreement bound the League to provide the Department of Soldier's Civil Re-establishment with sixty beds. Both the Indian Department and the D.S.C.R. agreed to pay for treatment rendered their patients at a rate of $3.00 per day.[68]

Actual Dominion assistance received by the League from 1918 to 1924 amounted to $61,029 in direct contributions and $247,418 had been "advanced or loaned".

The new agreement of 1924 was "validated and confirmed" by provincial statute in 1928.[69] The only change made in the original agreement was a re-adjustment of the rates to be paid by the two Dominion departments concerned.

Following World War I the number of veterans receiving treatment declined rapidly with the result that League earnings from the Dominion decreased. Although there was an increase in the League's earnings from the Department of Indian Affairs during this period this was insufficient to compensate for the rapid loss of revenues from the D.S.C.R. In 1919 the League reported that it was treating three veterans for every civilian. By 1924, however, there were six civilians for every veteran undergoing treatment.[70]

68. Memorandum of Agreement bound in Minutes of the Board, 1950

69. Statutes, 19 Geo.V,c.85.

70. Report of the S.A.T.L. for the Years 1920-1924 p.7.

Following the Second World War almost the same pattern appeared as in 1918. In 1945 the League entered into an agreement with the Department of Veteran's Affairs. In return for a grant of $85,000 the League agreed to provide eighty-five additional beds for veterans and all necessary treatment and maintenance.[71]

In the post-war period League earnings from the Department of Veteran's Affairs have been an important part of the League's revenues. In 1945 the League had 150 veterans undergoing treatment.[72] With improvements in techniques, however, the decline in this source of revenue was even more rapid than after the First World War. The result has not been as marked a decrease in League earnings from the Dominion, however, as in the previous situation, because of more rapid acceleration in work among the Indian population of the province. Total earnings from the Dominion as indicated by the Dominion Bureau of Statistics rose from $159,792 in 1944 to $328,718 in 1948, although they declined in 1949 to $304,888. The following table illustrates the reason for the continuing significance of the Dominion participation in the League's treatment program.[73]

71. Memorandum of Agreement bound in Minutes of the Board, 1951.

72. S.A.T.L.,"Annual Report of the Director of Medical Services for 1945",In Valley Echo,Vol.XXVII,No.8 August 1946, p.11.

73. From S.A.T.L.,"Annual Report of Medical Services for 1953", mimeographed,p.3.

TABLE II

HOSPITAL DAYS TREATMENT

YEAR	DIA	DVA	TOTAL TO DOMINION
1930	4,594	5,585	10,179
1940	11,526	1,496	13,022
1948	23,445	36,173	59,618
1949	25,647	27,229	52,876
1950	38,443	19,545	57,988
1951	48,865	17,105	65,970
1952	60,053	17,750	77,803
1953	66,213	14,010	80,223

While the earnings from treatment of veterans has tended to decrease since the end of the war, the earnings from treatment of Indians has more than offset this, with the result that total earnings from the Dominion have tended to increase up to 1953. There is some evidence to suggest, however, that the League does not expect any further increases in the treatment days devoted to Indians.

> Possibly the League has reached the peak so far as Indian days are concerned. As at December 31st, 1953, we had 171 Indians under treatment compared to 195 on the same date a year ago. 74

This would suggest that the League's total earnings from the Dominion in 1953 may represent the peak of the trend described.

Dominion Participation In The Preventive Program

As might be suspected from the above discussion the Dominion government cooperates with the League in the extension of the case finding program to the Indian population of the province. In addition to this, however,

74. Ioc.cit.

the Dominion also assists the League in its overall preventive program.

On May 14, 1948 the Federal government announced its health program which provided for annual grants totalling approximately $30,000,000 to the provinces for health services and hospital construction. Of this, three million was to be used for tuberculosis control.[75] The distribution of the grant among the provinces was to be fifty per cent on the basis of the per capita distribution of population as given by the preceding census and fifty per cent on the basis of the average number of deaths from tuberculosis in each province over the previous five years as certified by the Dominion statistician.[76] Saskatchewan's share was estimated at about $176,000 in 1948.[77]

The League, in cooperation with the provincial government, has devoted most of the revenue made available by this grant to expand certain elements of the preventive program in Saskatchewan. It has used it to develop its hospital admission x-ray program, to extend the use of streptomycin and other drug treatment, to finance B.C.G.

75. Canada, Dominion Bureau of Statistics, The Canada Year Book, 1948-1949, Ottawa, King's Printer, 1949, p.227.

76. Minutes of the Board, July 29, 1948.

77. Ioc.cit.

vaccination of the unavoidably exposed, for x-ray surveys of the apparently well population, to extend its surgical facilities, to organize a rehabilitation and follow-up program and to finance certain research projects.[78] In short, the Dominion grant has been used by the League to fill in certain gaps in a preventive program which is otherwise financed through voluntary contributions.

78. Province of Saskatchewan, Annual Report of the Department of Public Health, 1951-1952, Regina, Queen's Printer, 1953, p.20.

CHAPTER III

THE ACTIVITIES AND PROGRAMS OF THE LEAGUE

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THE ACTIVITIES AND PROGRAMS OF THE LEAGUE

The purpose of the present chapter is to describe the way in which the Saskatchewan Anti-Tuberculosis League has sought to combat the tuberculosis problem in Saskatchewan. Attention will be drawn to the principles underlying the League's approach to the problem as well as to the nature and scope of its activities.

The tuberculosis control program in Saskatchewan, as described in the preceding chapter, is conducted in its entirety by the Saskatchewan Anti-Tuberculosis League. Before proceeding to examine the nature of this program itself, it is necessary to advance an explanation of what might be called its "underlying philosophy".

This is indicated in the following extract from an address given in 1923 by Mr.A. B. Cook, then the Managing Director and President of the League.[1]

> Without the wholehearted support of the people we are doomed to distress. There is no government strong enough to force anti-tuberculosis measures on the people if they do not want it...

The League has been deliberately organized to obtain a maximum of such public support and the League's program has been designed in such a manner as to promote this same end.

1. Canadian Tuberculosis Association, Papers on Tuberculosis, Ottawa, printed and distributed by the Canadian Tuberculosis Association, June 1923, p.4.

This is clearly apparent throughout the entire history of the League in Saskatchewan. Succeeding chapters will show how this underlying principle has affected the financing and the management of the League. The following discussion will show how the activities of the League have been shaped by the same policy.

The Treatment Program

As in the previous chapter it is convenient here to consider the League's activities under two headings - the treatment program and the preventive program. The basis of the League's treatment program is its plant which consists of three specialized institutions for the treatment of tuberculosis. These sanatoria are strategically located throughout the province. The largest is at Fort Qu'Appelle with a capacity of 350 beds; the next in size is located at Prince Albert with 270 beds; and the smallest is at Saskatoon with 180 beds.

Functionally, each of the three sanatoria is independent of the others, although Saskatoon receives most of the patients requiring surgery. The two smaller sanatoria were built as a result of the findings of the Anti-tuberculosis Commission of 1922.[2]

2. This Commission was appointed in July 1921 by an Order in Council which charged it with the task of enquiring into "the question of tuberculosis in the province". The personnel of the commission were A. B. Cook, President and Managing Director of the Saskatchewan Anti-Tuberculosis League; R. G. Ferguson, Medical Superintendent of the League; J. F. Cairns, a member of the Board of Directors of the League; and R. H. Brighton. A. B. Cook was appointed Chairman of the Commission.

This commission favored the construction of two fairly large institutions located near larger centres of population apparently because it felt that an institution of approximately one hundred beds capacity would realize the optimum advantages of scale. Its report held that "it is impossible to operate a smaller institution effectively without increasing the maintenance expense", while at the same time it felt that it was questionable whether "economic advantage can be gained by exceeding one hundred beds in a single institution because this is approximately the accommodation needed to serve the average centre of population in Saskatchewan."[3]

While the economies of scale were given the equivalent of a modest paragraph in the report, however, the other advantages of moderate decentralization and location of the institutions near the larger centres of population were dealt with at considerably greater length. In addition to various conveniences, the following were significantly included in the list of advantages expected from building several smaller institutions throughout the province rather than one large, central, sanatorium.

> 4. To exercise an educational influence by keeping the importance of anti-tuberculosis activities before the people.
> 5. Opportunity for close co-operation with many practising physicians in the centres of population.
> 6. The co-operation of social service organizations would be more easily obtained.[4]

3. Commission, 1922, p.45.

4. Ibid.,p.44.

All three of these were important items to an organization primarily designed, and officially encouraged, to achieve the active cooperation of the public at large. The second point was important to the League's policy of handling its field work through the private practitioners of the province.

The educational considerations involved in the choosing of a site were again emphasized in 1928 when a committee of the Board of Directors presented two reasons for locating the third sanatorium at Prince Albert. These were given as:

1. The high death rate in the Northern area.
2. "...the advantage of small units and more centers of interest, education and available facilities for diagnosis."

It was also emphasized that "people in districts adjacent to a sanatorium get familiar with its advantages..."[5]

While the three sanatoria were actually built in accordance with these principles and while in operation they are separate units, the program itself is still highly centralized in this province. That is, the three sanatoria are managed and operated by the same overall organization in spite of their geographical dispersion. This is quite unlike the organization of the program in Ontario, for example, where the various sanatoria are operated by a number of official and voluntary agencies on what is essentially a local basis.

5. Minutes of the Board, February 8, 1928.

It should also be noted here that from the outset of the program in Saskatchewan there has been no attempt to separate the advanced from the early cases within the sanatoria. Instead, as early as 1911, the policy suggested in the following was adopted.

> The best results can be obtained when facilities are at hand for the treatment of both early and advanced cases, as the one management can attend to both; and in practice it is found difficult to differentiate between the case which should be in the Sanatorium, or in the hospital for advanced cases. Consequently, we must endeavor to make provision at the start for caring for both the early and the advanced cases. 6

In accordance with this, no distinction has been made between patients on the grounds of their condition when admitted for treatment. Nor has there ever been other than one class of treatment. Even prior to 1929, in the period when those patients who could were required to pay, the League maintained only one class of treatment. The Anti-Tuberculosis Commission of 1922 found that this treatment "was of a sufficiently high standard for those who were able to pay the cost of their treatment to desire no better."[7]

Adequacy of the Treatment Facilities

There is no definite standard by which to assess the adequacy of the League's treatment facilities. Comparisons are

6. Minutes of the Board, Report of the Honorary Secretary, November 17, 1911.

7. Commission, 1922, pp.32-33.

frequently made between provinces, but this approach is of dubious usefulness in view of the wide variation in circumstances involved. Simply comparing ratios of beds to population of the various provinces ignores the question of need - that is, it does not take into account the probable differences in the extent to which the particular populations are tuberculized.

A more useful method of comparison makes use of the ratio between the number of beds and the number of deaths from tuberculosis. In 1951 Saskatchewan had 5.1 beds per death while Ontario, by comparison, had 8.6.[8]

If "adequacy" refers to a "bare minimum" required to render the program operative, an estimate accepted by the present Director of Medical Services of the League might provide a rough guide. This estimate regards three beds per death as a certain minimum.[9] It is obvious, however, that if only the curative aspects of sanatorium accommodation are being considered, the number of beds required will depend upon the number of new cases appearing, the frequency with which they appear and such technical considerations as the length of time required for treatment. If an active preventive program is being carried on simultaneously, the treatment facilities required will vary with the intensity of the case finding program and the incidence of active disease.

8. Canadian Tuberculosis Association, Bulletin, Vol.XXXI, No.2, December-January, 1953, p.3.

9. S.A.T.L., "Annual Report of Medical Services", 1952, mimeographed, p.2.

If the object of the preventive program is to isolate the infectious cases from the well population, and if the death rate is thirty or less per 100,000 of population, one authority states that at the peak of the program five to six beds per death are required.[10] It may be assumed then, that since the tuberculosis death rate in Saskatchewan is well under 30 per 100,000 (being 10.1 in 1953), no more than six beds per death would be required by this standard. According to this method of estimating "adequacy" of treatment facilities, Saskatchewan has only recently had sufficient treatment accommodation. As late as 1949 this province had only 4.3 beds for every death from tuberculosis. The marked reduction in the number of deaths since then, however, has increased the "beds per death" ratio to a much higher level. In 1953, for example, Saskatchewan had 9.2 beds per death - considerably more than the maximum six to one ratio required to isolate the infected from the well population by Dr. Ferguson's estimate.

Free Treatment

The treatment of tuberculosis has been free to the individual in Saskatchewan since 1929. Twenty-five years later a survey showed that only four other provinces (Alberta, Manitoba, New Brunswick, and Nova Scotia) had followed Saskatchewan's lead in abolishing patient fees. While the other provinces require only a small number of patients to pay for the cost of their treatment, they still have not formally recognized the principle involved.

10. See R. G. Ferguson, Studies in Tuberculosis, Toronto, University of Toronto Press, 1955, p.92. (Hereafter referred to as Ferguson, Tuberculosis)

The actual reasons for Saskatchewan's remarkable lead over other provinces in this respect are, of course, highly complex. The reasoning underlying the free treatment argument itself, however, is quite simple. As suggested in Chapter One, the provision of facilities for curing, or at least isolating, the tuberculous sick is the essential element in any tuberculosis control program. The next most important step is to get these individuals into the sanatorium as early as possible so as to shorten the time (and hence the expense) of their cure and to minimize the possibility of them spreading the disease. This clearly cannot be done if the individual is unable to pay for treatment. He may delay his admission as long as possible; if he does go in he may leave before his treatment is complete; or he may overtax himself after discharge in an effort to regain his financial competence. But this is far more than a problem for the individual. Because tuberculosis is an infectious disease, it is an equally serious problem for the community. Even today the inconspicuous nature of the disease in its early stages obscures for many the necessity of regarding its control as a community problem.

The question of why community responsibility for financing tuberculosis treatment in Saskatchewan was formally recognized so readily can only be raised at this point. It might be noted at this point, however, that the question is more significant from the standpoint of principle than practice, for it actually had little effect upon the ultimate incidence of the financial burden of treatment. In 1928, the

last year of patient charges, only 3.5 per cent of the patients being treated were able to pay for their care.[11] (Uhrich Papers File, 10a, TB General).

The fact remains that free treatment was accepted in principle as early as 1929. This acceptance followed an apparently spontaneous outburst of enthusiasm for such a measure not among the general public, but in various interested and influential groups. Particularly significant among these were the two associations of municipalities. It will be recalled from the previous chapter that by 1928 the League had forged a strong bond with the municipalities of this province through the "pooling" schemes and the inclusion of five municipal directors in the Board of Directors. It is clear that the League's successful efforts to involve such organizations in its program played an important part in the free treatment movement in Saskatchewan.

Compulsory Treatment

There is no clearer illustration of the League's belief in its philosophy of education and persuasion than its attitude toward compulsory treatment for tuberculosis. The actual legal status of compulsory treatment is not clearly defined at present. The general consensus, however, appears

11. Minister's Correspondence, Uhrich Papers, File No. 10a, Tuberculosis-General, Archives of Saskatchewan, Saskatoon.

to be that while there is no specific statutory provision requiring tuberculous persons to enter a sanatorium, such compulsory procedures may be enforced under section 69 of the Public Health Act. Even so, however, it is apparently impossible to retain a person for treatment under the provisions of this statute.

From time to time this problem has attracted official attention. Within recent years it appears that the Department of Public Health has been concerned with the problem and has urged that the League make the necessary arrangements to accommodate recalcitrant patients.[12] Such a move, however, would conflict with the League's emphasis upon voluntary public cooperation. This is illustrated in the following extract from the minutes of the Annual Meeting of the League in 1952.

> Dr. Ferguson...urged that, if it was felt that the non-co-operative patient should be forced to accept treatment, that the place of detention should be in no way associated with the sanatorium or the League. The Department of Public Health would be better able to deal with this type of patient. 13

The implication of the above statement is clear. The League does not object in principle to the idea of compulsory treatment. There are obvious reasons for this, since, with the reduction in the incidence of the disease in this province to the point where it is a minor cause of death, the relative

12. S.A.T.L.,"Minutes of the Annual Meeting", August 1,1952.

13. Ioc.cit., underlining added.

importance of one recalcitrant active case is much greater than it was when the facilities were strained to provide even for the cooperative cases.

Now that the object is eradication and not merely control, it is apparent that the demands for compulsory treatment will increase. It is equally apparent, on the basis of its past policy, however, that the League will resist all attempts to make it the agent of such compulsion.

Research and Innovation

While the preceding chapter has illustrated the substantial differences between the League in its present form and the purely voluntary health agency, the League still retains many of the desirable characteristics of that type of organization. One of these is its demonstrated ability to attract persons able and willing to devote all their energies to the advancement of the League's work. In addition to this, the League has definitely retained a remarkable degree of independence.

One of the comprehensive studies devoted to the examination of voluntary health agencies in the United States found that one of their chief advantages lay in the fact that -

> ...these agencies typically embody certain characteristics which make it possible to use available talents as well as technical and material resources for advancing the public health in ways not always feasible through the official agencies. 14

14. S.M. Gunn and P.S. Platt, Voluntary Health Agencies An Interpretive Study, New York, Ronald Press, 1945, p.36. (Hereafter referred to as Gunn and Platt, Health Agencies)

Perhaps the clearest example of the League's ability to utilize this advantage is to be found in its research into the usefulness of the BCG vaccine. This vaccine was first produced in 1921 by two French scientists, Dr. Albert Calmette and Dr. Camille Guerin of the Pasteur Institute in Paris. To this day, however, the vaccine has been subject to varying degrees of professional disagreement as to its usefulness.

Significant research was begun into these questions by Dr. Ferguson, Director of Medical Services of the League over most of its history, among Indian infants in 1933. Encouraged by these and other studies, the League decided in September of 1938 to offer the vaccine to tuberculin negative (non-infected) nurses in eight large general hospitals and to all tuberculin negative employees in the three sanatoria in Saskatchewan.[15] Since then, use of the vaccine has been extended by the League. In 1951, for example, BCG was offered to all tuberculin negative persons in certain high case rate areas of the province.[16]

It is questionable if such a potentially controversial course of action could have been taken by official agencies in the province. The League, on the other hand, has worked for over forty years to win the voluntary support and the confidence of such organized groups as the Saskatchewan Medical Association which might have opposed official sponsorship of such innovations as the widespread use of BCG.

15. Ferguson, Tuberculosis, p.50 and p.99.

16. Minutes of the Board, August 3, 1950.

A further example of the League's ability and willingness to innovate is to be found in the story of the mass chest x-ray as a preventive technique, but this will be discussed when the preventive program in general is discussed later in this chapter. At this point, now that some illustrations of the advantages of the League's independence have been given, it is necessary to observe some of the costs of that independence, especially as they relate to the treatment program in Saskatchewan.

The League And The Department Of Public Health

As might be expected, in this as in other fields of community organization, the advantages of specialization are gained only at the expense of the advantages of integration. The League is a highly specialized organization designed to conduct the tuberculosis control program in the province with a minimum of official assistance.

There is considerable evidence of the actual independence of the League from government interference in its treatment program. In 1943, for example, the President of the League made the following statement:

> I feel that a record should be made here of the splendid, sympathetic support and financial assistance the League has received at all times from the Government of the Province of Saskatchewan; in addition to the financial support that has been given, they have, at no time, attempted to interfere in any way with the administration of the League. 17

In 1939 the Minister of Public Health gave concise explanation of the Government's position in the following words:

17. S.A.T.L., "Annual Report of the President, 1943", in Valley Echo, Vol.XXV, No.8, August 1944, P.10.

> ...the management and operation of the sanatoria in this province, including the appointment and supervision of staff, are under the jurisdiction of the Saskatchewan Anti-Tuberculosis League. The Government has no authority whatever in the matter. 18

As previously mentioned, the Department of Public Health itself has never played a significant part in the tuberculosis control program. It is true that a formal connection has been established between the Department and the League. In 1948 the Annual Report of the Department announced that -

> The Division of Communicable Disease administers the regulations governing tuberculosis, especially in the matter of delinquents, maintains a register of all cases, and transfers to the health regions concerned the case and family histories of all patients under League care. 19

The actual extent to which cooperation between the League and the Department exists, however, is difficult to establish. In general, it appears that until recently such cooperation has been virtually non-existent in practice. Personal experience of the writer suggests that the League seems quite unenthusiastic about the invasion of the field of tuberculosis control by the health department. At the same time, there appears to be a growing conviction in the health department that real benefits would be obtained if the League's program were so arranged as to make better use of the facilities of the department.

18. Minister's Correspondence, Uhrich Papers, File. No.106, Tuberculosis Sanatoria, Archives of Saskatchewan, Saskatoon.

19. Province of Saskatchewan, Annual Report of the Department of Public Health, 1948, King's Printer, Regina, 1949, p.14.

The nature and significance of the problem involved here is best illustrated by reference to a particular aspect of the program. For the most part, the League has carried out its case finding, post treatment care and other field services through its own staff working in cooperation with the private practitioners of the province. The League has operated a travelling consultant service and established local clinics to strengthen this relationship.[20]

The Department of Public Health, however, has a rather extensive field organization which could have been used to advantage in providing many extra-mural services to the League's patients. In 1950 the Deputy Minister addressed the Annual Meeting of the League and urged closer cooperation between the League and the Department in view of the fact that the Department's public health nurses and the increased number of health regions could make a substantial contribution to the League's work in the field.[21]

While the League has never released any concrete statements of policy in this connection, the Department's plea seems to have met with little response.

In the course of the writer's own employment in the League's case finding program it was quite apparent that the League did nothing to seek the assistance of field personnel of the Department of Public Health. When such assistance was

20. See section on Preventive Program following.

21. S.A.T.L., "Minutes of the Annual Meeting", August 4, 1950.

offered it was accepted, but the League's activities were usually so organized as to be in no way dependent upon it.

The League's preference in this matter seems to involve its own follow-up department supplemented by its association with the private practitioners of the province. Each year the League's own staff examines between three and four thousand ex-patients in the course of following such patients until death.[22] Apparently recognizing the need to do more than provide a certain amount of post-treatment medical supervision, however, in recent years the League has been considering the possibility of instituting a large scale rehabilitation program. In commenting upon the Dominion Tuberculosis Control Grant, the President of the League stated that it "will also provide for the development of a well rounded out rehabilitation plan for persons whose physical disability by the disease necessitates assistance of re-education in order to take their place in the community."[23] Here again it appears likely that the question of cooperation with the official agency will arise.

Such difficulties are merely symptoms of a more fundamental difference of opinion respecting the proper place of the specialized, non-official agency in relation to the general public health program. Whatever the solution to this problem may be, the problem itself is important. On the one hand, it seems possible that the tuberculosis control program

22. Ferguson, Tuberculosis, p.108.

23. S.A.T.L., "Annual Report of the President, 1947", in Valley Echo, Vol.XXIX, No.8, August 1948, p.11.

in Saskatchewan would benefit from closer cooperation between the Department of Public Health and this specialized agency. The Department, for example, has research and statistical facilities, as well as an extensive field organization, which are not being effectively utilized in the campaign against one of the most legitimate public health problems.

On the other hand, the supporters of the League point out that the League has obtained world wide recognition for its program which has been built upon the belief that a campaign which depends upon active public participation can most successfully be carried out by a body independent of the government. Those who hold this view argue that a government agency cannot inspire the public to participate in a "great crusade", that such inspiration can come only from an independent organization drawing its support from the public on a voluntary, as opposed to a coercive, basis.

Whatever the solution to this problem may prove to be, the problem itself arises from the conflicting principles of specialization and integration. This has been a characteristic problem created by the specialized health agency.[24] In the case of the League, its failure to effect any substantial degree of integration with the activities of the official agency must be regarded as the price paid in terms of efficiency of resource use by the community for the advantages attributed to the League's independence.

24. Gunn and Platt, Health Agencies, p.91.

Cost of the Treatment Program

Since the early years of World War II, the cost of providing treatment in the League's three sanatoria has been steadily increasing. This is shown in the following table which shows both the total cost of treatment and the cost of treating one patient for one day in each of the years indicated.

[25]

TABLE III

COSTS OF TREATMENT

[26]

Year	Per Diem Cost	Patient Days	Total Cost
1953	$6.510	285,665	1,868,374.01
1952	6.225	291,093	1,818,991.80
1951	6.115	290,635	1,800,589.39
1950	5.600	292,365	1,668,351.84
1949	5.586	290,147	1,620,784.91
1948	5.380	288,037	1,549,637.87
1947	4.733	292,848	1,386,185.63
1946	3.853	304,848	1,174,656.57
1945	3.230	279,967	904,317.65
1944	2.866	287,167	823,066.02
1943	2.761	272,945	753,610.45
1942	2.676	289,615	774,908.58

It is apparent from the relative stability of the total number of patient days treatment supplied each year that the steadily increasing total costs of treatment are due to an increase in the costs of providing treatment. The nature of this increase is shown by the per diem cost data. Not only is the total cost of treatment at an all time high in 1953, but the per

25. Compiled from the Annual Reports of the S.A.T.L. 1942-1953.

26. Total cost of treatment includes cost of administration, professional care of patients, stores, kitchen, housekeeping, heating, lighting, laundry, buildings and grounds.

diem cost has increased in every year throughout the entire war and post-war periods.

This increase in operating costs has been apparent in every province since the beginning of World War II. In 1948 the Dominion Bureau of Statistics Report of Tuberculosis Institutions indicated that the per diem cost of treatment in Canada had nearly doubled since 1939, with the most marked rise occuring after 1943. The explanation of this, as illustrated in the same report, was that almost the entire increase was due to the rising price level which exerted its effect chiefly through expenditures upon supplies and salaries.[27] The same general explanation appears to apply to the particular situation in Saskatchewan. In 1952 salaries accounted for 54.1 per cent of all the League's expenditures on treatment, and supplies were the next most important element in the total expenditures. With the general rise in salaries and commodity prices during the last ten years, therefore, the increase in operating costs appears to have been inevitable.

Scale of the Treatment Program

Table III above illustrates the fact that in spite of the declining death rate the treatment facilities of the League are still being operated near their peak capacity. This has brought about in two ways. First, the case finding program among the white population is being intensified as

27. Canada, Dominion Bureau of Statistics, Institutional Statistics Branch, Annual Report of Tuberculosis Institutions for 1948, Ottawa, King's Printer, 1951, p.17.

will be shown in the next section of this chapter. Secondly, the League is accelerating its work among the Indian population of the province in cooperation with the Dominion government. In 1950 the General Superintendent of the League reported to the Directors as follows:

> We are facing a period when our patient strength may show a sharp decline among the white population of Saskatchewan and this is the reason for concentrating on Indian Reservations so as to keep our beds full. 28

This increase in Indian work is reflected in the steadily increasing number of Indian patient days treatment being provided by the League.

TABLE IV

INDIAN PATIENT DAYS [29]

1930	4,594
1940	11,526
1948	23,445
1949	25,647
1950	38,443
1951	48,865
1952	60,053
1953	66,213

As a result of these activities there is little doubt that the sanatoria can be kept full for several years. This is supported by the fact that there is still a large amount of work to be done before the Indian death rate is reduced even to what the white death rate is now. In 1951, for example, the Indian death rate was quoted at 413.2 per 100,000 of population. [30]

28. Minutes of the Board, August 3,1950.

29. S.A.T.L.,"Annual Report of Medical Services,1953" mimeographed, p.3.

30. S.A.T.L."Annual Report of Medical Services,1952" mimeographed p.1

In the same year the white death rate was 18.7. It must be kept in mind, however, that the provision of treatment facilities for Indian patients is not a provincial responsibility.

The League is quite clearly drawing upon the backlog of Indian cases to maintain the same level of activity as was required at the peak of the campaign directed at the white tuberculosis death rate.

The Preventive Program

The only real justification for regarding the preventive and treatment aspects of the League's work as separate functions lies in the fact that the former is financed entirely through voluntary funds. In operation and management, however, the treatment and preventive functions of the League are indistinguishable. In the discussion of the treatment program above, it was obvious that a clear separation of the programs would be impossible, even for analytical purposes. The same will again be obvious in the following discussion. It has previously been observed, for example, that the isolation of tuberculous individuals for treatment is an essential factor in the preventive program as well. Similarly, the discovery of new cases, and in particular the discovery of early cases, has an important effect upon the treatment program.

In the simplest terms, the object of the preventive function of the League is to minimize the number of persons contracting tuberculosis. As will be recalled from Chapter One, where the nature of the disease was described, the possibility

of breakdown in the individual depends upon two factors - infection and resistance. It is obvious, once this is recognized, that the object of the preventive program may be promoted in two ways; by reducing the possibility of the individual becoming infected and by increasing his ability to resist the disease if he does become infected. Both approaches are used in the preventive program in Saskatchewan. The concern of this section is with the costs and results of each approach.

Prevention by Reducing Infection

The amount of infection in the community may be reduced in two ways, both of which must be used in any comprehensive preventive program. First, facilities must be provided for isolating all known cases from contact with other members of the community. Tuberculosis is a disease which requires treatment of such a nature that the isolation of patients and the treatment of patients are carried on simultaneously. In the preceding discussion it was found that the isolation function is performed quite adequately through the facilities presently available in this province.

The Case Finding Program

The second means of reducing infection is through the early discovery of unknown cases. Because tuberculosis is an insidious disease with no marked symptoms at its outset, it is obvious that a great deal of infection may be spread by persons who are in the earlier stages of disease before they feel sufficiently alarmed about their condition to seek medical

advice. The activities of the case finding program are directed against this source of infection. The effectiveness, or at least the results of the case finding program, may be indicated by the percentage of new cases admitted for treatment which are in the early or "minimal" stage of disease.

It is commonly believed that early diagnosis reduces the length of treatment necessary to render the patient non-infectious, thereby effecting a saving on treatment account. As suggested in Chapter Three, this would appear to be the economic basis for the informal cooperation of the municipalities in the preventive program. As early as 1928 the Union of Saskatchewan Municipalities, for example, was urging certain legislative alterations on the ground that "if preventive methods were introduced in the incipient stages, the cost of care and treatment would be greatly reduced and chances for complete recovery materially increased."[31]

Before considering the actual results of the case finding program, however, it is necessary to analyze its rather complex organization. The League at present employs many methods of discovering new cases - some more effective than others. An examination of the development of this case finding program has indicated a willingness on the part of the League to innovate and a certain ability to adapt the program to

31. Union of Saskatchewan Municipalities, Report of the Proceedings at the Annual Convention, 1928, p.23.

changing conditions, so long as such adaptations have not required an absolute reduction in the amount of work done by the League. Illustrations of both characteristics will be encountered in the following analysis.

While recent estimates are not available, in 1943, it was announced by the League that seventy-five per cent of the new cases found were diagnosed or suspected by family physicians.[32] The private practitioners of the province are also closely involved with the League in examining "contacts". In 1953 about six per cent of all contacts traced by the League were examined by family physicians.[33] In order to facilitate the discovery of cases through these family doctors the League instituted a system of stationary clinics and travelling consultants to assist physicians throughout the province in diagnosing tuberculosis.

The first stationary clinic was established at Regina in 1923. Since then eight other clinics have been established throughout the Province, with a tenth to be opened in Meadow Lake this year. The doctors in the areas surrounding these clinics send suspected patients to them for diagnosis by the League's specialists.

In the case of physicians in centers remote from both the sanatoria and the stationary clinics, assistance is provided by the travelling consultant service. The travelling consultants

32. "Submission, 1943", p.10.

33. S.A.T.L., "Annual Report of Medical Services, 1953", mimeographed, p.8.

are qualified League physicians who work throughout the province visiting private physicians and assisting them with their diagnosis problems.

The examination of contacts is done through the same organization with examinations being made by family doctors, stationary clinics (including the three sanatoria) and by the travelling consultants.

While not directly a part of the case finding program, the follow-up or review of ex-patients is a major source of admissions. During the past decade about one-third of all admissions to Saskatchewan sanatoria were ex-patients.[34] (Ferguson, p.108) Because there is a proportionately greater number of active spreaders in the readmissions than in the new admissions it has been suggested[35] that the results of the follow up program are even more valuable than the proportion of cases to examinations would suggest.[36]

The elements of the case finding program discussed above have been used by the League since the early 1920's and to this day are important components in the case finding program. All of them, it is seen, involve the cooperation of the family physician with the League and all of them are concerned with persons suspected of having the disease. The best known of the case finding methods used today, however, have yet to be discussed.

34. Ferguson, Tuberculosis, p.108.

35. loc.cit.

36. See Table VII below.

These are, first, the mass x-ray surveys and, second, the hospital admission x-ray program. Both of these were made technically and economically feasible by advances in x-ray technology during the late 1930's. Both are designed to discover new cases even before they are suspected by the individuals concerned or by their doctors.

The story of the mass x-ray survey in Saskatchewan is a clear example of the League's ability and willingness to innovate. The technique of miniature photofluorography was developed just before the outbreak of the Second World War. With the war, however, it became impossible to obtain the new equipment. Nevertheless, the League, apparently impressed with the possibilities of the technique, succeeded in constructing the necessary apparatus. The result was that, in 1941, the League conducted the first North American mass chest x-ray survey in the town of Melville.[37]

By 1943 the League had acquired three portable fluorographic units capable of x-raying one thousand persons per day. In 1946 these units were replaced with the present self-contained vans with double that capacity.

The object of the mass survey is to x-ray the entire population, whether sick or apparently well without discrimination. The greatest difficulty involved is that of organizing a predominantly rural area in such a way as to ensure maximum

37. S.A.T.L., "Annual Report of the President, 1949" Valley Echo, Vol.XXXII, No.8, August 1950, p.27.

coverage. The League's approach to this problem is typical of its attitude toward the public. The surveys are organized roughly on a municipal basis. An itinerary is mapped out for each of three survey units, one of which is based at each of the sanatoria. The secretary of the League and one assistant then tour the routes ahead of the vans holding public meetings. Arrangements for the meetings are made in each center by the municipal secretary and town and village clerks. These officials are asked to invite all the ladies' organizations, service, and church groups to send representatives to the meetings. The town, village and rural municipal councillors are also asked to attend. At the meeting, the League organizer (either the Secretary or his assistant) helps the representatives at the meeting to set up a number of committees, each charged with making certain arrangements necessary for the survey.

In this way the various communities are induced to organize themselves and to provide, voluntarily, the labor, transportation, publicity, hall, and other services necessary to the success of the survey. Each rural councillor, for example, is usually asked to volunteer to canvass every family in his division and to obtain from the head of each family a signed promise to attend the survey with his family.

In 1950 it was estimated that during the time when the vans were on the road the League was receiving the assistance of at least 12,000 voluntary workers.[38]

38. S.A.T.L. Progress Report of the Christmas Seal Committee", July 1950, in Valley Echo, Vol.XXXII,No.8,August 1950,p.27.

Between 1941 and 1953 the League conducted three such surveys of the entire province. The results of these surveys are summarized in the following table.

TABLE V

MASS SURVEY RESULTS[39]

Years	Attendance	Attendence	New Cases	Cases per Examination
1942-47	604,297	74.3%	440	1:1,373
1947-50	640,348	79.0%	294	1:2,178
1950-52	616,862	76.4%	160	1:3,855

In 1952 it became apparent that the effectiveness of the mass x-ray survey was decreasing rapidly. It was clearly becoming increasingly difficult to find a new case through indiscriminate x-raying of the entire population.

Instead of reducing the scope of the mass x-ray surveys in 1953, however, their use was somewhat altered. In the fourth general survey, which will be completed by 1957, instead of comprehensive coverage of the entire province the vans are concentrating on the high case rate areas of the province. The results to be expected are suggested in the following table.

TABLE VI[40]

Year	No.Examined	New Cases	Examinations/Case
1948	189,162	83	2,279
1949	251,948	113	2,229
1950	277,470	83	3,343
1951	238,017	67	3,552
1952	225,631	49	4,605
1953	205,383	64	3,209

39. S.A.T.L.,"Annual Report of Medical Services, 1952", mimeographed.

40. S.A.T.L.,"Annual Report of Medical Services,1953", mimeographed, p.5.

The examinations per case ratio fell from 4,605 to 1 in 1952 to 3,209 to 1 in 1953. With the continued reduction in infection in the province, the effectiveness (in terms of examinations per case) of the mass x-ray survey technique may again be expected to decrease markedly. Because of this, the League is gradually converting the mass x-ray survey into another type of survey - the "tuberculin survey" which represents a further step in the case finding procedure. Reviewing briefly, it will be recalled that the family physicians, the stationary clinics and the travelling consultant service - the earliest techniques employed in case finding - are aimed at persons suspected of having the disease. The mass x-ray survey, which came next, is designed to discover apparently well persons who have the disease, but who are not suspected. The most recent technique, the mass tuberculin survey, is designed to find persons who are potential cases and potential spreaders.

> It may be logical enough to map out large areas for survey, but something additional is required, and it would seem logical on discovery of a new case to place a team in the area, do a tuberculin mass survey, take x-ray films of the positive reactors, and follow the positives as these are the potential cases and potential spreaders. 41

It seems apparent from this that in spite of the declining death rate and the reduction of infection in the province that the case finding program is in no way being curtailed. It is equally apparent that this policy will be pursued far beyond the point where tuberculosis is a minor cause of death (as it is

41. Ibid., p.3.

indeed at present). The objective of the League is clearly the complete elimination of the disease. And this is one of the clearest examples of the League's tendency to deal in absolute terms and in terms of a single disease, rather than in terms of an integrated health program.

It will be noticed from the above tables that about twenty-five per cent of the population of the province is missed by the mass surveys. The League believes that many of these are caught by the hospital admission x-ray program.[42] This program was initiated in 1946 when the League entered into an agreement with the Department of Public Health and with the Hospitals of the province to install miniature photofluorographic x-ray equipment in all hospitals of 100 beds and over. With this equipment it is feasible for the hospitals to take a diagnostic chest film of every person admitted. By 1953 ninety-three hospitals in the province were participating in this program. The relative efficiency of this program is much greater than that of the mass surveys, since the incidence of tuberculosis among the sick, as would be expected, is much higher than among those well enough to attend the community mass surveys.

Relative Efficiency Of Various Elements In The Case Finding Program

Some comparison of the relative efficiency in terms of the examinations per case ratio of the various elements of the case finding program may be drawn from the following table.

42. op.cit.,p.4.

TABLE VII

PREVENTIVE SERVICES 1953[43]

Technique	No. of Examinations	No. Cases	Examinations/Case Ratio[44]
Review ex-patients	4,042	161	25:1
Exam. of Contacts	4,345	87	50:1
Consultants	214	0	--
Stationary clinics	6,000	69	62:1
Hospital Admiss.	66,175	91	727:1
Mass x-ray	205,383	64	3209:1

Since no estimates of the costs of each type of activity are available, no conclusions may be drawn as to the economic efficiency of the various activities. It must also be remembered that there may be some difference in the nature of the cases found by each method and hence a difference in the "value" of the various methods. It has been pointed out above, for example, that the proportion of infectious cases discovered among ex-patients is higher than among the other groups examined. In spite of these qualifications, however, it is apparent that there is a clear distinction between the techniques insofar as their effectiveness in terms of the examinations per case ratio is concerned. This is particularly true as between the mass surveys of the "well" population and the hospital admission program. It is clear from this that the mass surveys are relatively inefficient as case finding devices, although it would be necessary to estimate and compare the

43. Adapted from S.A.T.L., "Annual Report of Medical Services, 1953", mimeographed.

44. Refers to new active cases except for "Review of ex-patients" item.

actual costs of each activity before it could be concluded that they were relatively uneconomic.

While specific comparisons of costs cannot be made with available data, it is possible to determine the average cost of finding one new case by all methods over the years with which we are concerned. The following table is compiled from data published in the Annual Reports of the League. It is only an approximate picture of the costs of the case finding program because the total cost of all preventive service includes the League's share of the preventorium costs. These are costs of caring for infants born of tuberculous mothers and are largely defrayed by the I.O.D.E. of the province. Since these are only a small and relatively stable part of the costs, however, the general trend is not likely to be obscured by them.

TABLE VIII

AVERAGE COST OF FINDING ONE NEW CASE

Year	No. New Cases	Costs of all Examinations	Approximate Cost Per New Case
1953	372	$ 132,788	$ 356.00
1952	299	152,926	508.00
1951	288	126,924	445.00
1950	415	129,041	311.00
1949	472	118,621	288.00
1947	480	81,702	170.00
1943	488	54,531	112.00
1940	427	41,814	98.00
1934	509	33,200	65.00

While a certain amount of the cost increase shown above may be attributed to an increase in costs of supplies and in salaries, this could not be sufficiently great to explain the steady rise shown up to 1952. From 1934 to 1952 this increase, we may conclude, reflected the steadily increasing difficulty of

detecting new cases. The most striking feature of the table is, of course, the marked fall in the per case cost in 1953. This is partly the result of a reduction in the total expenditures from $152,926 in 1952 to $132,788 in 1953. The greater part of the fall in the per case cost is, however, due to the marked increase in the number of cases discovered. This in turn reflects the adoption of the new policy described above concerning the mass x-ray surveys. (It must be pointed out, however, that the data for the number of new cases discovered includes the cases found by the hospital admission program, whereas the cost data does not include the costs of this program. Even when these cases are removed, however, the number of new cases discovered in 1953 increased to 281 from 229 in 1952).

It has already been observed that, in spite of the increased costs of the case finding program, there is nothing to suggest that the League is considering a curtailment of these activities. It is suggested that this is a clear demonstration of the League's tendency to think in "absolute" terms - that is, to regard its own special cause as an end in itself - rather than in terms of more general social objectives. The following quotation appears to illustrate the League's failure to see its activities as only one part of the community's over-all efforts in the field of public health.

> The decline in the number of cases... is most encouraging in every way, even though it may cause some concern in the immediate economy of operation. However, if favorable results are to be maintained, there must be no diminution

> in the scope of the program. Any change would rather be a shifting of emphasis from one phase of operations to another rather than curtailment of general activity. 45

Prevention By Increasing Resistance

In addition to the general increase in resistance to tuberculosis resulting from a rising standard of living and increased knowledge of sanitation, nutrition and health, there is also the possibility of artificially increasing resistance through the use of the BCG vaccine. To date, as indicated in Chapter One, this vaccine has been used extensively in Saskatchewan to protect the "unavoidably exposed". There is some evidence to suggest, however, that within the near future the vaccine may be used to incite resistance to the disease among all the non-infected members of the community.

In 1950 the General Superintendent, in discussing the possibility of converting the mass x-ray survey into another form, stated that "in selected areas an intensive drive will be made to x-ray and tuberculin test the entire population, followed by BCG vaccination of tuberculin negative reactors". 46 Since then this program has been instituted and is being enlarged each year. In 1953, for example, 13,637 persons were tuberculin tested in the heavily infected North West corner of

45. S.A.T.L.,"Annual Report of Medical Services,1951", mimeographed, p.3.

46. S.A.T.L., "Annual Report of Medical Services, 1950", in Valley Echo, Vol.XXXIII, No.8, p.12.

the province and 4,967 negative reactors were vaccinated with BCG.[47]

While the long-run effects of this program will not be known for several years, it is expected that they will be reflected in a reduction in the number of new active cases found. Its immediate significance for this study, however, is two-fold. First, it is another clear indication that the League is determined at least to maintain the scope of its preventive work. At the same time it further illustrated the League's willingness to innovate and to rearrange the elements of its program to suit changing situations. The League's policy seems well summed up in the following statement of the General Superintendent.

> Maybe the day will come when widespread vaccination will be advocated. I think it is something that should come slowly and I think it is something which for a considerable period of time should be under the supervision of the League. 48

Compulsory Examination

One of the most popular criticisms of the preventive program as it is organized by the League is that it is highly inefficient compared to what it could be if only the necessary legislation was passed making periodic examinations compulsory.

47. S.A.T.L.,"Annual Report of the President,1953", mimeographed,.

48. Correspondence between General Superintendent and the Department of Public Health, Central Files, Department of Public Health, File No.013-G.

In 1949, for example, the Saskatchewan Association of Rural Municipalities passed a resulution at its annual convention to the following effect.

> Whereas the response by the public in attending the travelling T.B. Clinic in the Province on its second time around has been very poor; Now therefore be it resolved that we request the Government of the Province of Saskatchewan to make periodic T.B. test for humans compulsory. 49

Such suggestions as this have always either been ignored by the League or their sponsors have been informed that "in the opinion of the Board...compulsory legislation would not prove in the best interests of our Preventive Program."[50]

The League argues that the compulsory examination system would probably result in no greater coverage than is obtained at present with the voluntary system and that it would have the added disadvantage of requiring extensive police action to render it effective. On the other hand, when the cost to the community in terms of both paid and voluntary labor and the seventy-five per cent mass survey coverage of the voluntary system are taken into account, it seems justifiable to suggest that the matter warrants more thorough investigation.

Whether compulsory examination would be politically feasible is also a matter of conjecture. The entire question, not only of compulsory examination, but also of compulsory treatment under present circumstances seems worthy of more

49. S.A.R.M.,"Minutes of the Annual Convention,1949", Resolution No.107.

50. Minutes of the Board, July 27,1945.

serious attention that it appears to have received in the past.

While the problem of compulsory examination can only be raised in the present study, it is relevant to this analysis. It is submitted that once again the League's policy in this matter can be nothing other than what it is simply because of the overwhelming influence of the League's "underlying philosophy". As described at the beginning of this chapter, the activities and programs of the League throughout its history have been designed with the object of achieving a maximum of public support. The persistence of this purpose is reflected in the League's present attitude toward compulsion in any form. With reference to the passage quoted above, it is clear, once this underlying principle has been perceived, that the "best interests of our Preventive Program" are conceived as hinging upon the maintenance of a maximum of voluntary public support.

Results of the Tuberculosis Control Program

There are two general methods of measuring the results of the tuberculosis control program. Neither, however, serves to distinguish the results of the treatment program from those of the preventive program.

One method of gauging the results of the program is to observe the behavior of the tuberculosis death rate. The following table shows that the tuberculosis death rate in Saskatchewan has been falling steadily since 1930, with the exception of the war years when tuberculosis once again showed itself to be the "foremost campfollower of war".

TABLE IX

TUBERCULOSIS DEATH RATE (WHITE)[51]

1930	44.4
1935	27.8
1940	25.2
1943	29.7
1944	26.4
1945	26.9
1947	27.7
1948	26.8
1949	21.5
1950	18.5
1951	18.7
1952	12.3
1953	10.1

Another indication of the results obtained by the League's program is the decrease in the amount of infection in the province. This is most apparent in the public school age groups as revealed by sample surveys dating back to 1921.

TABLE X

EXTENT OF TUBERCULOSIS INFECTION IN PUBLIC SCHOOL CHILDREN[52]

Year	Percentage infected
1921	51.0
1924	40.2
1935	10.2
1938	8.2
1948	6.0

The significance of this data lies in its long run implications for the League's treatment program. While it is clear from the preceding section that the League's existing facilities will be made full use of within the immediate future,

51. Compiled from Annual Reports of the S.A.T.L., 1930-1953.

52. Ferguson, Tuberculosis, p.91.

it is equally clear that in the long run this will not be the case. It is certain that if the death rate and the amount of infection continue to decline in the next decade as they have in the last, there will be little need for extensive treatment facilities for tuberculosis in Saskatchewan.

The significance of the reduction in the amount of tuberculosis in Saskatchewan, from the standpoint of this study, lies in its effect upon the problem of financing tuberculosis control in this province. One of the most noticeable characteristics of the control program being conducted here is the extent to which the municipalities have become financially involved in the treatment program. One of the chief justifications for this has been the argument that the municipalities will, in this way, be induced to participate actively in the League's work in the hope of reducing the amount of treatment for which they are responsible.

In view of this it is relevant to consider the effect of the declining amount of tuberculosis upon the amount of treatment provided persons for whom the municipalities (including the Local Improvement Districts and the Northern Administration District) are financially responsible. This is shown in Table XI which excludes treatment services rendered Indians, veterans and other persons whose treatment costs are paid by agencies outside the province.

TABLE XI

DAYS TREATMENT PROVIDED "PROVINCIAL" PATIENTS [53]

	Rural	Urban	L.I.D.	N.A.D.	Total
1930	144,419	121,205	5,594	-	271,218
1940	142,223	111,009	21,546	-	274,778
1948	97,157	104,028	11,010	16,224	228,419
1949	97,591	110,196	12,428	17,056	227,271
1950	89,500	110,362	16,528	17,987	234,377
1951	77,516	107,248	16,539	23,362	224,665
1952	71,754	102,771	15,571	23,194	213,290
1953	70,768	96,482	14,291	23,901	205,442

It is seen from this that in the twenty-three years between 1930 and 1953 the annual total treatment days required by "provincial" patients fell by approximately twenty-five per cent. Because of the increase in treatment costs, however, the actual cost of treatment to the municipalities increased by approximately twenty-five per cent over the same period. Treatment costs charged to the municipalities rose from $575,574 in 1930 to approximately $755,000 in 1953. Because of this, the real results of the tuberculosis control program have been obscured.

In addition to the general rise in treatment costs, there is one other factor which has prevented the reduction in the amount of tuberculosis being reflected in the annual expenditures on treatment. The annual total days treatment provided by the League has been supported as a result of an increase in the length of treatment given the average case. This is illustrated in Table XII following.

53. Compiled from S.A.T.L.,"Annual Report of Medical Services, 1953", mimeographed.

TABLE XII

AVERAGE LENGTH OF TREATMENT [54]

1930	10.06 (months)
1935	13.30
1940	12.70
1945	13.79
1946	12.50
1947	12.90
1948	12.77
1949	12.98
1950	12.40
1951	13.82
1952	15.74
1953	16.29

Summary and Conclusions

1. The activities and programs of the Saskatchewan Anti-Tuberculosis League have been designed and carried out in such a way as to implement the League's belief in the advantages of voluntary methods to bring about the necessary degree of public participation in the tuberculosis control program. An illustration of this is the manner in which even the physical treatment facilities of the League were planned.
2. According to an estimate of one recognized authority as to the number of beds per death required at the peak of the program to provide "adequate" treatment and isolation, Saskatchewan now has a considerably greater number of beds per death than is necessary to fulfill this requirement. This condition has only come about with the marked reductions in the tuberculosis death rate following the war.

54. Compiled from S.A.T.L.,"Annual Reports of Medical Services, 1930-1953".

3. The League's attitude toward the problem of the recalcitrant patient is a clear illustration of its conviction that its support is dependent upon the policy of voluntary participation. Although the League recognized the increasing importance of this problem it is apparent that it is determined to avoid identification in the public mind between the League and compulsory measures of any kind.
4. The freedom enjoyed by the League in carrying out research and in introducing new techniques is illustrated by its BCG vaccination program. In spite of the potentially controversial nature of this program, the League has succeeded in introducing and developing the use of BCG in Saskatchewan with little difficulty.
5. Although it is difficult to discover the actual nature of the relationship between the League and the official health agency in the province, it appears that a minimum of cooperation exists between the two organizations. In view of what would appear to be possible advantages attached to closer integration of the anti-tuberculosis program and the general health program carried on by the Department of Public Health, whatever advantages the community gains from the League's independence must be offset to some extent by the losses associated with this lack of integration.
6. In spite of a marked reduction in the amount of tuberculosis in the province as indicated by the reduced death rate and the decrease in the amount of infection detected by tuberculin testing, the League is maintaining the scale of its treatment program through offering the Dominion increased accommodation

for Indian patients and by intensifying its case finding campaign among the white population. In addition to this, the average length of treatment has increased within recent years, thereby offsetting, to some extent, the expected decline in the scale of the treatment program.

7. In spite of a twenty-five per cent decline in the amount of treatment rendered "provincial" patients between 1930 and 1953, a rising price level has increased the cost of treatment by approximately the same amount. This has served to obscure the real results of the program in Saskatchewan.

8. The League's management of the preventive program in the face of declining tuberculosis problem has been used to illustrate its tendency to think of economy in an absolute sense and to frame its policy without consideration of relative social needs. This is reflected in its willingness to alter only the emphasis upon activities within its program and not to consider reductions in the over-all scope of that program.

CHAPTER FOUR

FINANCING THE ANTI-TUBERCULOSIS PROGRAM IN SASKATCHEWAN

CHAPTER IV

FINANCING THE ANTI-TUBERCULOSIS PROGRAM IN SASKATCHEWAN

The general nature of the League's revenue structure has been described in Chapter Three. It will be recalled from that description that in Saskatchewan financial responsibility for the treatment of tuberculosis is divided among all three levels of government. At present, local governments raise approximately forty-five per cent of the League's revenues on treatment account; the provincial government raises about thirty per cent; and the remaining twenty-five per cent is obtained by the League from the Dominion Government.[1]

This division of treatment costs has evolved over a period of almost forty years and even today represents little more than an expedient compromise between markedly divergent views upon the proper distribution of financial responsibility for the treatment of the tuberculous sick. Because it is essential to an understanding of the present revenue problems of the League, and because alternative allocations of financial responsibility are accepted in other provinces, this chapter will consider various methods of financing tuberculosis treatment and will describe the experience Saskatchewan has had with them.

1. S.A.R.M.,"Report of the Rural Municipal Directors on the Board of Directors of the S.A.T.L.", Report of the proceedings at the Annual Convention,1951,p.89.

Just what method of financing will be employed at any given time appears to depend largely upon the prevailing social philosophy. Hence, in a period when the principles of individualism were esteemed it appears to have been assumed that the individual patient should accept the responsibility for the costs of his treatment.

Even then, however, the peculiar characteristics of tuberculosis described in Chapter One soon made it apparent that individual responsibility was a rather impractical principle in this particular circumstance. The only acceptable alternative, given the social philosophy of the time, was voluntary private charity.

By the time this method had proved its inadequacy in Saskatchewan, the structure of municipal government had been sufficiently developed to make operative the previously neglected principle of municipal responsibility for the care of the indigent sick. Even in the 1920's, however, the individual patient was held responsible for his treatment and it was only when he was financially incompetent that the municipality became responsible for his care.

The growth in the scope of government activity of all kinds in succeeding years, however, reflected a profound alteration in the attitude toward the nature and scope of government responsibility for health and other social services. The fact that tuberculosis was a community problem because of its infectious nature and because of its obvious association with social conditions made it a particularly appropriate

subject for public, as opposed to private, responsibility.

Individual Responsibility

Saskatchewan has never accepted the principle of individual responsibility in its pure form, for even in the period from 1917 to 1929 the sanatoria received a per diem grant from the provincial government which was applied on treatment account. During this period, however, the individual was held responsible for treatment cost not defrayed by the small provincial per diem grant.[2]

While such a charge upon the individual cannot be regarded as a "tax" in the true sense of the term, because of the definite quid pro quo element involved, it will be convenient to think of it in similar terms. In doing so, it becomes immediately apparent that such a charge cannot be justified either on the grounds of "benefit" or "ability" to pay.

It cannot be denied that the individual who receives treatment, also receives the immediate benefit of that treatment, but it is equally true that the nature of the disease also implies a benefit to the community as a whole. Treatment of the individual, as shown previously, is only one function of the sanatorium. The isolation of the individual and his

2. Treatment cost was calculated by dividing total net operating costs of the Sanatoria by the number of patient days treatment given during the year. The per diem cost resulting from this calculation was used as the rate upon which individual patient fees were calculated.

treatment to render him non-infectious reflects the community's interest in the program. No one would seek to assess the leper for the cost of his incarceration on a remote island on the grounds of benefit, even though he might receive treatment there which was beneficial to himself.

The ability-to-pay principle is also inappropriate as a justification for individual responsibility for treatment costs and again the reason is to be found in the nature of the disease. It was shown in Chapter One that tuberculosis and poverty have always been associated and the nature of this relationship was discussed at that time. Suffice it to repeat here that in 1928, the last year of individual responsibility for treatment in Saskatchewan, only 3.5 per cent of the patients receiving treatment were able to pay for their own treatment.[3] Because of the prevalence of indigency among individuals afflicted with the disease, it is impossible to apply the "ability" principle and it is evident that almost any other method of financing treatment would be relatively "progressive" in its net effect. That is, it is doubtful if any group of taxpayers (as subjects of either municipal or provincial taxes) or of voluntary contributors would be as lacking in ability-to-pay for the treatment program as the patients themselves - a group of which 96.5 per cent had been accepted by municipalities as "indigents" in 1928.

The experience in Saskatchewan with the "patient fee" system demonstrated its inherent defects. The major difficulty

3. J.M. Uhrich Papers, File 10A, Tuberculosis-General 2, Archives of Saskatchewan, Saskatoon.

was that already mentioned - the prevalence of indigency among the tuberculous sick. The effect of this upon the financing of the first sanatorium in Saskatchewan would have been disastrous had not the League secured "temporary" loans from the provincial government. In the first year of its operations it requested a loan of $16,500 from the province as a means of "financing the current operations of the League until such time as the Institution was on a paying basis".[4]

During this early period (1917 to 1923) in which the patient fee system was relied upon in a relatively pure form the League was proud of its liberal handling of indigent cases, as is indicated by the following statement by the General Superintendent.

> Up to the present time we have never refused admission to any patient, either child or adult on account of the lack of financial support, but many persons when they are told by their physicians of the cost of treatment decide that they are unable to pay the charges and fail to make application. 5

While such a policy was commendable from a humanitarian standpoint it overlooked the fact that the League had no source of revenue sufficiently strong to support such a policy. This was recognized two years later when the League tightened up its admission procedures. At that time a new system was inaugurated by which the medical staff of the

4. Minutes of the Board, October 22, 1917.

5. Correspondence, Director of Medical Services, S.A.T.L., September 25, 1920, reproduced in Minutes of the Board, 1920.

sanatorium first ascertained whether the prospective patient was a suitable case for sanatorium treatment. If the applicant passed this test he was then to be referred to the Secretary's office where "definite" arrangements were to be made for the payment of his fees. The new regulations held that the patient was not to be admitted for treatment until such definite arrangements had been made.[6]

That the result of this new policy was undesirable is reflected in the report of the Anti-Tuberculosis Commission in 1922. This Commission found that among the most pressing needs of the tuberculosis control program in Saskatchewan was some means to "improve the present system of financing the cost of treatment so as to enable all sufferers who need treatment to obtain it with the least delay".[7]

This experience has not been restricted to Saskatchewan for the patient fee system has almost disappeared, in practice if not in principle, in every province of the Dominion. In 1950, for example, of the four Western provinces Saskatchewan was the only province to receive no revenue from patient fees, but, even so, British Columbia derived only 3.6% of total revenue from such fees, Alberta 0.2% and Manitoba 0.3%.[8]

6. Minutes of the Board, June 20, 1922.

7. Commission 1922, p.58

8. Canada, Dominion Bureau of Statistics, Institutional Statistics Branch, Annual Report of Tuberculosis Institutions, 1950, Ottawa, Queen's Printer, 1953.

This would suggest that the patient fee system may be neglected as an effective solution to the problem of financing the treatment of tuberculosis.

Voluntary Community Responsibility

It should not be inferred from the above that the patient fee system was abandoned in Saskatchewan without a struggle. As late as 1922 the Anti-Tuberculosis Commission seems to have had little hope or even desire to see total abolition of the patient fee system.[9] During the period from 1917 to 1923 the League itself made strenuous efforts to make the patient fee system work. The tightening of admission procedures referred to above is one illustration of this. Another was its attempt to supplement the patient fee system by an "endowment" scheme. In effect this was simply an appeal for voluntary public contributions to the League out of which the treatment of indigent patients could be financed. All non-indigent patients, it was assumed, would continue to pay for their own treatment. At the time the municipalities do not appear to have recognized any responsibility for the treatment of their tuberculous sick, although the League was already at work attempting to remedy this situation.

By 1922 the financial situation of the League was critical. Although its line of credit at the bank was only $60,000, by 1922 this had been exceeded by $11,583. A request for a further loan of $20,000 from the bank was being held

9. See Commission 1922, pp.12-14.

up until the bank received "the proposed plan for financing the League".[10] The same year the League asked the provincial government for another loan of $76,000 to be paid monthly to the League as needed to the end of the 1922 fiscal year "to aid in operating the Sanatorium".[11]

It was under these circumstances that the League adopted "a programme of suggested endowments and contributions by societies and individuals". As implemented, this plan offered various inducements to such "societies and individuals to endow, in whole or in part, beds in the sanatorium." In a pamphlet entitles "Suggestions for Assisting the Sanatorium" (1922) two classes of endowments were announced with "rewards offered commensurate with the size of the endowment". For example a "Class One" endowment of $10,000 to support one bed in perpetuity offered the contributor of such a sum a life membership on the Board of Trustees of the League.

Smaller benefactions were rewarded by the privilege of naming the occupant of an endowed bed for one year, and by "a plate attached to the bed showing the name of the benefactor maintaining it". The same pamphlet reminded prospective benefactors that "no better or more fitting memorial could be left to the memory of a departed friend than a permanently endowed ward in the Sanatorium".

10. Correspondence between The Imperial Bank of Canada (Regina) and the Board of Directors of the S.A.T.L.,July 13,1922, reproduced in Minutes of the Board, 1922.

11. Minutes of the Board, May 16,1922.

These provisions serve only to add substance to the League's final plea in the pamphlet to the effect that "donations to the funds of the League are urgently needed....".

While no information as to the results of this scheme is available it apparently failed to bring in any appreciable amount of revenue since no more has been heard of it since 1922.

It is suggested that this experience merely suggests that certain types of activity are not capable of stimulating the philanthropic motive in private individuals to the extent that some other types of activity are. As long ago as 1923 this point was made at a convention of the Canadian Tuberculosis Association.[12] It would appear that the experience of tuberculosis associations on this continent has suggested that voluntary public financing of such novel and dynamic activities as mass x-ray programs, for example, has been a practical method of raising the required revenue. It is not to be expected, however, that the continuous and "static" revenue requirements for the day-to-day operation of a sanatorium can arouse the same kind of public support.

Municipal Responsibility

If not already apparent, it should be indicated here that the analysis being developed is organized in such a manner as to coincide with the chronological development of

12. See J.H. Holbrook, "The Story of the Hamilton Health Association", Papers on Tuberculosis, the Canadian Tuberculosis Association, Ottawa, 1923, pp.75-76.

the revenue structure of the Saskatchewan Anti-Tuberculosis League. While there has been no period in this development in which one single allocation of financial responsibility for the treatment of tuberculosis has been depended upon to the exclusion of other possible allocations, there have been periods in which one has stood out most clearly. Sometimes this was the result of nothing more than a particular crisis which caused attention to be focused upon some single source of revenue, such as when the patient fee system finally collapsed in the early 1920's. Other times it was the result of a quantitative predominance of a single source of revenue as in the 1940's when the municipal burden became particularly heavy relative to that placed on the provincial treasury.

So far this method of analysis has permitted the consideration of two possible allocations of financial responsibility for the treatment of tuberculosis - the patient fee system and the private endowment system just discussed. The illustrations of these systems have been drawn from the early experience of the League in a period covering the years 1917 to 1923. I have rather arbitrarily selected this latter date on the grounds that it was in that year the principle of municipal responsibility was asserted in a form that was to become the basis of the present revenue system of the League. From that time to this the financial history of the League has provided the material for the following analysis of the principle of municipal responsibility for the treatment of tuberculosis in Saskatchewan.

It is to be suggested here that this experience demonstrates three facts; first, that the principle of municipal responsibility has been maintained in this province only with difficulty; second, that the municipalities provide a rather unstable flow of revenues when the very purpose of the operations being financed is defeated if they are interrupted, and third; that the equitable allocation of this burden among the municipalities is a difficult and troublesome problem.

Before proceeding to support these three propositions it is necessary to review the development of the principle of municipal responsibility in this province.

The earliest type of municipal responsibility for the care and treatment of the tuberculous sick was associated with indigency and as such dated back to the Poor Law principles of England in the Elizabethan period. This responsibility then was clearly of a contingent nature, for only if neither the patient, his friends, nor his relatives could finance his care did the municipality become responsible. In this sense municipal responsibility for the care and treatment of the tuberculous sick was a contingent liability on the municipalities of Saskatchewan up to 1929. In that year treatment was made a joint municipal-provincial responsibility for all persons afflicted with the disease - whether indigent or not.

It has already been suggested on the grounds of the number of indigents thrown upon the League without financial

backing of any kind that the municipalities seem to have ignored this responsibility up to 1920.

At the same time, however, the League's desperate financial position in this period drove it to the task of stirring the municipalities to action. In 1918 the League brought in Dr. Stewart of Ninette Sanatorium in Manitoba to address the Convention of Rural Municipalities, at which gathering he was given a "splendid hearing".[13] Following this the President of the League reported that "while he had nothing official to state, he was of the opinion that considerable financial help would be in future given to that Sanatorium by the Municipalities."[14]

The following year, in 1919, the League approached the Urban Municipalities in convention to raise the possibility of "having a fund created to take care of indigent patients by creating a tax on all municipalities for that purpose".[15]

That same year the Rural Municipalities expressed a rather vague desire to assist the League in its work, and to their surprise[16] saw legislation passed at the next session requiring all rural municipalities in the province to pay to

13. Minutes of the Board, March 8, 1918.

14. loc.cit.

15. Minutes of the Board, May 20, 1919.

16. See S.A.R.M.,"Proceedings of the Annual Convention 1920".

the League a minimum of $100 and a maximum of $500 per annum.[17]

Regardless of the details surrounding the origins of this legislation, it may be regarded as the outcome of the failure of voluntary municipal acceptance of the principle of municipal responsibility for the indigent victims of tuberculosis. The reason for the failure of the voluntary municipal system is to be found in the attitude of the municipal councils of the day. The Commission of 1922 found that when the municipalities did extend charity to a tuberculosis "indigent", this charity was, in the words of the Commission:

> "...usually delayed as long as possible, and often secured by mortgages on personal belongings, assignments on life insurance, and other forms of security, thereby placing the unfortunate one under life-long obligations to repay the outlay regardless of the condition of the home from which the patient comes, or the wants of an already stricken family". 18

This same process of compulsory financial commitments having to be forced upon the municipalities when more or less voluntary commitments were ignored will again be recognized when the operations of the "Urban Pool" are discussed below.

There is little need to state here that the reaction of the Rural Municipalities to the $100 levy was strong and immediate. So long as it could be argued that this law had been "placed on the statute books at the request of the Rural

17. Statutes, 11 Geo.V,c.37,s.201a.

18. Commission 1922, p.50.

Municipalities themselves",[19] there was little direct agitation for its repeal, so the Rurals merely urged that out of fairness a similar levy should be made on the Urban Municipalities of the Province, although in convention they added to this resolution the request that if the levy was not extended to the Urbans "that Section 201A be repealed".[20]

It should be clear from this description of the origins of municipal financial responsibility that the principle was only established and made effective through the efforts of the League and the provincial government. Before the League began its campaign the municipalities shirked and proved quite unreliable as sources of treatment revenue even for indigents. The compulsory $100 levy on rural municipalities was protested by them on the grounds of fairness and also on the grounds that it was a definite commitment imposed upon them as a result of only a general statement of a desire to support the work of the League.[21]

This is merely the first event in the troubled history of municipal responsibility. It is the first illustration of the contention that the principle of municipal responsibility in Saskatchewan has been fostered only with difficulty. It could never have appeared "spontaneously" and even if it had, it would never have survived the next thirty-five years.

19. Correspondence between President of the S.A.T.L. and Premier W.M.Martin, January 14, 1922, Dunning Papers, File Y-16-1,Archives of Saskatchewan, Saskatoon.

20. S.A.R.M., "Minutes of the Annual Convention,1922".

21. See S.A.R.M.,"Minutes of the Annual Convention,1921".

The next step in the development of the principle came in 1923 when the dissatisfaction of the Rural Municipalities with the $100 compulsory levy led to the formation of the "Rural Pool".

In view of the prevailing enthusiasm for co-operative methods and the "pooling" principle in particular in Saskatchewan during the early 1920's, it is not surprising that the rural municipalities should have turned to a scheme for pooling their responsibility for indigent tuberculous patients of the League. It was an established fact that some municipalities had more patients than others and that there was an equally wide disparity in their financial positions. In view of this some of the municipalities, the League and the government thought it desirable to pool the responsibility and the cost. This was expected to have two advantages. First, it would tend to spread the burden of cost and, second, it would overcome the "unfairness" of the 1920 legislation by converting the $100 levies into a fund earmarked for the financing of treatment for rural indigents.

The institution of the pooling scheme in 1923 must be regarded, not as an endorsement of the principle of municipal responsibility, but as an attempt to save that principle by the League and the provincial government. So far as the municipalities were concerned, it was only a means to make the best of a difficult situation. The reaction of the Rurals to the $100 compulsory levy has already been indicated.

In 1923, the same year that the Rurals adopted the pooling method, they went on record at their annual convention as being of the opinion that responsibility for tuberculous indigents "is a state or Provincial question and that the burden so placed (upon the municipalities) is too great..."[22] The urban municipalities had also expressed a desire to shift their responsibility. In three successive years they passed the same resolution to the effect that:

> ...the legislature be asked to so amend the law that the expense of caring for sick destitutes will be equally distributed over the entire Province, preferably by the government providing for the treatment of all such cases out of the public revenue of the Province.[23]

The reaction of the provincial government to this attitude of the municipalities is summed up in the following statement by the Minister of Municipal Affairs:

> You propose that we should treat destitute sickness in the province as a matter of provincial rather than municipal activity. I do not know of any system of municipal government into which I have enquired where the question of the destitute sick was not regarded as a local charge. I do not believe the government of Saskatchewan will take any other view.[24]

22. S.A.R.M., "Minutes of the Annual Convention, 1923".

23. Union of Saskatchewan Municipalities, Proceedings at the Annual Convention, 1918, p.18 (also 1919, p.141 and 1920, p.87).

24. Ibid., p.82.

The attitude taken by the provincial government reflected more, however, than this apparent belief in the sanctity of the Poor Law philosophy. The fact was that the provincial government was merely boosting what I have described as the "underlying philosophy" of the League.[25] This will be explained at greater length in a later section of this chapter. Here, however, another brief extract from the Minister's speech quoted above will support my interpretation of the government's attitude:

> "We want every municipality to feel that it is an active factor in dealing with this dread disease and by merely paying a provincial tax you cannot secure that philanthropic feeling, and I think to attempt to deal with the subject without that would be a fatal mistake". 26

By 1923, it was apparent to all the municipalities of the province that they would not be allowed to escape the principle of their responsibility for the care of the destitute tuberculous sick. The League was working to advance the pooling scheme, which, when introduced, always had the strongest support from the League.[27] Indeed, it's extension to the urban municipalities appears to have been primarily the result of the League's efforts.

The "Rural Pool" was originally formed out of the $100 compulsory levies upon the rural municipalities instituted by the legislation of 1920. Since there was no provision as to how these funds should be expended by the League, the Rural

25. See Chapter Four.

26. Union of Saskatchewan Municipalities, op.cit., p.81.

27. See Minutes of the Board, November 16, 1920.

Municipalities, in 1921, urged that they were entitled to a definite quid pro quo based upon this payment. They suggested that this be effected by pooling these funds and using them to finance the treatment of rural charges receiving treatment in the Sanatorium.[28] Since there were 301 rural municipalities at the time, the fund would receive a minimum of $30,100 anually. This fund was to be handled by a body known as the "Rural Pool Trustees" which was to be "entirely beyond the control of the League".[29]

In 1923 the Tuberculosis Sanatoria and Hospitals Act was amended to authorize the League and the various municipalities to enter into an agreement by which the League would provide free care and treatment to indigent patients and to establish the annual contributions which would be required of the contracting municipalities.[30]

Such an agreement was signed by the League and 75 rural municipalities and brought into effect on January 1st, 1923. According to this agreement the funds of the pool were to be made up of "the total of the grants paid under...Sec.201A of the Rural Municipalities Act", and the total aggregate fees of all patients receiving care and treatment under the agreement were to be the first charge against the pool. That is, the $30,100 compulsory levy upon all rural municipalities was to

28. S.A.R.M.,"Minutes of the Annual Convention,1921" p.13.

29. Saskatchewan, Department of Public Health, memo dated September 3,1925, Central Files, File No.742.

30. See Statutes,14,Geo.V,c.551 and c.552.

be used to pay the treatment costs of all indigent patients recommended by contracting municipalities and approved by the Pool Trustees.

These contracting municipalities further agreed to meet any additional cost in excess of the Pool's funds by assessment at the termination of each year of the pool's operation.

Membership in the Pool increased rapidly up to 1925 when 210 of the rural municipalities of the province had signed contracts with the League. Total membership, however, never exceeded 214 in any one year.

TABLE XIII

MEMBERSHIP IN THE RURAL POOL [31]

Year	No. of Municipalities in Pool
1923	75
1924	165
1925	210
1926	204
1927	207
1928	214

As an example of the method used to finance the rural pool, its operations in 1927 might be examined. In that year, 207 municipalities belonged to the pool. Among them they had 183 patients receiving treatment from the League. The distribution of these patients was as follows:

31. Compiled from the Annual Reports of the Rural Conventions, 1924-1929.

TABLE XIV

6	rural	municipalities	had no	patients
54	"	"	" 1	"
52	"	"	" 2	"
29	"	"	" 3	"
29	"	"	" 4	"
18	"	"	" 5	"
8	"	"	" 6	"
3	"	"	" 7	"
3	"	"	" 8	"
1	"	"	" 10	"
1	"	"	" 11	"
1	"	"	" 12	"
1	"	"	" 16	"
1	"	"	" 26	"

The compulsory levy of $100 upon all rural municipalities yielded the pool $30,100. The total cost of treating pool patients for 1927, however, exceeded this revenue by the sum of $71,833.74. The total assessment of the 207 contracting municipalities in the pool in 1927 amounted to $624,641,225. The Rural Pool Trustees then struck a rate of 0.115 mills which yielded the required revenue of $71,833.74.[32]

It is seen from Table XIII above that there was never less than 31 per cent of the rural municipalities which remained out of the pool. Some never joined, while others joined and then withdrew. These non-pool municipalities were required to contribute their $100 minimum annual levy to the pool, but in addition were required to pay for treatment rendered their indigent patients, if any, at the same rate as was charged paying patients of the League.

32. Data from Annual Report of the Rural Pool Trustees to the S.A.R.M. in "Minutes of the Annual Convention, 1927".

The chief disadvantage of the pooling scheme was its inability to spread the cost of treatment for indigents over the entire 301 rural municipalities of the province. The failure of so many Rural Municipalities to join the pool made it difficult in the opinion of the League, to obtain patients for early treatment from the non-pool areas of the province.[33]

What success the rural pool did have would appear to be due largely to the fact that $30,000 was guaranteed to the pool by the requirements of section 201a of the Rural Municipalities Act. This provided a constant nucleus for the revenues of the pool. Without this compulsory element in the scheme it is not likely that it would have survived as was demonstrated by the experience of the urban pool.

The Urban Pool

Unlike the rural pool which grew out of a compulsory annual grant to the League, the urban pool began as a "voluntary pool". That is, not only was membership in the urban pool voluntary, but payment of even the "initial levy" was required only of pool members.

The urban pool began operations January first, 1925, and like the Rural pool, was managed by a board of trustees appointed by the contracting municipalities.[34]

The League itself appears to have been instrumental in promoting the urban pool idea.

33. A.B. Cook, "The Urban and Rural Pools for the Treatment of Tuberculous Patients", Valley Echo, Vol.VII, No.12 December 1926, p.10.

34. A.B. Cook, The Urban Municipal Pool, Pamphlet distributed to the Urban Municipalities of Saskatchewan, 1924, p.3.

> Representatives of the Anti-Tuberculosis League have held numerous conferences with Councils and representative municipal Officials, which have resulted in the Pool Agreement being drafted and forwarded to all Urban Councils for their approval and completion. 35

In addition to these conferences the League sent its president to the 1924 convention of the Union of Saskatchewan Municipalities at which he urged the adoption of a pooling plan.[36]

The arguments used to win the approval of the USM for the pooling scheme point up some of the problems associated with the principle of municipal financial responsibility for tuberculosis treatment. Insofar as the smaller urban municipalities were concerned, the institution of a pooling plan promised relief from what was often an unbearable financial burden. In 1924, for example, one village with an annual total revenue of $1500 had a tuberculous family receiving treatment at a cost to the municipality of $600 annually.[37]

Taking the 1924 cost of treatment at $2.50 per day and the average length of treatment at a minimum of five months, the cost to the municipality for each indigent patient would be approximately $375.00. As the League pointed out, in the absence of a pooling system a municipality having one or more indigent cases had either to assume the full cost of

35. Ioc.cit.

36. See Union of Saskatchewan Municipalities, Proceedings of the Annual Convention, 1924, p.28.

37. Ibid.,p.29.

such cases (which few could or would do) or let the patient suffer until he (and often his family) became a permanent charge upon the municipality until his death.[38]

The larger urban centers had a different, but equally serious problem. This was outlined by President Cook of the League as follows:

> Patients tend to drift from the small urban districts to the larger ones, where, it is hoped, better hospital accommodation can be obtained and where the assistance of the municipal health department may be of service to them. A number of these, by establishing their residence in the cities not only become hospital charges but their families also require charitable assistance. 39

The League's contention in this respect was that the pooling system would provide geographical uniformity of service with the result that patients would not drift to the larger centers and the relief burden would cease to be concentrated on the cities.

In consequence of the League's efforts, the Union of Saskatchewan Municipalities agreed to the formation of an "optional membership" urban pool.[40] According to the agreement drawn up by the League and the executive of the USM, every municipality joining the pool would be required to make an initial annual payment to the pool of ten cents per capita

38. A.B. Cook, op.cit.,p.4.

39. Ioc.cit.

40. Union of Saskatchewan Municipalities,Proceedings of the Annual Convention, 1924,p.29.

according to the municipality's last census population.[41] If the revenues so raised were insufficient to meet the treatment costs of the patients sent by the contracting municipalities (and approved as pool charges by the Pool Trustees) the balance was to be raised by an additional levy on a per capita basis against the contracting municipalities.

In an effort to attract municipalities to the scheme the League extended to the patients of the contracting municipalities a twenty per cent reduction in charges over that required from the indigent patients of the municipalities which remained outside the pool.[42]

The pool was initiated January first, 1925, and operated until 1929. Just as the rural pool failed to attract all the rural municipalities to the scheme, the urban pool never succeeded in attracting all the urban municipalities. The nature of the membership in the urban pool was more complicated than in the case of the rural because of the variety of local units involved. By the end of the pooling period all the cities, about half the towns and only one-third of the villages in the province had joined the pool.

41. Minutes of the Board, January 13, 1925.

42. A.B. Cook, The Urban Municipal Pool, Pamphlet distributed to the Urban Municipalities of Saskatchewan, 1924, p.3.

TABLE XV

MEMBERSHIP IN THE URBAN POOL [43]

	1925	1926	1927	1928	Total Mun. in Prov. '28
Cities	4	5	5	8	8
Towns	28	35	35	37	79
Villages	73	83	89	104	367

On the basis of population this meant that 100 per cent of the population of cities, 53.4 per cent of the population of towns and 34.1 per cent of the population of villages was covered by the pooling arrangement.

For the purpose of this analysis the most significant lesson taught by the urban pooling experience is to be found in the behavior of the smaller municipalities. As indicated by the above table the pooling scheme was less popular with the smaller than with the larger urban municipal units. In addition to this, the membership of individual municipalities was erratic. Far from being motivated by a desire to use the pooling system as a means to control this disease, many of the municipalities were clearly using it for nothing more than their short run financial advantage. One of the urban pool trustees reported on the early experience of the voluntary urban pool in the following words.

> We have found that during the first year practically all the municipalities in the province made a combing out and found all the cases they could and shipped them into the pool. We also found that a lot of municipalities had deferred

43. From Union of Saskatchewan Municipalities, Proceedings of the Annual Convention, 1929, p.60.

> joining the pool until they got a case and that increased the cost. 44

Commenting further on the troubles they had encountered, the pool trustees stated that they believed the voluntary pool system "was an incentive to the smaller municipalities to stay out of the pool until they have a patient and withdraw as soon as the patient is disposed of." 45 This attitude, of course, denied the very principle upon which the pooling scheme was built.

In an effort to overcome this defect the union of Saskatchewan Municipalities passed a resolution urging that all urban municipalities be required to make an initial payment to the pool.

At the session of 1926 the provincial legislature passed the following amendment to the city, town and village acts in compliance with the above request.

> The council shall make an annual grant of 10¢ a head of the population, as shown by the last Dominion census, to the Saskatchewan Anti-Tuberculosis League, to be forwarded to the treasurer of the League not later than the thirty-first day of December each year. On receipt of the amount of the grant the treasurer shall place it in a special trust account to be expended for the care and treatment of indigent patients from any municipality which has entered into an agreement under section 268. 46

44. Ibid.,1926,p.70

45. Ibid.,p.71

46. Statutes, 17, GeoV, c.23,s.268a.

This had the effect of substantially reducing the burden upon the pool members. Although the per diem cost increased from $1.62 to $1.86 between 1926 and 1927, the net cost per capita of pool population fell from $0.49 to $0.365 with the introduction of the compulsory payment. The amount contributed in 1927 by non-pool urban municipalities was $8,924.40. This reduced the net per capita cost to $0.365 from the $0.423 which it would have been without the compulsory per capita levy. (The total actual cost to pool members, however, was 0.465 when the ten cent per capita initial payment of pool members is added in.)[47]

The operations of the urban pool were further strengthened by a ruling of the trustees which required that contracting municipalities pay into the pool for a minimum of three months before they could be eligible to charge patients against it.[48]

The necessity for these cumbersome safeguards reflects the weakness of the pooling system. Individual municipal responsibility for the treatment of the indigent tuberculous sick failed because many of the municipalities refused to recognize their responsibility. Similarly voluntary pooling failed because of the failure of many municipalities to cooperate in the program. It was only when compulsory contributions were maintained or introduced that the pooling system was made workable, but even then its full benefits were never realized due to

47. Data from Union of Saskatchewan Municipalities, "Report of the Urban Pool Trustees, Proceedings of the Annual Convention, 1927.

48. A.B.Cook, "The Urban and Rural Pools for the Treatment of Tuberculous Patients", Valley Echo, Vol.VII, No.12, Dec.1926, p.1

its limited coverage.

As the pools operated in the period before 1929 it became increasingly obvious that they were at best only an imperfect method of financing the treatment of tuberculosis. One of the most obvious difficulties encountered was associated with the concept of "indigency". Just how an "indigent" was to be defined posed a constant problem to the pool trustees, whose task it was to approve patients sent by the contracting municipalities.[49] In an effort to overcome this difficulty the practice of approving patients as "partial charges" against the pool was employed.[50] While this added a certain amount of flexibility to the decisions of the trustees, it also made the system more cumbersome. Because of these difficulties in establishing the legitimacy of applications to the pools, it was suggested at the SARM convention in 1926 that "the cost of care and treatment of all tuberculous patients whether indigent or not be accepted at the sanatorium as a charge to the pool.."[51] After much discussion this resolution was defeated and the existing system maintained.

In the course of the same discussion, however, another and related objection to the pooling system was revealed. Those supporting the above suggestion argued, with apparent justification,

49. See S.A.R.M., "Minutes of the Annual Convention", 1926.

50. A.B.Cook, The Urban Municipal Pool, Pamphlet distributed to the Urban Municipalities of Saskatchewan, 1924.

51. S.A.R.M., op.cit.

that the distinction between indigents and non-indigents was more trouble than it was worth, insofar as more than ninety per cent of the patients treated in the sanatorium were classed as indigents.[52] It was hardly to be expected that the revenue derived from presumably solvent patients would warrant the large administrative expenditure involved in screening applicants and in attempting to collect fees from the non-indigent patients.

A further objection to the pooling system was that it did nothing to relieve the patient of the burden of financial ruin even if his immediate costs of treatment were borne by the pools. Just as under the system of individual municipal responsibility, many municipalities would sponsor a patient only after placing him, and often his family, under a prolonged financial commitment to the municipality. This was made possible by provisions in the various municipality acts cited above. The Town Act, as amended in 1924, for example, provided that any expenses "which are paid out of any fund created by the municipalities" entering into such an agreement may be recovered by the municipality to which the patient belongs"by action or by distraint by the treasurer of the town, and in the event of the death of the patient the council may recover from his administrators or executors the said sum".[53]

52. loc.cit.

53. Statutes, 15 Geo.V,c.22,s.244c.

Under these provisions the discharged patient could scarcely look forward to a successful or even minimum period of convelescence unless he was again successful in obtaining some form of charity.

An equally serious defect in the pooling plan was the stigma of "charity" associated with it. This was a defect because one of the essential requirements of an adequate revenue system for a tuberculosis control program is that it encourages early admission of the patient for treatment. The natural reluctance of persons to apply for charity from the municipality frequently led them to postpone treatment for as long as possible. In short, the pooling scheme appears to have been fundamentally an attempt to make the principle of municipal responsibility less repugnant to the municipalities. It did little to improve the revenue system of the League in other respects.

The Institution of Free Treatment

The abandonment of the pooling system came in 1929 when the distinction between indigent and other patients was dropped. As would be expected following the above discussion, this move had little effect upon the actual finances of the League, since in 1928 only 3.5 per cent of the patients receiving treatment were self-supporting. More significant than the slight increase in the scope of this responsibility was the acceptance by the municipalities of a fixed, incontrast to a contingent, liability. Prior to 1929 the municipality was liable only if it had a case and only if such a case was "indigent". After 1929 each municipality was subject to a certain liability.

The first suggestion of free treatment appears to have been made in 1926 at the convention of the Saskatchewan Association of Rural Municipalities. As mentioned above, this came in the form of a resolution urging that all patients be made pool charges.[54] With about 600 delegates present only about twenty supported the resolution and it was defeated.[55]

At this time there is evidence to suggest that the League itself was not active in promoting free treatment. Writing in the Valley Echo in the same year, the President and Managing Director of the League stated that in considering methods of financing the cost of treatment for those suffering from tuberculosis "it should be understood that those requiring treatment for tuberculosis should, in all cases, be required to pay for their own care, if they are in a position to do so".[56]

In spite of this lack of encouragement, the following year the free treatment resolution was again introduced and this time it was passed by a small majority.[57] Some indication of the feeling of the rural municipalities at this time is given

54. S.A.R.M., op.cit., p.7.

55. F.C.Middleton, "Evolution of Tuberculosis Control in Saskatchewan", Canadian Public Health Journal, Vol.XXIV, No.11, November 1933, p.510.

56. A.B.Cook, "The Urban and Rural Pools for the Treatment of Tuberculous Patients", Valley Echo, Vol.XII, No.12, December 1926, p.9.

57. Middleton, op.cit., p.509.

by the results of a mail inquiry made by the secretary of the rural association. A copy of the resolution was forwarded to the members of the Rural Pool who were asked for their opinion of it. Forty-eight municipalities replied in favor of the resolution, sixteen were opposed to it and seventy-three were "non-committal".[58] With this dubious support for the proposal it is not surprising that the government did nothing to implement it.

It appears, however, that these developments caused a complete alteration in the League's policy respecting the financing of treatment, for, in January 1928 the directors of the League stated that -

> ...in the opinion of this Board and as a general principle the free treatment of all tubercular patients would materially assist in the earlier treatment of the disease and tend to its ultimate eradication and would at the same time assist in the cure by relieving the patients of a considerable amount of financial worry. 59

In 1928 a revised resolution was passed unanimously by the SARM which urged that the Sanatoria Act be amended "so that all classes of T.B. patients shall have free treatment available at the public expense, and further that the same be paid,

> (a) partly by the Government,
> (b) partly by all rural and urban municipalities in the province. 60

Similar resolutions were passed by the urban municipalities association, the United Farmers of Canada Saskatchewan Section

58. Minutes of the Board, January 11,1928

59. Ioc.cit.

and the I.O.D.E. endorsing the principle of free treatment.[61]

This principle was duly given statutory approval when the Tuberculosis Sanatoria and Hospitals Act 1929 was passed. The revised Act contained the provision that -

> ...Every person suffering from tuberculosis and every person who, on the certificate of a duly qualified medical practitioner, is suspected of so suffering, shall be entitled to receive care and treatment at the expense of the League. 62

The League was to receive the required revenue for these purposes from the one dollar per patient day provincial grant as before and from a levy upon the municipalities of the province. According to the original provisions of the 1929 Act, each year the Board of Directors of the League was to prepare an estimate of the portion of the probable net expenditure of the League for the year to be borne by municipalities and an estimate of the portion of such expenditures to be borne by local improvement districts. The Board was then to apportion that part of the net estimated expenditure to be borne by municipalities among all the municipalities in the province (both urban and rural) on the basis of their total equalized assessment for the preceding year as provided by the Saskatchewan Assessment Commission.

This clearly was a drastic change in the principle of municipal responsibility for now it was no longer to be justified on the basis of municipal responsibility for indigency. Instead of the municipalities merely acting as a last resort for its citizens when they became insolvent

61."Submission 1943",p.19

62. Statutes, 19 Geo.V,c.61,s.40,ss.2.

and not before, they were now assuming a blanket responsibility in association with the provincial government for the health of their citizens insofar as tuberculosis posed a threat to it. In short, tuberculosis was to be financed as a community responsibility instead of an individual responsibility as had previously been the case. While this was undoubtedly desirable from the standpoint of the tuberculosis control program in Saskatchewan, it committed the municipalities to a much more rigid financial obligation than had the contingent responsibility of the previous system. The disadvantages of the form which community financing of tuberculosis treatment took in Saskatchewan will be illustrated in the following section.

The Experience of the 1930's

The new system of municipal support of the League's treatment program introduced in 1929 was immediately subjected to the rigorous trials imposed upon all financial schemes by the depression and drought of the 1930's. This experience demonstrated the lengths to which the League and the provincial government were prepared to go in order to preserve the revenue system of the League as established in 1929. While there is clear evidence that the system of partial municipal responsibility failed completely under the stress of depression and drought, there appears to be no evidence that either the League or the provincial government considered the possibility of adopting some other system.

The financing system adopted by the League in 1929 was based upon the principle of levying estimated expenditures

and carrying on for about six months on borrowed funds before the taxes levied came due and the provincial grant was paid. This promised to work quite satisfactorily so long as the municipalities were able to pay their levies. Unfortunately this ability was weakened in the year following 1930 and by 1936 the system had broken down completely.

It will be seen from Table XVII below that the League's collections from the municipalities as a percentage of the annual levy held up and actually increased, between 1930 and 1935. The explanation of this rather unexpected strength is not to be found so much in the revenue structure of the League as in its expenditures. Table XVI (cf.n.64) shows that between 1929 and 1934 the per diem cost of treatment was reduced by seventy-one cents, from $3.020 in 1929 to $2,306 in 1934. This cost reduction was the result of a deliberate effort of the League to cut operating costs and of the falling price level. During 1934 a Committee of the Board of Directors was established to study "the detail of the administration of the various Sanatoria with a view to initiating economies".[63] The reduction in the per diem cost was brought about through salary reductions, increased work by staff, lower commodity prices and a shortening of the

63. Minutes of the Board, September 18,1934.

64

average length of treatment.

During the next several years, however, from 1935 to 1939 the League found that operating costs, while flexible to some degree, could not be reduced beyond the point reached in 1934. In fact, a slight rise in per diem costs in the 1935 to 1939 period could not be avoided. (See table XVI) Under these circumstances, with the adjustment of expenditures no longer possible, the League felt the full impact of the imperfection in its revenue system. Table XVII below shows that while it was possible to collect 90 per cent of the 1935 municipal levy, in 1937 only 57 per cent of the levy could be collected from the hart-pressed municipalities.

64.

TABLE XVI

PER DIEM COST

1929-1942

Year	Cost
1929	3.020
1930	2.920
1931	2.650
1932	2.435
1933	2.305
1934	2.306
1935	2.357
1936	2.388
1937	2.386
1938	2.396
1939	2.400
1940	2.397
1941	2.458
1942	2.676

TABLE XVII

MUNICIPAL LEVY COLLECTIONS [65]

1929-1943

Year	Collections	Amount of Levy	% of Levy Paid in Each Year
1929	$223,136.66	341,106.34	65%
1930	471,427.90	575,574.17	82
1931	386,059.34	475,533.13	81
1932	325,350.95	436,832.33	79
1933	338,122.76	375,487.89	89
1934	321,484.75	360,178.92	89
1935	323,174.73	362,006.60	90
1936	300,452.27	370,825.32	81
1937	211,213.69	371,402.65	57
1938	228,256.88	371,393.61	61
1939	412,735.65	363,988.48	114
1940	428,189.39	363,994.09	117
1941	450,217.31	379,872.21	119
1942	531,828.26	396,422.61	134
1943	705,490.07	397,950.74	177

Faced with this situation, the League undertook to carry the municipalities by borrowing sufficient funds to support its treatment expenditures. The nature of this borrowing is shown in Table XVIII. Although the League's borrowings increased by only $82,566 between 1930 and 1936, they increased by $294,552 in the single year 1937. By 1938 the cost to the League of carrying the municipalities is suggested by the fact that, aside from cancellation of interest on levy arrears, the League was paying out over $32,000 anually in interest on loans.

By 1937 the League was in a desperate financial position. It had reduced its costs as far as possible by instituting "the most drastic economies consistent with the

65. From S.A.R.M.,"Report of Rural Municipal Directors on the Board of Directors of the S.A.T.L."Report of the Proceedings at the Annual Convention, 1944, p.14.

efficient treatment of the sick" and had thereby succeeded in reducing the municipal levy by approximately 35 per cent between 1930 and 1937.[66] In spite of this it could still collect only half the municipal levy for 1937. By the end of 1938 the municipalities of the province owed the League $911,661 in arrears on levies.[67]

TABLE XVIII

BORROWINGS OF THE LEAGUE[68]

1930-1942

1930	384,000.00
1931	406,050.59
1932	412,566.94
1933	404,566.94
1934	404,766.94
1935	417,666.94
1936	466,566.94
1937	761,119.77
1938	671,082.47
1939	647,963.58
1940	596,583.58
1941	575,472.68
1942	459,500.00

In an effort to maintain its operations in spite of this, the League had exhausted its credit by the end of 1937. Its bank borrowing was limited to $400,000 per year and the League had borrowed $156,582 from its own Endowment Trust Fund on treatment account.[69]

66. Minutes of the Board, Memo to Local Government Board, October 13, 1937.

67. S.A.T.L., "Annual Report of the President, 1938" in Valley Echo, Vol.XV, No.8, August 1939, p.9.

68. Compiled from the Annual Reports of the League, 1930-1942.

69. S.A.T.L., op.cit.,p.8.

The League was saved from almost certain financial disaster only through the intervention of the provincial government. This intervention took two forms. First, the government responded to the League's appeal for assistance by extending a loan of $204,537 on treatment account. Commenting upon this assistance, the President of the League wrote in 1938 that:

> ...But for this substantial loan from the Government of the Province it is extremely doubtful whether the League could have continued to function. 70

In addition to this the League was protected from the forced cancellation of levy arrears throughout the critical period of its operations. As a result, the municipalities were left with a direct liability to the League for the total amount of the Levies, including interest on arrears at the rate of 8 per cent per annum.[71]

The League did, however, cancel much of this accrued interest. In 1940 the Tuberculosis Sanatoria and Hospitals Act was amended to authorize the Board of Directors to compromise the League's claim against a municipality for accrued interest and to "remit so much thereof as the board deems expedient, or...cancel the same."[72]

70. loc. cit.

71. Saskatchewan Urban Municipalities Association, Proceedings at the Annual Convention, 1941, pp.22-23.

72. Statutes, 4 Geo.VI,c.106,s.3.

Pursuant to this authority the League cancelled all interest up to and including December 31, 1939. While this amounted to a substantial reduction in the League's claim on the municipalities it was considered by the Local Government Board in 1941 to be inadequate for the needs of many municipalities in the province.[73] As a result of orders of adjustment made by the Local Government Board in 1941, the League wrote off $101,542 in the Debt Adjustment Area.[74] By that date, however, the League was financially far removed from the crisis of 1937 and was making collections in excess of the annual levies.

It is suggested that the experience of the 1930's demonstrates the interest which the League and the provincial government apparently had in preserving the principle of municipal participation in the League's revenue system. The extent to which the League borrowed in order to "carry" the municipalities after 1936 and the government's exclusion of the sanatorium levies from the provisions of the Debt Adjustment Act until after the critical period are the clearest illustrations of this determination to save the form of the revenue system established by the 1929 legislation.

Apportioning the Municipal Share

Even with the adoption of the new system of municipal

73. Saskatchewan Urban Municipalities Association, op. cit.,p.23.

74. S.A.T.L.,"Annual Report of the General Superintendent, 1941, in Valley Echo, Vol.XVIII,No.8,August 1942.

responsibility in 1929, there remained considerable municipal discontent with the allocation of the treatment burden. There were several sources of this discontent. Most troublesome, perhaps was the controversy between the rural and the urban municipalities as to how the total municipal levy should be allocated between them.

According to the provisions of the Act of 1929, the Board of Directors of the League was to apportion that part of its net estimated expenditure to be borne by municipalities "among all the municipalities in the province, both rural and urban, on the basis of their total equalized assessments for the preceding year..."[75] The levies upon Local Improvement Districts were to be collected and paid to the League by the Minister of Municipal Affairs.[76]

The Act had no sooner been passed than the Saskatchewan Association of Rural Municipalities objected that the allocation of the burden was quite unfair when the number of patients sent to the sanatoria by rural municipalities was compared with the number sent by the urbans.[77] In effect, they were arguing that the distribution of the burden was unfair on the grounds of the "benefit" principle.

Subsequently, the Act was amended to provide that the

75. Statutes, 19 Geo.V,c.61,s.25.

76. Statutes, 19 Geo.V,c.61,s.30 and 31.

77. S.A.R.M.,"Minutes of the Annual Convention, 1930", pp.14-15.

Board of Directors would apportion the levy and that the proportion of the net estimated expenditure to be borne by the urban municipalities was to be forty per cent and that borne by the rural municipalities, sixty per cent.[78] This ratio appears to have been based upon the 1929 ratio of rural to urban patients. It apparently proved satisfactory to the rural municipalities, for they made no further significant complaints for almost twenty years.

The urban municipalities, however, immediately protested that 1930 amendment. A resolution passed in that year at the urban convention contained the following clauses - the significance of which lies in their reflection of the "ability-to-pay" principle.

> ...the apportionment of the cost based on the equalized assessment for the year 1929 was approximately 19 per cent to urban municipalities and 81 per cent to rural municipalities; and...the distribution of the cost for social services of this nature can only be equitably apportioned on the basis of ability to pay, and not for services rendered or per capita.[79]

On the basis of this reasoning the urbans concluded that the forty-sixty apportionment was unsatisfactory in that it had created a burden which was unfair "and in some instances beyond the ability of the municipality to pay".[80]

78. Statutes, 20 Geo.V,c.84,s.25.

79. Union of Saskatchewan Municipalities, Proceedings at the Annual Convention, 1930, Resolution No.1.

80. loc.cit.

It is obvious from the controversy to this point that the two groups of municipalities were employing strictly different principles to support their arguments. Quite clearly the rurals were arguing that a just distribution of the burden was one which was based upon the benefit principle. The benefit in this case was to be represented by the number of patient days treatment received by each type of municipality. The urbans, on the other hand were arguing that the ability to pay principle was the only just basis for distributing the burden.

In spite of the urban protests, the sixty-forty allocation remained in effect for twenty-two years. In 1950 , however, the controversy broke out anew. Once again the principles of benefit and ability to pay were invoked. The association of rural municipalities passed resolutions to the effect that the sixty-forty basis was "unsound and unfair in that it makes an arbitrary division of the levies without consideration of the relative number of patient days treatment of rural and urban patients".[81]

The agreement of the rural municipalities was based upon the following "facts". Between 1930 and 1949 the number of treatment days received by patients from rural municipalities declined by 46,826 whereas the reduction in the number of urban patient days was only 11,009. Hence, in 1949 the rurals received 73,246 patient days and paid

81. S.A.R.M., "Minutes of the Annual Convention, 1950", p.18.

sixty per cent of the municipal levy, or $574,368. This was a cost of $7.84 per patient day. In the same year the urbans received 81,845 patient days and paid forty per cent of the total levy, or $382,911. This amounted to a cost of $4.67 per patient day.[82] According to benefit then, the rurals were bearing an excessive part of the burden.

Even granting the benefit principle, however, the urban municipalities argued that this conclusion may not follow. The old complaint of the urban municipalities that the sick tended to gravitate toward them from the rural areas was revived in an effort to discredit the foundation of the argument used by the rurals. As one urban supporter put it:

> No figures are sound as to urban and rural residents. People who are ill tend to move to the city, and if the background of all patients admitted to the sanatoria were examined, it would change the figures. We have made a sampling which supports this. 83

In addition to this, the urbans argued that the 1949 levy data used above supported their contention that the sixty-forty allocation was unfair. They, however, implicitly applied the ability to pay principle. Instead of considering the 1949 levy shares in relation to the days treatment received as had the rurals, they considered them in terms of the relative mill rates resulting from them - that is, upon the basis of

82. Based upon the data from Minutes of the Board, October 28, 1949 and February 3, 1950.

83. Saskatchewan Urban Municipalities Association, Proceedings at the Annual Convention, 1951, p.31.

total assessments.

> The figures for the 1949 T.B.levy show that the urban municipal rate was 1.75 mills on the equalized assessment while that for rurals was 0.92 mills. It is hard to see any justification for this discrimination against the urban municipalities which has been going on since 1930.84

The basis of this argument is again to be found in the urban contention that since the basis of municipal taxation is the equalized assessment, and since this provides a rough basis for estimating ability to pay, the allocation of the municipal share in the cost of providing treatment for tuberculosis should be on the basis of the equalized assessment of municipalities regardless of whether they be urban or rural.[85]

The settlement of this controversy could come only through a compromise of the two principles involved, for each clearly led to opposing conclusions in this case. As for which principle was actually most "just", this was a matter of social philosophy and, what was perhaps more fundamental, of sectional advantage. It is not likely a mere coincidence that the use of the benefit principle by the rurals would have reduced the rural share of the cost, nor that the use of the ability principle by the urbans would have reduced the urban share.

It is interesting to note, however, that the Board of Directors of the League appears to accept the benefit principle when it comes to distributing the burden among the

84. Ibid., 1950,p.32.

85. loc.cit.

various types of local government units. While the Board seems to have taken no particular stand with respect to the rural-urban controversy, it did raise an objection to the share of the burden taken by the Local Improvement Districts and the Northern Administration District. In 1950 a special committee reported to the Board that it had -

> ...made a study of the hospital days treatment for the past twenty years which proves conclusively that the Rural and Urban municipalities have been called upon to shoulder not only their share of the cost of treatment of the tuberculous patients, but the heaviest end of the share that should have been carried by the Northern Administration District and Local Improvement Districts as well. 86

The League's contention was that since these local units would contribute more patients in the future as a result of the extension of case finding work in the northern areas, their levy should be raised. This suggests that the Board of Directors accepts the benefit principle as the correct basis for this kind of distribution of the cost of treatment.

The compromise which was finally adopted was drafted by a committee set up in 1951 by the Minister of Municipal Affairs. In accordance with the recommendations of the committee the sanatorium act was amended in 1952 to effect the present distribution of the burden as described in Chapter Three.

This method distributes the burden according to three factors - population, total assessment and days treatment

86. Minutes of the Board, February 3, 1950.

received by patients from each type of municipality. Each factor is given equal weight.

How successful the compromise will be in averting further controversy between the two types of municipality has yet to be observed. It would appear, however, that the compromise has replaced a rather simple with a very complex method of calculating the annual distribution of the municipal levy.

Apportioning the Levy Among The Several Municipalities

In spite of the preference of the Saskatchewan Association of Rural Municipalities for the benefit principle in allocating the municipal share of the treatment burden and the apparent acceptance by the Directors of the League of the same principle, the ultimate basis for its allocation among the individual municipalities within the respective urban and rural categories has always coincided with the ability principle insofar as it is approximated through the use of equalized assessments.

The effect of this is to spread the incidence over a much larger area than would otherwise be the case. If the benefit principle were used and the benefit measured in terms of patient days, many municipalities would completely avoid the levy for considerable periods of time. During the period from 1944 to 1951 some municipalities had neither a death nor a single case of tuberculosis. 87.

87.S.A.T.L.,"Report of the Director of Medical Services, 1952", mimeographed,p.2.

Hence, if it is true that all municipalities in the province have some ability-to-pay, it may be assumed that the use of this principle to distribute the cost of treatment among the municipalities of the province will ensure a greater dispersion of the burden than would the use of the benefit principle.

The chief advantage of such dispersion would appear to lie in its promise of greater stability in the revenues of the League. Such increased stability could be expected in view of the considerable variation in economic conditions in any one year throughout Saskatchewan.

The writer is of the opinion that this advantage more than offsets the possibility that use of the ability principle for this purpose might reduce the incentive to high case rate municipalities to cooperate with the League in its program. It is possible that the use of the benefit principle to distribute the cost of treatment might induce such municipalities to increase their efforts to reduce their case rate. Personal experience of the writer would suggest, however, that such financial inducements are relatively insignificant factors affecting the willingness of individual municipalities to cooperate effectively in the League's tuberculosis control program.

The Provincial Grant

The nature of the fixed provincial *per diem* grants has already been described in Chapter Three. Beginning as a fifty-cent per patient-day "hospital" grant to the original sanatorium in 1917, it was raised to one dollar in

1923, one dollar and fifty cents in 1950 and to two dollars in 1951. The problem associated with this grant arises from its inflexibility. In spite of the great fluctuations in the League's operating costs between 1923 and 1950, for example, the provincial grant on treatment account remained at one dollar per patient day.

According to the League's financing procedure as established by the Act of 1929, the rigidity of the provincial grant necessitated annual alterations in the municipal levy to offset fluctuations in the costs of treatment. In 1930 the provincial grant provided approximately 31 per cent of the League's revenues. By 1949 it accounted for only 18 per cent.

This rigidity in the financing scheme did not become significant until the League's operating costs began to rise in response to a rising price level after 1945. In the years following 1945 the large increases in the municipal levies aroused vigorous objections from the municipalities. This went so far as to threaten the entire revenue structure of the League. The feelings of the municipalities at this time were made more intense by the introduction of the Saskatchewan Hospital Services Plan in 1947 which provided "free" hospitalization for all illnesses except tuberculosis which was still to be financed upon the basis established in 1949.

In 1948 the SARM representatives on the Board of Directors of the League reported to their convention that now "everybody gets free treatment except those suffering from tuberculosis and these are left to the tender mercies of the

municipalities to provide for. It is time for a change in policy by the Government.[88]

By 1947 the municipal sanatorium levy was approaching one mill and the League was besieged by complaints from the municipalities. (See Table XIX below for increase in municipal levy during this period) In his annual report for that year the President of the League wrote that -

> It is becoming more and more evident that unless the ever increasing financial burden carried by the municipalities is shared to a much greater extent than in the past, the municipalities may be compelled to withdraw their support from the League....89

In commenting upon the increasing dissatisfaction of the municipalities with the League's revenue system, the President went on to argue that the increasing municipal sanatorium levy in Saskatchewan was out of step with changing conceptions of municipal responsibility for health services.

> There has been a general movement in the past number of years, both provincially and federally to lift the financial responsibility for health and hospital care from the shoulders of the municipalities as is evidenced by the Saskatchewan Hospitalization Act providing free hospitalization...and the recent announcements made by the Dominion Government to provide Federal Health Grants to the provinces....90

88. S.A.R.M.,"Minutes of the Annual Convention,1949".

89. S.A.T.L.,"Annual Report of the President,1947", in Valley Echo, Vol.XXIX, No.8, August 1948,p.9.

90. Ibid.,p.10

The explanation of the League's interest in this situation is to be found in the concluding sentence of the report cited.

> Should this situation be allowed to continue it would jeopardize the cooperation and the good will of the general public and the tax payer of the province upon which depends the success of the League's preventive program. 91

It would appear that the League felt that taxes levied by the province would appear less onerous than those levied by the municipalities. Actually, since the author of the above sentence has had a long career in the work of the rural municipalities, it may merely reflect the belief that real property taxation is excessive and incapable of further extension. This interpretation is supported by a resolution passed at the 1948 S.A.R.M. convention and beginning with the statement that "the constantly rising costs of operating the T.B. Sanatoria [sic] is placing an excessive burden on land".[92]

By 1948 the municipal levies (including the L.I.D. and N.A.D. Levies) had increased by 161 per cent of their 1941 amoumt.[93] The following year the Saskatchewan Urban Municipalities Association resolved that the"municipalities should have a fixed levy, not exceeding one mill, for this service, and the Province should assume the balance".

In response to this agitation the provincial government

91. Ioc.cit.

92. For a discussion of the validity of this contention see Province of Saskatchewan, Report of the Committee on Provincial Municipal Relations,1950,Regina,King's Printer,1951,p.99.

93. S.A.T.L.,"Annual Report of the President,1948", in Valley Echo, Vol.XXX,No.8,August 1949,p.9.

raised the per diem grant from $1.00 to $1.50 effective April 1, 1950. This, however, reduced the 1950 levy by only $75,000 from the 1949 amount and did little to quell the efforts of the municipalities to obtain further relief from the burden of rising treatment costs.[94] Their cause was again supported by the President of the League who stated that -

> If the provincial government can afford the entire cost of all hospital patients they should pay for 40 per cent of treatment costs in Saskatchewan Sanatoria.[95]

In 1950 the provincial share amounted to only about one-quarter the operating costs of the League.[96] Following the report of the Committee on Provincial-Municipal Relations in 1950, however, the grant was again raised by fifty cents to $2.00 per patient day. This has remained without further change to the present and has raised the provincial share to approximately thirty per cent of total revenues. It should be observed here, however, that part of the provincial grant is in the form of a "hidden subsidy". The annual grant is calculated on the basis of the total number of patient days treatment provided each year by the League. Hence, the League collects $2.00 per patient day for treatment rendered patients

94. S.A.T.L., "Annual Report of the General Superintendent, 1949", in Valley Echo, Vol.XXX, No.8, August 1949, p.12.

95. Saskatoon Star-Phoenix, August 4, 1950, p.5.

96. Saskatchewan Urban Municipalities Association, Proceedings of the Annual Convention, 1950, p.61.

whose costs of treatment are paid by the Dominion and other governments. In 1953, with 163,132 patient days rendered "non-provincial" patients, this hidden subsidy amounted to $326.264.[97]

In 1953, the last year for which data is available, the provincial grant amounted to thirty-one per cent of total revenues. It is interesting to notice that this is exactly the percentage for which it accounted in 1930.

How satisfactory the present rate is will depend upon the future operating costs of the League, which in turn will vary with the general level of commodity prices and wages. If these costs level off or decline, the present grant will no doubt remain satisfactory to the municipalities. If they should begin another rise, however, this element in the League's revenue structure will again become a problem.

The difficulties of the past decade would suggest that there may be some justification for the contention of Saskatchewan Urban Municipalities Association that the flexibility in the League's revenue would be better built into the provincial share than the municipal as at present.[98] This could be accomplished simply by fixing the municipal share at a certain percentage of the League's annual treatment costs and making the provincial share the residual item.

97. Patient day data from S.A.T.L.,"Report of Medical Services, 1953", mimeographed, p.3.

98. See Saskatchewan Urban Municipalities Association, Proceedings of the Annual Convention, 1950, p.61.

Failing this, it would appear desirable from the standpoint of the League's relationship with the municipalities, that some system be established for adjusting the provincial grant at definite intervals, thereby reducing the possibility of future "provincial grant controversies".

Non-financial Aspects of Municipal Responsibility

It is suggested as a possible explanation for the persistence of the principle of municipal responsibility in Saskatchewan that this principle was an important factor in the application of the League's "underlying philosophy" to the tuberculosis problem in this province. For thirty-six years the League and the provincial government have fostered the principle of partial municipal responsibility even when its serious imperfections were most apparent.

The experience of the 1930's demonstrated the lengths to which the League (with the frequent backing of the government) was prepared to go in order to prevent the permanent disruption of the system. It would appear that the League has felt that the active financial involvement of the municipalities is necessary to its program. With it the League has been able to maintain its appearance of independence from the government - an end desired, as has been demonstrated previously, by the founders of the League and by the governments in power during the years when the League was being moulded into its present form.

The question immediately raised by this is whether the present situation of the League and the problems confronting

TABLE XIX

REVENUES OF THE LEAGUE ON TREATMENT ACCOUNT

	Provincial Grant	Urban Levy	Rural Levy	L.I.D. Levy	Fees etc.	Total Revenues
	$					
1929	214,018.00	61,417.89	264,688.45	15,000.00	43,376.33	598,500.67
1930	281,378.00	223,130.47	334,695.70	17,748.00	30,105.99	890,058.16
1931	293,379.00	186,271.25	279,406.88	9,855.00	20,389.90	789,302.03
1932	283,878.00	168,524.39	252,786.58	15,521.36	16,740.05	737,450.38
1933	285,529.00	144,675.80	217,013.69	13,798.40	18,705.14	679,722.03
1934	284,081.00	137,469.13	206,203.69	16,506.10	24,354.59	668,614.51
1935	276,502.00	137,485.09	206,227.63	18,293.88	26,788.20	665,296.80
1936	282,113.00	137,533.06	206,300.33	26,991.43	25,776.03	678,714.35
1937	275,183.00	137,751.38	206,627.07	27,124.20	13,418.20	660,003.85
1938	286,818.00	137,749.64	206,624.45	27,019.52	31,475.20	689,686.81
1939	296,713.00	134,799.71	202,199.57	26,989.20	44,517.79	705,219.27
1940	287,800.00	134,797.64	202,196.45	27,000.00	35,937.53	687,731.62
1941	292,196.00	140,748.88	211,123.33	28,000.00	48,091.94	720,160.15
1942	289,615.00	146,766.05	220,149.06	29,507.50	86,655.34	772,692.95
1943	272,945.00				140,092.59	
1944	287,167.00	147,220.12	221,195.34	25,776.03	163,570.07	847,084.87
1945	279,967.00	160,588.54	241,075.87	18,060.00	179,813.95	880,524.21
1946	204,848.00	211,761.52	317,607.12	20,760.00	305,501.22	1,160,477.76
1947	292,848.00	289,833.58	434,669.46	25,950.00	358,618.63	1,401,919.67
1948	288,037.00	382,911.31	574,367.64	33,994.50	341,243.06	1,620,553.51
1949	290,147.00	382,819.88	574,367.27	28,000.00	334,484.74	1,625,818.89
1950	401,970.00	352,593.38	529,276.78	26,000.00	374,966.26	1,711,840.90

(Compiled from Annual Reports of the Municipal Representative on the Board of Directors of the League to the SARM)

*Comparable data for 1943 not available.

it warrant a continuation of a policy based upon the conditions prevailing in Saskatchewan over a quarter of a century ago. Under those conditions it is easy to appreciate the argument that a somewhat inappropriate revenue system from the point of view of efficient financing could be tolerated so long as it was important to the development of public interest and mass education with respect to a previously uncontrolled disease. At present, however, with the white death rate reduced to 10 per 100,000 of population and with the League approaching a period when the tuberculosis control program will become a matter of maintaining the disease at a minimum level rather than of expanding the program, it appears reasonable to question the soundness of this argument. Such a course would also be suggested by the alteration in the conditions surrounding the provision of health services in general. With the introduction of the contributory hospitalization scheme on a province-wide basis in 1947, the justification for continuing the 1929 revenue scheme for a single disease appears even more questionable.

Financing the Preventive Program

The present scheme for financing preventive work dates from 1928 when the League began its Christmas Seal Campaign. The first sale of Christmas Seals in Saskatchewan however, was made by the Red Cross five years earlier.[99]

99. Minutes of the Board, October 11,1927.

Considerable confusion appears to have existed for the first two years of the League's seal sale as to which organization was entitled to the use of this source of revenue and publicity.

In 1928 the Red Cross suggested that the League give to it the exclusive use of the seals in return for a percentage of the returns. This suggestion was rejected by the League on the grounds that it "had ample facilities for carrying on its own activities without delegating these to an outside organization."[100]

The Red Cross, in turn rejected the League's proposal to reserve their suggestion "as they were not prepared to give up the publicity attached to the sale of seals, whether they sold seals for the League or continued to sell their own."[101] From the outset the non-financial considerations involved in the use of this source of revenue were quite explicit.

The controversy was finally settled in 1930 through a compromise by which the League would restrict its seal sales to direct sales to adults and the Red Cross would sell its seals indirectly through school children.[102]

In 1937 the League further secured its revenue domain from external influences by refusing to cooperate with the

100. Minutes of the Board, April 4, 1928.

101. Ioc.cit.

102. Minutes of the Board, September 18,1930.

Canadian Tuberculosis Association in raising funds in Saskatchewan except for such funds as might be raised for the C.T.A. by the League.[103]

These experiences emphasize the League's determination to derive publicity for itself and its cause through the raising of voluntary contributions. The reasoning underlying this attitude of the League is explicitly laid out in the report of the 1922 Commission. This commission expressed the belief that if the entire cost of the League's work were financed by the government "all the educational advantages of campaigns for money" would be lost. Hence, it found that -

> Sums of money voted to this work by governments should provide for the most of the cost connected with it, but a considerable sum must be provided through private contributions solicited through organizations from the individual. In this way only can the danger of tuberculosis be repeated over and over again, until those who have given the matter very little thought are brought to realize the actual cruelty of the disease and are enlisted in the army or anti-tuberculosis workers.[104]

This, in turn, once again reflects the principle upon which the League and its program has been constructed. Indeed, the commission itself made this quite clear when it stated that "every effort should be made to develop voluntary work along this line and nothing should be undertaken by the government that can be as well done by the private individual or organization".[105]

103. Minutes of the Board, January 27, 1937.

104. Commission, 1922, p.53.

105. Ioc.cit.

In addition to the annual mail appeal conducted by the League, there are two other major sources of preventive revenues. Most important of these is the annual contributions made by the Associated Canadian Travellers. This revenue dates from 1934 when the A.C.T. adopted tuberculosis prevention as its humanitarian service. In cooperation with radio stations throughout the province, the A.C.T. conduct an extensive series of "amateur programs" during the winter months.

Another source of revenue on preventive account is the "Rural Secretaries Christmas Seal Campaign" organized in 1939. This campaign is conducted by the Rural Municipal Secretaries who volunteer to sell Christmas Seals in their municipalities. Some revenue is also received from the sale of "Health Bonds" as described in Chapter Three.

All these revenues are collected by the Christmas Seal Committee of the League. This is a rather large committee which at present consists of a chairman and nineteen members, only one of whom is a member of the Board of Directors. This Committee is responsible for the management of the annual Christmas Seal Campaign.

Each "Annual Christmas Seal Campaign" includes the annual receipts from the mail appeal (in which seals are mailed to potential contributors), the Health Bonds, the Rural Secretaries Campaign, the A.C.T. amateur programs and occasional special canvasses. These revenues are turned over to the "Preventive Fund" of the League which is then

charged with the annual costs of the League's Preventive program.

Revenues on Preventive Account 1928-1953

The use of such a fund offers obvious advantages in that it serves as a buffer between revenues and expenditures. Table XX below shows that from 1932 to 1934 the charges against the preventive fund exceeded the revenues credited to it. This was the result of the League's effort to maintain its preventive program throughout the depression in accordance with their avowed belief that it was the "foremost economy" available insofar as the cost of treatment was concerned. By January 1943 the preventive fund had a deficit of $11,040. The sharp increase in revenues in 1943 and 1944, however, served to eliminate this deficit and provide a surplus of $15,993.[106]

In an effort to overcome the possibility of a recurrence of this situation, the League announced in 1945 that it was its intention "to build up some reserve in the Preventive fund, if possible, to safeguard any curtailment of this work in the lean years".[107]

By 1947 the preventive fund had a surplus of $80,000 and with the establishment of the Federal Tuberculosis Control Grants it has been possible for the League to accumulate

106. S.A.T.L.,"Annual Preventorium Report,1944" in Valley Echo, Vol.XXVI,No.8,August 1945,p.21.

107. Ioc.cit.

substantial reserves even while expanding its preventive program.[108]

Apparently concerned over the effect such reserves might have upon future revenues, particularly those provided by the A.C.T., the Directors met with the A.C.T.,

> ...pointing out to them that the League needed the continued support of the A.C.T. in view of the fact that, should the Federal Tuberculosis Control grants be discontinued, the Preventive Programme now in effect would exceed the current revenue and would in a short while deplete the present reserve of the Preventive Fund. [109]

The returns to the League on preventive account are seen to be remarkably stable, especially when compared with the behavior of the League's revenues on treatment account. It appears from the net total returns given in Table XXI that even the economic conditions of the 1930's had little significant effect upon the voluntary contributions to the League. Even without the support given the returns after 1934 by the inclusion of the A.C.T. contributions it is evident that while the returns did not increase as rapidly as the League's expansion of the program, they were in no danger collapsing as did a large part of the League's treatment revenues.

In addition to the apparent resistance of the voluntary contributions on preventive account to fluctuations in the general level of economic activity, they appear also to have

108. Minutes of the Board, October 31, 1952.

109. Ioc.cit.

withstood the increased competition of other appeals for voluntary funds. This has been the case, not only in Saskatchewan, but in Canada as a whole. Addressing the Annual Meeting of the League in 1951, Dr. Wherret of the C.T.A. observed that returns from the seal campaigns had continued to increase "despite the fact that since the initiation of the Christmas Seal Campaign in Canada when it was the only national appeal, there have since been added many other Dominion-wide appeals for voluntary funds".[110]

Efficiency of the Appeal For Voluntary Contributions

The gross and net receipts data given in Table XXI show that approximately ten to fifteen per cent of the gross receipts are lost annually to the costs of the campaign. This percentage has remained almost constant since 1928, being 14.9 per cent in that year, 13.5 per cent in 1935 and 12.2 per cent in 1953.

The nature of these costs is indicated by the following extract from the 1953 Report of the Christmas Seal Committee.[111]

110. S.A.T.L.,"Minutes of the Annual Meeting",July 27,1951.

111. S.A.T.L."Annual Report of the Christmas Seal Committee,1953", mimeographed, p.4.

TABLE XX

EXPENDITURES-1953 CHRISTMAS SEAL CAMPAIGN

To CTA for supplies	6,266.96
Salaries	7,343.75
Postage	2,343.75
Printing etc	628.87
Contributions to CTA and the International Union Against Tuberculosis	1,723.41
	18,641.10

For several years, according to reports from the Canadian Tuberculosis Association, Saskatchewan has led the other provinces in the efficiency of the seal sale. In 1953, for example, the League received an average of $1.03 for every letter mailed to potential contributors, the highest return per letter in Canada. It also exceeded the other provinces in the average return per mail sale with an average contribution of $2.56.[112]

There is no method by which the real net returns of the appeal for voluntary funds may be measured, for it would be necessary to estimate the value to the program of the publicity gained by the League for its work in the course of raising the funds. The League believes that this non-monetary return has a real value to the program because it stimulates active public participation in it.

112. loc.cit.

TABLE XXI

REVENUES OF THE CHRISTMAS SEAL CAMPAIGN [113]

Year	Total Gross Receipts	Total Net Receipts	Preventive Program Expenditures
1928	12,130	10,326	-
1929	17,774	10,503	- (Data not
1930	13,203	9,512	- comparable)
1931	10,603	8,484	-
1932	9,919	8,352	-
1933	9,760	8,389	29,071
1934	11,484	9,933	33,200
1935	12,929	11,183	31,414
1936	15,230	13,251	30,737
1937	19,275	16,862	29,625
1938	21,684	16,272	31,507
1939	24,113	21,126	41,814
1940	26,041	22,796	41,305
1941	31,055	27,316	44,602
1942	36,115	31,848	45,541
1943	51,303	45,153	54,531
1944	90,329	79,774	64,231
1945	100,409	88,669	76,925
1946	131,159	117,067	73,522
1947	134,630	123,732	81,702
1948	136,322	126,436	96,048
1949	139,218	126,091	118,621
1950	120,821	105,628	129,041
1951	124,015	107,309	126,924
1952	133,045	115,208	152,926
1953	152,638	133,997	132,788

(Source: receipts data, Christmas Seal Report 1953, expenditure data compiled from Annual Reports of Medical Services 1928-1953)

113. Receipts data from loc.cit. Expenditures data compiled from S.A.T.L.,"Annual Reports of Medical Services,", 1928-1953.

Personal experience of the writer has suggested that the League does receive a remarkable amount of public participation in its preventive program and that its work is generally familiar to the public throughout the province. Again, however, it is impossible to estimate the extent to which this is attributable to the appeal for voluntary contributions. If it is assumed, however, that part of it is attributable to the fund raising campaign, and since the campaign is from 85 to 90 per cent efficient, there appears to be little reason to challenge the League's belief as the overall advantage of this method of raising revenue over the alternative method of taxation.

It must be recognized, however, that the League's method is not without a real economic danger when regarded from the standpoint of the over-all public health program. The extent of this danger depends, from the economic standpoint, upon the ability of the contributing public to give according to the legitimacy of the appeal and not according to whim or the emotional aspects of the appeal. Even so, however, it is difficult, if not impossible, to establish the "legitimacy" of the various appeals for voluntary contributions because of the subjective nature of the "results" of the programs which depend upon the public for support. Perhaps the best that can be hoped for is that the distribution of the funds raised by this method will reflect an informed community preference.

Conclusions

The main conclusions to be drawn from this examination of the revenues of the Saskatchewan Anti-Tuberculosis League may be summarized as follows:

1. The prevalence of indigency among the tuberculous sick makes individual financial responsibility impractical as a means of financing treatment. But at the same time, because individual and community benefit cannot be separated, individual responsibility cannot be justified by the benefit principle either.
2. The maintenance costs of tuberculosis sanatoria cannot inspire voluntary contributions on a mass scale and the absence of large fortunes in a newly settled and predominantly agricultural area means that the endowment principle cannot be contemplated a s a practical revenue source on treatment account.
3. Municipal responsibility for a share of the treatment costs grew, in practise, out of the principle of municipal responsibility for indigents. With the introduction of free treatment in 1929 it lost this basis and seemed to reflect municipal responsibility for certain health services. But with the development of comprehensive provincial health services, a well organized department of public health and a contributory hospital services

plan which provides hospitalization for every disease (but) it appears less reasonable now to assign partial responsibility for tuberculosis treatment to the municipalities than it did in 1929.

In practice it appears that the municipalities have not been an entirely satisfactory source of revenue for the treatment program. Throughout the history of the League various methods have been used to render the system of municipal financial responsibility workable. The pooling schemes of the 1920's were perhaps the outstanding example of this. During the depression years of the 1930's it appeared as if the League's revenue structure would be broken down completely as a result of the collapse of municipal revenues. In spite of this, however, there was no suggestion that this reflected upon the soundness of the system and the League and the provincial government succeeded in carrying the municipalities through the critical years of 1936 and 1937 without disturbing the principle of municipal financial responsibility for part of the League's treatment program.

Aside from the experience of the 1930's there have been two other sources of difficulty associated with the system by which the League raises its revenues on treatment account. One of these has been the "just" allocation of the municipal burden

between the two types of municipality - urban and rural - in the province. The other has been the determination of the share of treatment costs which should be assumed by the provincial government.

In spite of these difficulties, however, the League appears to be well satisfied with the revenue system adopted in 1929. This suggests that the League (and the governments under which the system took shape) sees in the League's financial relationship with the municipalities more than a means of raising revenue. That is, it is suggested that it serves as -

(a) a means of enlisting active municipal participation in all phases of the tuberculosis control program and

(b) as a means of providing the League with other than government support so as to make it possible for the League to attract voluntary, active public support.

4. The use of voluntary funds to finance the treatment program appears to have been quite successful. While such revenues were inadequate for a period during the 1930's there seems to be no evidence to suggest that the preventive program has ever been significantly curtailed because of difficulties in raising revenue. The voluntary contributions have shown much greater resistance to downward movements in the level of economic activity than the revenues derived from the municipalities on treatment account. In view of this and their apparent

resistance to competition from other fund raising campaigns, the voluntary contributions on preventive account appear to be a fairly reliable source of revenue from which to finance these activities.

It is difficult to estimate the real value of the voluntary method of raising these revenues but the writer is of the opinion that in view of the efficiency of the campaign as conducted by the League, the importance of public interest to the success of preventive work of this nature and the large degree of public support which the League does enjoy in the province, there is little reason to challenge the League's belief as to the overall advantage of this method of raising revenue for the preventive program.

While it is important to bear in mind the danger that the League's appeal for funds might be more successful than the relative social value of its work warrants, the writer believes that the other advantages of the voluntary method compensate for any cost which might result from the inability of the contributing public to evaluate the relative merits of the various appeals for voluntary funds.

CHAPTER V

THE MANAGEMENT OF THE SASKATCHEWAN ANTI-TUBERCULOSIS LEAGUE

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THE MANAGEMENT OF THE SASKATCHEWAN ANTI-TUBERCULOSIS LEAGUE

The general nature of the management of the anti-tuberculosis program in Saskatchewan has been described in Chapter Three. The purpose of the present chapter is to examine the implications of certain aspects of the policy making and administrative structure of the League.

The Board of Directors

The powers of the Board of Directors of the League are to be found in the Revised Statutes of Saskatchewan, Cap.235. The Tuberculosis Sanatoria and Hospitals Act states that "the Board may exercise all powers of the League which are not by this Act required to be exercised by the League in general meeting."[1] Except for the election of certain directors and the approval by the members of the League of bylaws passed by the Board these other powers are not specifically set out in the present Act. In practice it appears that the Board is not restricted in its authority to manage the tuberculosis control program in Saskatchewan by the reservation of certain powers for the general meeting of the membership of the League.

A study of the minutes of the annual meetings has

1. Revised Statutes of Saskatchewan, 1953,c.235, s.9. (Hereafter R.S.S.)

supported this interpretation of the Board's powers. This is not surprising in view of the attendance at the annual meetings. In 1951, for example, only thirty-four persons attended the annual meeting of the League. Of these thirty-four, twenty were either directors or senior administrative officials responsible to the Board.[2]

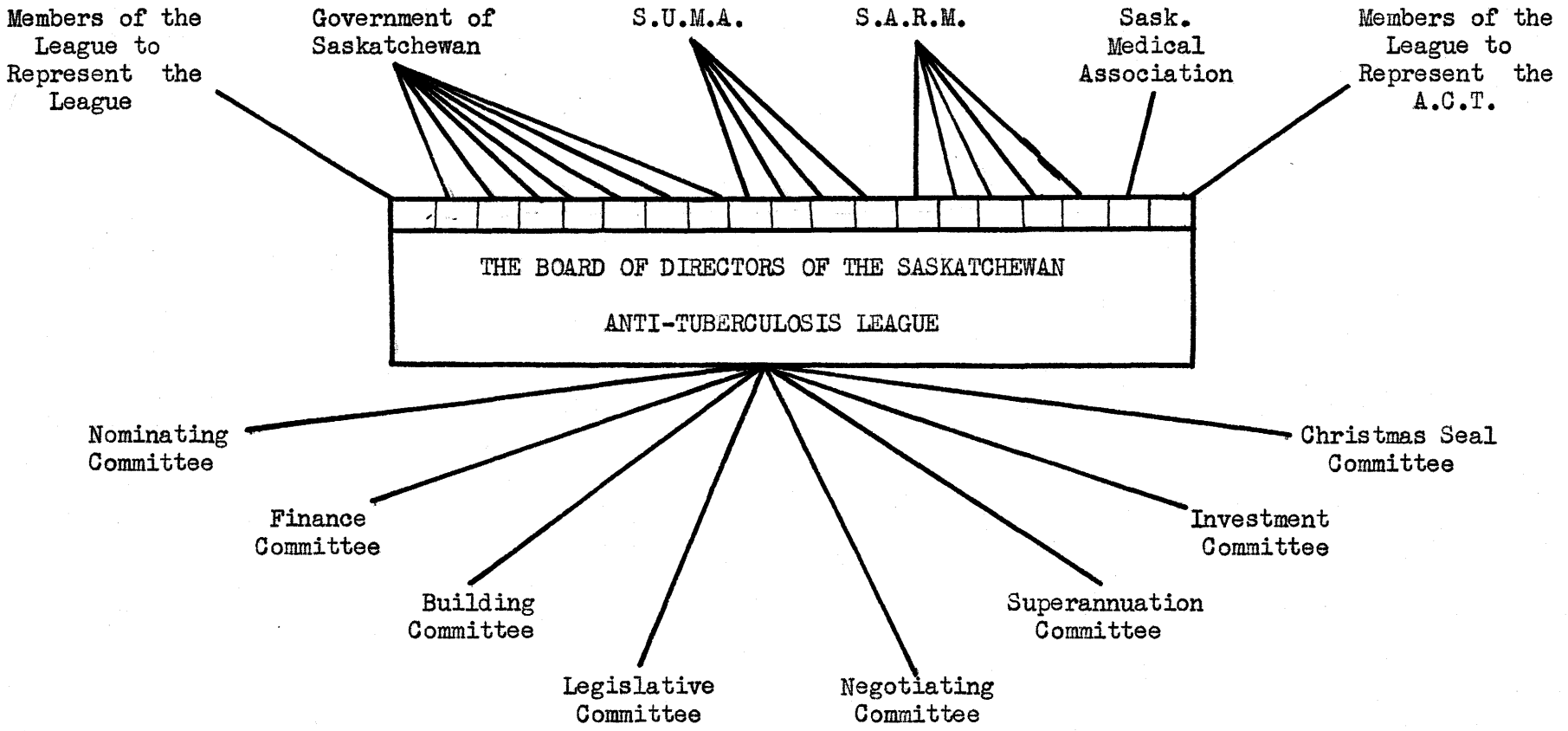
From the chart it is quite apparent that the Board of Directors of the League, as its governing body, is intended to be responsible for the operation and management of the tuberculosis control program in this province. How strictly this is true in practice depends upon how "independent" the Board is as a policy making body. Before discussing the degree of independence enjoyed by the Board, however, it appears necessary to recapitulate, in somewhat greater detail, the characteristics of the Board as introduced in Chapter Three.

The present composition of the Board is summarized in the chart on page 174...The Board consists of 19 directors who are elected or appointed by the organized interests most intimately concerned with the tuberculosis program in Saskatchewan. The appointments are all made annually except for the five directors appointed by the provincial government to represent the people of the province in general. These directors are appointed for two year terms.[3]

2. These twenty were made up of twelve directors, the General Superintendent and Director of Medical Services, the Chief Steward and Purchasing Agent, the Chief Accountant, the three Medical Superintendents, the Secretary and his Assistant.

3. R.S.S., c.235, s.6, ss.2.

COMPOSITION OF THE BOARD OF DIRECTORS



The members of the original Saskatchewan Anti-Tuberculosis League are represented by one director who is elected at the annual meeting of the League. The same individual has been elected to this post every year from 1934 to 1953.

Seven other directors are appointed by the provincial government. Two of these are intended to represent special geographical areas - the Northern Administration District and the "Unorganized Territories". The other five government appointed directors are persons who are broadly representative of the population of the province. They are usually individuals who have distinguished themselves in social activities in their local communities.[4] Within recent years one of the five has always been a woman. The other four appointees reflect medical, legal, business and agricultural interests. Their geographical affiliations are also diverse. In 1953 the government appointees to the Board resided in Swift Current, Prince Albert, Regina, Sintaluta and Fort Qu'Appelle.

The government appointments for special geographic areas and, within recent years, two or three of the general appointments have been filled with a succession of newcomers to the Board. One appointment, however, has been held ever since 1936 by the same individual and another was held for seventeen consecutive years.

The substantial interests of the municipalities of the province in the affairs of the League are represented by nine directors. Four of these are appointed by the Saskatchewan

4. Personal communication with League official.

Urban Municipalities Association and five by the Saskatchewan Association of Rural Municipalities.

These appointments are remarkable for the length of time certain individuals have held them. One has been held ever since the Municipalities were given representation in 1927, another individual represented first the Rurals and then the Urbans to accumulate eighteen years on the Board, while another held office for sixteen years.[5]

The Saskatchewan Medical Association appoints one director. Reappointment is also common in this case, for in the last twenty years only four persons have held the appointment and one of them served for twelve consecutive years.

The remaining director is appointed by the membership of the League to represent the Associated Canadian Travellers of the Province. As pointed out in Chapter Three, the League appointment in this case is a mere formality, for the A.C.T. nominee is always elected.

These 19 directors comprise the Board of Directors of the League. The Board elects one of its number to the position of "President of the League and Chairman of the Board". This appointment is made annually but in practise reappointment is the rule. The "Chairman" by statute is the presiding officer at meetings of the League and of the Board.[6]

5. Years of service compiled from the Annual Reports of the League, 1919-1953.

6. R.S.S., c.235,s.8.

This title reflects the rather curious relationship between the "League" and the Board of Directors. The Board is quite clearly far more than the policy making committee of "the League". Insofar as, in effect, eighteen of the nineteen members are appointed by organizations external to the League it must be regarded,primarily, as a body synthesizing the interests of these other organizations - of which the Saskatchewan Anti-Tuberculosis League is only one.

Chapter Three showed how this peculiar situation evolved historically. What is of interest here is that no effort has ever been made to clarify this relationship between the League and the Board. In fact, if the interpretation being used in this study of the purposes underlying the organization of the tuberculosis control program in Saskatchewan is correct, such clarification has not been desired by the authors of the program.

For the purposes of identifying "the League", the control program, and public participation, it is convenient to ignore the fact that the operation and management of the program is <u>not</u> in the hands of a "voluntary health agency" <u>per se</u>. In any event the offices of "President of the League " and "Chairman of the Board of Directors" at present are in the hands of a single member of the Board.

It must be remembered, however, that this position is by no means comparable with that held by the early "Presidents of the League". These men were, in fact, the senior officers

of a voluntary health agency and the "boards" which they headed were actually executive committees of that agency.

Bearing this in mind it is still pertinent to recall that there have been very few senior directors of the program in Saskatchewan. As outlined in Chapter Three, three men have held this post for forty-three of the League's forty-four years of operation. All these men were intimate with the development of the program in Saskatchewan. The present holder of the senior office has served on the Board since the original sanatorium was opened.

Committees of the Board

The chart on page 174 shows that there are eight committees of the Board. All the directors are on one or other of the committees except the two medical members who are exempted from committee work because of the press of their professional duties.[7] The work of the committees is coordinated by the President, who, in addition to being chairman of the Investment Committee, is ex-officio a member of all the other committees.

The distribution of the individual directors among the eight committees is the responsibility of the "nominating committee". This committee has the task of reviewing the slate of Directors from time to time and to recommend for nomination to the various committees the names of junior members of the

7. Minutes of the Board, July 30, 1954.

board "so as to enable these members to gain experience in the working of these committees".[8] The nominating committee itself consists of three members appointed by the President from the Board.[9]

The most important committee of the Board is the Finance Committee. This is the largest committee comprised solely of directors, having a chairman and seven members. In 1953 these were the five S.A.R.M. directors, one S.U.M.A. director, the A.C.T. representative and one of the provincial government appointees.[10] This committee studies all expenditures to be authorized by the Board and supervises the management of the League's revenues.

A separate committee is maintained to handle the various "funds" of the League. This "investment committee" is actually a sub-committee of the finance committee, for it reports to the Board through the latter group. Its responsibility is to invest the principal of the Superannuation, Endowment, Preventive, Equipment and Workmen's Compensation funds of the League. As of December 31, 1953 the Committee had investments totalling (at par) $1,301,710 in bonds and

8. Minutes of the Board, August 1, 1952.

9. Minutes of the Board, November 2n, 1951.

10. See slate of directors in S.A.T.L., "Annual Report", 1953.

debentures.[11]

The duties of the Building and Legislative committees are obvious. The Building committee is responsible for study and supervision of new construction and alterations to the League's plant. It consists of five members of the Board. The Legislative committee has both the directors with legal training and two other members of the Board. It reports to the Board on legislative developments affecting the League and drafts its bylaws and representations to the government.

The "negotiating committee" was formed in 1946 when the non-medical staff of the three sanatoria organized labor unions. The committee was to consist of one member representing the Rural municipalities, one the Urbans and one the remaining directors on the Board. (Directors Feb.7, 1946). During the labour disputes following the war this committee acted very strongly, as would be expected from its composition, to minimize wage concessions to the unions.[12]

The superannuation committee is composed of five members who administer the League's obligations respecting a superannuation plan for its employees as established by statute

11. Minutes of the Board, February 5, 1954.

12. In the course of the dispute it was announced that before the League would "capitulate to unreasonable and excessive demands" it would turn the tuberculosis control program over to the provincial government. See Regina Leader-Post, March 10, 1949, p.5.

in 1935. (An Act Respecting the Superannuation of Employees in Tuberculosis Sanatoria and Hospitals.)

The final committee to be described is the Christmas Seal Committee. There is little resemblance between this committee and those described above. While the latter are strictly committees of the Board, the Christman Seal Committee would more properly be described as a "committee of the League". In 1953 only the chairman and one member of the committee were at the same time members of the Board of Directors. The other eighteen members were either former directors or other prominent members of the "League".

The function of the Christmas Seal Committee was indicated in Chapter Five.

The above then, is the machinery of the policy making body of the quasi-voluntary agency, the Saskatchewan Anti-Tuberculosis League, which is responsible for -

> ...the care, conduct and management of sanatoria and hospitals for the treatment of tuberculosis, the establishing either independently or in cooperation with municipal, hospital or other authorities, of clinics for examination and diagnosis, and the adoption of such measures and the promotion of works and undertakings in its opinion necessary or desirable for preventing the spread of tuberculosis in Saskatchewan. 13

The Independence of the Board as a Policy Making Body

The Board of Directors appears to enjoy a remarkable freedom from official intervention in its activities. At first sight it would appear that the right of the provincial

13. R.S.S., c.235,s.3.

government to appoint seven directors provided a substantial measure of governmental control over the affairs of the Board. The origins of the provincial appointments to the Board were attributed by the League to the belief that the people of the province had the right "through their elected representatives in the Government of Saskatchewan to have full and proper knowledge of the financial requirements of the institution and the disposition of funds granted by the Provincial Government...".[14]

While the persons appointed by the government are, no doubt, acceptable to the government it would appear erroneous to regard their posts as "political appointments" in the usual sense of the term. As pointed out above, they are, instead, persons prominent in community affairs and could be as well appointed by any of the other appointing bodies as by the government.[15] Although they are appointed by the government, these individuals are not officials or persons formally associated with it.

The nature of the control exercised by the government was explained by the President of the League in 1925 when the present ownership of the plant and system of administration was established.

14. S.A.T.L., "Minutes of the Annual Meeting", October 26, 1920.

15. Personal communication with League Official.

> In other words, the Provincial Government are the sole owners of the buildings and equipment operated by the Anti-Tuberculosis League. It is distinctly understood, however, that the Government has no responsibility for the operations of the League, other than to see that the books and accounts are kept in order, and that the work is being carried on in a way satisfactory to the people of the Province. For this purpose it has reserved the right to appoint... representatives of the Government to the Board of Directors....16

Such official controls as do restrict the autonomy of the Board are primarily of a negative character. An example of this is the requirements that the Board secure the permission of the Minister of Public Health before adding surpluses to reserves. The Board is also required to submit an annual report on its activities to the Minister "showing in detail the assets and liabilities of the League at the end of the preceding financial year and the number of patients received and treated during that year...and such further information as to the sanatoria and hospitals and the affairs of the League as the minister may require".[17]

The interpretation given to the Board's status by one senior government official supports the conclusion that in practice "the League" (in the sense of the "Board") is essentially autonomous.

16. S.A.T.L., Report for the Years 1920-1924, pp. 7-8 (underlining added).

17. R.S.S., c.235,s.45.

> In the province of Saskatchewan, the tuberculosis program is carried on by the Saskatchewan Anti-Tuberculosis League which is an independent body receiving financial support from the Provincial Government and the municipalities of the Province. The record of the League for the past thirty years is such that, although some may wonder at an organization being independent of the government, all parts of the world look to Saskatchewan for leadership in an anti-tuberculosis program. 18

The lack of direct financial control of the League by the provincial government should be apparent from the discussion in the preceding chapter. So long as the Board is dependent upon the Government for only thirty per cent of its revenues, and so long as the remainder may be raised from the municipalities, it is obvious that the provincial government can exert little pressure in this direction. While a significant curtailment of the per diem grant on current account would certainly embarass the League and strain its relations with the municipalities it would be the latter who would suffer the burden of the inconvenience under existing legislation. The possibility of so arousing the municipalities would make this course of action for the provincial government seem rather improbable.

It is interesting to notice the possible effect which reversing the provincial and municipal shares in the

18. Saskatchewan, Department of Public Health, Deputy Minister to C.H. Cochrane, Fairvale, New Brunswick, April 19,1949, Central Files, File No.013-G.

League's revenue structure would have upon the independence of the Board. In the preceding chapter it was suggested that from a financial standpoint there would be certain benefits derived from fixing the annual municipal levy and making the provincial grant the variable item in the League's revenues. If this were done the grant could be used as an effective financial control over the Board by the government.

Advantages of the Board's Independence

The thesis has been advanced in preceding chapters that the persons, private and official, who were responsible for the organization of the tuberculosis control program in Saskatchewan sought deliberately to establish the League as an agency independent of the government. In 1929 when the present form of the organization was emerging, the acting Deputy Minister of Public Health wrote that -

> ...this system of having the Government now assuming the cost of erecting the buildings and turning them over to the Anti-Tuberculosis League to be operated by them, has been the means of creating a desire on the part of every one in the province to assist in eradicating and providing treatment for this disease. Through the operation of the League the public feel that they have a much more direct interest in the matter of dealing with tuberculosis than they would have if it were an entirely Governmental institution, and much more educational work has been accomplished through the League than would have been possible through Governmental agencies alone...19

The advantages of an "independent" but highly representative Board implied in the above, however, must be

19. Saskatchewan, Department of Public Health, Acting Deputy Minister to P.P. Jacobs, N.T.A.,New York, March 14,1929,Central Files,File No.497.

regarded as being relative to the program itself and to the given institutional structure within which the Board is to operate.

These two elements in the situation have changed drastically since 1929. In that year the tuberculosis control program was being developed and expanded. The treatment facilities were being built up and the preventive aspects of the program were still in the first stages of organization. The support of the public had to be developed, an intensive mass educational program was still necessary and the appeal for voluntary preventive funds had just been launched. The main task confronting the persons concerned with tuberculosis was to develop the program. Added to this was the fact that the official health agency's general public health program was relatively insignificant in comparison with its present stage of development. In 1929 provincial expenditures on health and welfare accounted for barely one-quarter of the total estimated provincial expenditure, whereas by 1940 they accounted for more than one-third.[20]

Under these circumstances the advantages of handing the program over to an "independent" and non-official agency must have been relatively greater than they would be today. The voluntary agency could be expected to win the support of the public, to appeal for voluntary contributions and to attract

20. Province of Saskatchewan, Report of the Commission on Provincial-Municipal Relations, 1950, Regina King's Printer, 1951, p.63.

(as it did) individuals who were able and willing to lead and innovate, with greater ease than any then existing government agency.

Certainly it cannot be argued that the official agency could have appealed effectively to the public for voluntary contributions. Without such an appeal it appears questionable as to whether the tuberculosis control program could have enjoyed the degree of public participation which it has under the management of the League. This disadvantage of the official agency could have been overcome, perhaps, by making public participation in the program compulsory. If such compulsion was feasible on economic grounds (and there is little certainty even here), it is assumed that it would be politically impractical within our framework of democratic ideals. This is not to suggest that these ideals extend to the individual the right to infect others with a communicable disease, for example, but it is meant to suggest that if two alternative methods are available to induce him to cooperate in preventing contagion - one entailing persuasion and the other force - within the political criteria of our society the former must be preferred.

As for the non-official agency's superior ability to attract men with the ability to provide the kind of leadership necessary to make a "program" into a "cause", the findings of a comprehensive study of this field in the United States might be cited.

> The importance of...board and committee members of health agencies can scareely be overestimated. Their service, often given at considerable sacrifice of time and money, cannot be appraised in dollars. Here is a strength that sets the voluntary agency apart from the official agency. 21

With reference to the specific agency under consideration in this discussion, the association of the writer with the League has led to the belief that its activities are directed by individuals who have somehow come to regard the campaign against tuberculosis as a personal and lifelong cause. Such individuals are more apt to feel at home in an independent, non-official agency than in an official organization.

In short, even a quasi-voluntary agency could be expected to turn the tuberculosis control program into a "crusade". The extent to which the League did this is exemplified by the familiarity with which the symbol of this crusade, the double-barred "Cross of Lorraine" is greeted throughout this province today.

Disadvantages of the Board's Independence

The chief disadvantage of the degree of autonomy achieved by the Board of Directors of the League lies in the danger of it developing a "vested interest" in the work

21. Gunn and Platt, Health Agencies, p.38.

which it is doing. The danger of this would appear, at first sight, to be removed by the diversity of interests which appoint the directors comprising the Board. Upon further examination, however, this is not so convincing a safeguard.

Even when the appointees to the recently created seats on the Board are included, the average term served by those individuals comprising the slate of directors in 1953 was approximately eight years. During twenty years, from 1933 to 1953, two directors held office continuously, one sat for eighteen years, another for seventeen, two for sixteen, one for thirteen and one for twelve years.

To a certain extent such continuity of service is desirable, of course, insofar as it provides the Board with experience and familiarity with the problems and objectives of the League. On the other hand, however, it may have quite undesirable effects.

One of the most dangerous of these is so obvious that it is easily overlooked. In previous chapters it has been shown how the League tends to think in absolute rather than relative terms. This was particularly obvious in the discussion of the preventive program in Chapter Four. It is only too easy for persons who have spent years in furthering some particular work to fall into the error of

regarding that work, especially if it is a "cause", as being absolutely necessary even when the need for it, relative to the need for other services, is much reduced. A study of voluntary health agencies in the United States led one writer to state that -

> Since a health agency is usually set up with the highest of motives, those who direct its affairs may easily develop the feeling that the institution must live on at any cost. 22

The total annual expenditures of the League today total approximately two million dollars. Obviously the persons responsible for this expenditure should, from an economic standpoint, be constantly conscious of whether the returns to the community per dollar of expenditure on this health service are roughly equal to the returns which would be obtained from a dollar spent upon some other health or other government services or by the returns through private expenditure by persons contributing to the League's revenue. Of course, these returns cannot be measured precisely as might units of

22. Ibid.,p.89.

production in manufacturing, but such an awareness of relative returns is essential if the maximum social returns from the expenditure are to be realized. The significance of this to the present discussion lies in the writer's belief that persons who have dedicated themselves to the promotion of a single health service for substantial periods of time are almost certain to have difficulty thinking in terms of maximizing general, as opposed to particular, social ends.

It is not likely that this was so grave a danger when the tuberculosis control program was in its earlier, or formative, stages. While no attempt has been made in this study to estimate the relative returns from expenditures made upon tuberculosis control in Saskatchewan, it would appear reasonable to assume that these returns must have been relatively large when tuberculosis, with a death rate of almost 50 per 100,000 of population, was the primary cause of death. With the passage of time, however, and the reduction of the tuberculosis death rate to approximately 10 per 100,000, the returns realized from the expenditure on tuberculosis control in Saskatchewan have undoubtedly declined relative to what they were in the early phases of the program. Because of this, the special ability to initiate and develop a program attributed to the non-official type of

organization by its supporters must be evaluated, from an economic standpoint, in relation to the nature of the problem with which it is concerned at any given time.

Hence, the non-official type of organization may have been relatively appropriate when the tuberculosis control program was being developed in Saskatchewan. But now, when the non-official agency has gained control of the problem which it is designed to combat, what were desirable characteristics from a social standpoint may now become disadvantageous from the same standpoint. Now, with the severity of the problem reduced and with its revenue structure established, the problem is apt to become one of reducing inputs so as to increase the marginal returns to the level required to maximize the community's gain from the use of available resources.[23]

It is suggested here that this is a situation which will confront the League in the near future, if not at the present time. The actual point at which the resources committed to anti-tuberculosis activities in Saskatchewan will (or have)become excessive from this economic standpoint cannot be calculated precisely because of the difficulty associated with measuring the returns involved. It was shown in Chapter Three, however, that the League is intensifying

23. On the subject of marginal returns the reader is referred to the note in Appendix A.

its case finding efforts and that with the tuberculosis death rate reduced to 10 per 100,000 of population, the League is hoping completely to eradicate the disease. Since it is becoming increasingly difficult (and expensive) to find cases to treat, however, the returns per unit of expenditure must be falling. Under such circumstances the question returns to that of management.

Will the Board of Directors, as presently constituted be able to recognize the need for curtailing the activities of the League when it does become obvious, if it is not already so, that their scale of activities is no longer justifiable? This is relevent to the present topic, for it is suggested here that the tenure of office and the independence which characterize the Board are not conducive to the approach suggested above.

Again it is interesting to refer to the study made of non-official health agencies in the United States.

> Each voluntary health agency as it arose may have appeared necessary for its times. It does not follow, however, that the pattern of the past must remain the pattern of the future. The fact that an organization has once established a claim to public approval and support is not a vested "right" to continue in its own way permanently. 24

This danger would be reduced if the Board of Directors were required to operate more closely with the

24. Gunn and Platt, op.cit., p.65.

official government agency and if stronger controls were available to force the Board to frame its policies, not alone in terms of tuberculosis but in terms of the general public health program. Because of this, the danger of the Board behaving in a socially unproductive manner may, in part, be regarded as a product of the independence of action enjoyed by the Board.

In Chapter Three the representative nature of the Board was emphasized. Except for the responsibility of the Minister of Public Health for the per diem grant and the reserves of the League, however, there appears to be little governmental control of the financial operations of the Board of Directors. The result is that the Board, as a body, is not directly responsible to the persons from whom it derives its revenues.

Of the two thirds of its revenue which is spent on "provincial patients" roughly one-half is raised by the provincial government and the other half by the individual municipalities. The revenues, however, are expended by a board which, while containing representatives of the authorities which raise the funds, contains no clear majority which can be held responsible for its policies. While the nine municipal representatives come close to being a majority the fact that since 1946 the President of the League has been one of the Municipal appointees means that the municipalities appoint only eight of the eighteen voting directors because the President votes only when there is an equality of votes.

The only part of the Board's revenues for which it is directly responsible to the individuals from whom it is raised is the revenue derived from the Christmas Seal Sale.

Obviously the Board's policies would be more certain reflections of the value placed upon its activities by the community if it was directly responsible for raising its required revenue. The confusion of such responsibility in the present complex system compares quite unfavorably from the standpoint of democratic control with the system in which the provincial government is clearly responsible for the treatment program and the collection of the revenues required for it.

This danger resulting from the independence of the Board of Directors is increased by the present policy of the Board with respect to reserves. Obviously in an effort to overcome the instability in its revenue system as described in Chapter Four, the Board decided in 1952 that it should -

> ...continue, during the period of relative good times, to accumulate a substantial reserve in the General Reserve of the League, and that the amount set for a goal should be one million dollars....25

While such intentions are no doubt well intentioned and perhaps justifiable from a financial standpoint, they represent a further separation of the disbursement of revenue from the collection of it. This is controlled, however, by the requirement that the Board secure the approval of the Minister of Public Health before sinking surplus funds into

25. Minutes of the Board, October 31, 1952.

the reserve account instead of crediting them against the estimates of the succeeding year's expenditures.

From the above discussion it is concluded that while the advantages accruing to the independence of the Board of Directors during the formative years of the tuberculosis control program in Saskatchewan perhaps justified it, under present circumstances the independence of the Board entails an infringement of several generally accepted principles associated with economic efficiency and democratic political control.

The Administration of the League

The administrative staff of the League is appointed by the Board of Directors as required by the Tuberculosis Sanatoria and Hospitals Act.[26] The chief administrative officer is the "General Superintendent and Director of Medical Services" who is directly responsible to the Board for all the activities of the administration. When the present administrative organization was established in 1931 the responsibilities of the General Superintendent and Director of Medical Services were defined as follows:

> The Superintendent, under the Board, shall be responsible for the direction of the Medical Services of the League, Sanatorium treatment, Hospital treatment under the League, Diagnosic Clinics, Travelling Consultants, Follow-up work, Recommendation for Post Graduate courses, direction of personnel, etc....27

26. R.S.S., c.235,s.15.

27. Minutes of the Board, May 27, 1931.

Only two men have held this position since 1930. The first served from 1930 to 1948 and the second from 1948 to the present.

The General Superintendent manages the treatment operations of the three sanatoria of the League through a "Medical Superintendent" located at each of them. The positions of these employees were defined in 1931 in the following terms:

> The Medical Superintendent of each Sanatorium shall be responsible for the carrying out of the instructions received from the Superintendent. He shall superintend the Medical Services of the Sanatorium, and shall be responsible for the medical, nursing and dietetic departments.28

In addition to these general requirements the Medical Superintendents were also to be responsible for the "good will, character and discipline of the Sanatorium and the education of the Sanatoria staff regarding the prevention of tuberculosis and the maintenance of health".

With respect to the supervision of the non-medical departments of the sanatoria, the Medical Superintendents were first to take the matter up with the department concerned and if the difficulty could not be overcome, to submit a report on the problem to the General Superintendent.[29]

Two of the sanatoria have been under the management of the same Medical Superintendents since the time of their

28. Ioc.cit.

29. Minutes of the Board, July 8,1931.

construction in 1925 and 1930 respectively.

The Medical Superintendents are assisted at each sanatorium by a "Lady Superintendent".

> The Lady Superintendent,under the direction of the Medical Superintendent shall be in charge of all nursing service, and shall have authority over her own staff. Also in cooperation with the Medical Superintendent she shall direct the duties of the dietician. 30

An interesting characteristic of the administrative organization of the League is the attempt to centralize responsibility for particular services. In design the various sanatoria are not self contained administrative units. Medical services are administered by the Medical Superintendents at the three sanatoria under the direction of the General Superintendent. Similarly accounting, purchasing, and supply functions are centralized at Fort San, the administrative headquarters of the League.

As defined in 1931, the Chief Accountant of the League was to be responsible for "the control of the whole accounting staff of the League including the Assistant Accountants at branch Sanatoria" and the "receipt and disbursement of all funds of the League". 31

Similarly the Chief Steward and Purchasing Agent is responsible (to the General Superintendent) for the control of the entire steward's staff of the League

30. Minutes of the Board, May 27,1931.

31. Ioc.cit.

("orderlies" etc.), all the stores, vehicles and purchases made with the approval of the General Superintendent.[32]

The position of Secretary in the administrative organization of the League is rather difficult to define in practice. Insofar as his duties as Secretary per se are defined he has no administrative duties whatever and is responsible only for the recording of the minutes of all meetings of the League and of the Board of Directors and the forwarding of such minutes to the General Superintendent as soon as possible after these meetings.[33]

In practice, however, a large part of the Secretary's time is spent organizing the mass surveys. In the past, for a number of years the secretary was also the "Personnel Officer" of the League.[34]

Management of Treatment and Preventive Services

From the standpoint of this study, the most interesting manifestation of the League's tendency to centralize its administrative facilities is the lack of distinction between the administration of its treatment and preventive services.

As seen from the foregoing discussion, the General Superintendent is responsible for the entire program of the League. The actual management of the treatment services,

32. loc.cit.

33. loc.cit.

34. Minutes of the Board, April 26, 1951.

however, is delegated to the three Medical Superintendents. With the expansion of the preventive services of the League since 1930 the burden placed upon the General Superintendent was substantially increased. As a result of this, in 1952 the Board of Directors considered the following proposal made by a committee appointed to study the possibility of revising the preventive program.

> That a separate Division of Prevention be set up under the direction of a Medical Superintendent who would be responsible to the Director of Medical Services and General Superintendent in the same manner as are the present Superintendents of the three Sanatoria. This would relieve the Director of Medical Services of the added responsibilities which the direction of the preventive program has placed upon him. 35

The Board, however, seemed quite unwilling to separate the administration of the preventive and treatment services. Instead, it decided to retain the system in which the General Superintendent and Director of Medical Services was directly in charge of the preventive program. Provisions were made for the hiring of additional staff so as "to permit the Medical Superintendents and senior medical staff of the League to devote a greater part of their time to preventive work...".[36]

This would suggest that should the treatment services of the League decline in a quantitative sense the existing administrative structure could be converted into an organization

35. Minutes of the Board, August 1, 1952.

36. Minutes of the Board, October 31, 1952.

specializing in preventive work with relative ease. If the two functions were separately administered, however, the shift of activity would require a reduction in the importance of the central administration.

Summary and Conclusions

1. The anti-tuberculosis program in Saskatchewan is in practice managed by the Board of Directors of the Saskatchewan Anti-Tuberculosis League. This is a representative body comprised of persons appointed by various organizations in the province having an interest in the tuberculosis control program. Only one of the nineteen directors is appointed by the membership of the League.

2. The most remarkable characteristic of the Board is the practice of reappointment - the result of which is a "hard core" of directors who have been associated with the program for long periods of time.

3. The Board of Directors appears to enjoy a remarkable degree of independence from governmental control. Aside from certain "negative" restrictions upon its power, the Board is virtually autonomous in practice. This independence is enhanced by the organization of the Board's revenue structure.

4. Both the senior policy making and the senior administrative offices of the League appear to be filled by men who have adopted the campaign against tuberculosis as personal causes to which they are prepared to devote a large part of their lives.

5. Under the conditions which prevailed in this province when the League was organized, the advantages associated with placing the tuberculosis control program in the hands of a non-official agency were no doubt relatively apparent in contrast with the situation today. On the basis of the Board's past policy and present organization, it is suspected by the writer that the Board's specialization and independence make it an unlikely source of reappraisal of the League's objectives in the light of broad social criteria.

CHAPTER SIX

CONCLUSIONS

CHAPTER VI

CONCLUSIONS

The Saskatchewan Anti-Tuberculosis League is a unique type of organization specially designed to obtain a maximum of public participation in the tuberculosis control program. The provincial authorities deliberately encouraged the creation of a non-official agency, apparently in the belief that such an organization would be best able to organize a tuberculosis control program in an area where none previously existed.

The determination of these authorities to put this belief into practice is demonstrated by the constant support given the League in times of crisis by the provincial government. It is significant that in spite of the amount of such assistance required by the League, the government never sought to reduce the League's authority over anti-tuberculosis work in the province.

Every effort has been made to promote the public belief that the League is an agency independent of the government and, in fact, the League, or more properly the Board of Directors of the League, does appear to be an autonomous policy making authority in its own field.

The League itself has always formulated its policy in such a way as to emphasize its non-official status. The most obvious illustration of this is its undeviating emphasis upon

voluntary participation by individuals and organizations in its activities. The League has consistently refused to participate in schemes involving compulsion even when such a policy would appear to be beneficial to the program. The League's attitude toward the recalcitrant patient is the outstanding illustration of this position.

Insofar as the League has succeeded in organizing a highly developed tuberculosis control program under the conditions of a predominantly rural environment, it may be assumed that the non-official status of the League may have enabled it to attract a much greater amount of public cooperation than could have been attracted by an official agency.

It is suggested here, however, that the nature of the support which the League attracted was not quite that which was intended by its creators. The pronouncements of government officials encouraging or supporting the status of the League suggest the belief that an apparently independent agency would attract the sympathy and support of the general public. I suggest that this has not been the case - that the League has never directly attracted general public support by virtue of its independence because personal experience of the writer would suggest that the majority of individuals in the province even today appear to believe that the League is a government agency. With the exception of the mail appeal for voluntary contributions, it is suggested that instead of attracting mass public support directly the League has attracted the support of organized interests in the province. The two associations of municipalities, the rather conservative press

of the province, the clergy, womens' and business organizations have all become active supporters of the League.

The effect of this has been to enable the League to achieve substantially the same ends as would have been obtained if it had succeeded in raising active public support directly. At the same time, however, it has given the League a remarkable political significance. Neither the "hard core" of influential long term directors on the Board or the groups which have rallied to the League's cause would be expected to favor government absorption of an "independent" agency, especially if the agency had a long record of achievement and the government involved was of a socialist pursuasion.

It is suggested that the independence of the League per se has been given a political significance not warranted by the real issues connected with it. The danger is that such a political consideration will obscure the more important social implications of the continued independence of action permitted the League.

The success enjoyed by the League in combating tuberculosis in Saskatchewan appears to have justified the faith placed in the non-official type of organization by its early promoters. The League has succeeded in attracting (indirectly) public support, it has obtained the services of men with remarkable qualities of leadership, it has been progressive in its techniques and it has succeeded in reducing the tuberculosis death rate in Saskatchewan to one of the lowest in the world. It has succeeded in converting a problem in public health administration into a popular crusade.

It is not difficult, perhaps, to concede that this could have been done only by a non-official agency. But even if this is granted, does it justify the maintenance of such a type of organization indefinitely? Obviously conditions change and so must the institutions associated with them. In this case much of the change was brought about by the institution itself.

The significant change in the tuberculosis situation in Saskatchewan is the sharp reduction in the amount of tuberculosis in the province. As was shown in Chapter Three, however, this alleviation of the tuberculosis problem has not resulted in a reduction in the total activities of the League. Quite the contrary, with new cases becoming more difficult to find, the League has intensified its search for them. This fact was used to illustrate the League's tendency to formulate policy in terms of absolute goals rather than in terms of the maximum social gain.

This tendency was attributed in Chapter Five to the long tenure of office enjoyed by a small number of the individuals most intimately associated with the tuberculosis program in Saskatchewan. This characteristic was shown to prevail in both the policy making (Chapter Five) and the senior administrative (Chapter Two) levels of authority. It was suggested that these individuals, while motivated by the highest ideals, were apt to lose sight of broader social objectives. In this is found one illustration of the paradox of the non-official agency. From the one standpoint it is an advantage of the non-official agency that it can attract men

capable of leading a crusade - men who are prepared to devote themselves unstintingly to a "cause". This is a highly desirable ability on the part of the non-official agency when its task is to initiate a previously neglected activity. But when the activity has been implemented this same ability becomes dangerous in that the zealous crusaders for the agency's particular cause are apt to insist that the cause be pursued at any cost to the community. It is concluded, then, that this ability of the non-official agency to attract human resources of a particular calibre may or may not be an advantage, depending upon the prevailing circumstances.

Chapter Three attempted to show that the conditions which prevailed when the peculiar form of the League was devised have given place to new conditions. In addition to the remarkable reduction in the tuberculosis problem, the "frontier approach" of the official health authority has been replaced by an advanced and well integrated public health scheme. Under the conditions which prevailed upon the frontier forty-five years ago the public health authority was confronted with the task of attracting resources to an activity which did not enjoy the approval of public opinion which it does today. The social philosophy of a generation ago was far less concerned with public health and other welfare services than is that of the 1950's. Under such circumstances there could be little concern over the possibility of an agency attracting resources in excess of the economic proportions -

especially when such resources were to be expended against the greatest single cause of death in the province.

If the agency did operate according to a philosophy of voluntary cooperation thereby enabling some infected persons who did not desire treatment to remain at large, this could be overlooked so long as treatment facilities were inadequate to care even for those who sought help voluntarily. If the agency encouraged participation in its activities by the municipalities through a financially inappropriate revenue system, this could be written off to the large gains in assistance rendered the agency in its preventive program by the local governments involved. If the agency was so highly specialized that it could not integrate its activities with those of the official agency it could be argued that since the latter were negligible in extent more was gained through specialization than was lost through lack of integration. In short, under the prevailing conditions the peculiar characteristics of the non-official health agency could be regarded as advantages.

Reducing the above to simple economic terms of returns from resources committed to this particular public health activity, it may be concluded that when the League was organized no resources were being committed to activities directed against the disease. The task of the new organization was to attract resources to this particular enterprise. From the social standpoint it was desirable that the League attract resources up to the point where the marginal returns to the community were just equal to those which could have been

realized by committing the last unit of resource to any other use. Even if it were possible to measure these returns such an attempt would exceed the scope of this study. Because of this no attempt has been made to identify the point at which the League's specialized activities should be (or should have been) curtailed.

It is suggested, however, that the conditions prevailing in the public health field today make it doubtful if the characteristics of the League as a non-official agency are still desirable. The nature of the human resources which it attracts has already been identified as a possible danger insofar as these individuals see the eradication of tuberculosis as a goal in itself and are apt to ignore the larger social goal of alleviating total suffering and loss from all such causes (given the available resources). With tuberculosis reduced from the first to a minor cause of death in the province this becomes a pertinent consideration.

Furthermore, the increase in the number of beds per case observed in Chapter Three and the reduction in the case rate means that the problem of the recalcitrant patient can no longer be ignored. Under prevailing conditions one recalcitrant patient is highly significant from the standpoint of control. Unfortunately the League so values its traditional principles of voluntary cooperation that it apparently cannot adapt its policy to these changed conditions. While such principles may have been so important to the success of the League's program in earlier years and under different circumstances, they are now to some extent a definite hindrance.

The problem of integration is also rendered significant by an alteration in conditions over the past forty years. It can no longer be argued with assurance that the benefits of specialization in the public health field in Saskatchewan outweigh the loss of efficiency from lack of integration. The alteration in circumstances over the past forty-five years in this respect is illustrated by the institution of a contributory hospitalization insurance scheme. While this scheme provides general hospital treatment for all illnesses and for all persons in the province, it excludes hospitalization of the tuberculous sick. Treatment of persons suffering from this disease is financed through an entirely different scheme based upon the social philosophy of twenty-seven years ago.

The point is that prior to 1947 there was no question of integrating the revenue system associated with tuberculosis control with a general hospitalization system, but at present such a possibility presents itself. This is one example of how the general field of public health in Saskatchewan has changed. There are many others such as the organization of health regions, the development of an extensive system of field workers, the establishment of research facilities, the organization of health education and publicity schemes and, in general, the creation of a modern public health program. Under these new circumstances it seems doubtful that the League's specialized and independent nature yields the community more than it loses through the League's apparently inability to coordinate its activities

with those of the general provincial health program.

It is concluded from the above that the problem of tuberculosis and the organization of other public health services have changed since the League was organized. The alteration in the conditions surrounding anti-tuberculosis work has taken place as a result, in part, of the tuberculosis control program itself, but also as a result of great changes in social philosophy and a consequent alteration in the status of the official health agency. It has been suggested that due to the nature of the League's management the League has not adjusted its outlook to correspond with these changes. Hence, what were once the League's most desirable features - its ability to attract certain types of support, its emphasis upon voluntary public participation in its program and its ability to attract certain types of human resources, for example - have now become undesirable from the broader social standpoint.

Unfortunately events have conspired to render it virtually impossible to correct the danger of the non-official agency under present conditions. It has been suggested that as a result of the type of support aroused by the League the independence of the League has become politically inviolable. At the same time the nature of the League's management virtually precludes any alteration in its outlook from within.

Under present circumstances, however, it would appear to be socially desirable that the League's activities should be made to conform with the requirements of the general public health program in Saskatchewan. If this were done, the proportion of total public health resources committed to

tuberculosis control could be adjusted to correspond with the relative returns from the various alternative uses of those resources.

The preceding chapters have shown, however, that the same independence of the League which contributed to its success in initiating the tuberculosis control program now prevents the adaptation of that program to the requirements of modern conditions. It was shown that the amount of actual jurisdiction over the League's activities by the official agency is virtually restricted to certain checks on the League's authority. Such negative provisions, however, are inadequate to enable the official agency to regulate the extent of the League's activity.

It would be expected by some, perhaps, that the fact of the League being dependent upon the government for approximately one-third of its revenue on treatment account would enable the government to regulate the scope of the program carried on by the League. It was shown in Chapter Four, however, that the peculiar manner in which the League's revenues are organized makes this unlikely. The procedure of deducting the provincial contribution from the total estimates for the succeeding years and of levying the balance against the municipalities of the province means that the latter, and not the League, bear the burden of fluctuations in the provincial share. Financial control over the League by the provincial government is further weakened by the extent of the League's earnings from the federal government and its independent source of voluntary contributions on preventive

account.

It was also suggested in Chapter Four that the revenues of the League on treatment account were less efficiently organized than they might be, but that the principle of municipal responsibility appeared to be so esteemed by the League that no attempt has been made to alter the revenue system. It was shown that the municipalities have been a rather unstable source of revenue and that it was difficult to allocate the burden among the two types of municipality. It was shown, however, that in spite of these difficulties the League has gone to considerable lengths to preserve the partial responsibility of the municipalities for this health service. The explanation was advanced that the League's attitude was related to its belief that financial affiliation with the municipalities both strengthened its independence from the provincial government and stimulated municipal cooperation in the preventive program.

According to the present analysis, however, it is possible that the League's independence should not be strengthened and it is doubted if the latter point is very convincing. If the actual cooperation in the preventive program were to be realized from the municipalities as a group it might be expected that their financial responsibility for treatment would stimulate their cooperation. In practice, however, it is the individual municipality which is approached by the League when seeking cooperation in organizing its preventive work in the field. Personal experience of the writer would suggest that the degree of cooperation forthcoming

is determined by other than financial considerations. The simple spirit of community responsibility would seem to be one of several possible motives more significant than the vague possibility that in the future the general reduction in the total municipal burden resulting from a reduction in the local death or case rate might be reflected in a reduction in the sanatorium levy.

It is suggested that there is little real justification at present for the League's continued dependence upon its traditional sources of treatment revenue.

This study would indicate that the League should re-assess its objectives in terms of modern conditions and needs and that in so doing it should regard the control of tuberculosis not as a single and absolute goal, but as one part of the total public health program.

The writer suggests that many of the problems associated with the present organization of the tuberculosis control program in Saskatchewan could be solved by the League relinquishing certain of its activities to the official health agency in the province. It is felt that the League should continue to exist, but now that the tuberculosis control program has been organized and developed to its present extent, the more usual practice of having the actual treatment program operated by the official agency would appear desirable. The League could then be left free to carry on with the preventive program.

The chief advantage of such a scheme would be that it would enable the provincial government to regulate the

extent of the tuberculosis program according to the relative returns to each of the elements in the over-all public health program. It is suspected, for reasons already advanced, that the League is incapable of doing this.

In this way the danger of the League maintaining an extensive campaign to the point where it was causing an uneconomic allocation of the communities health resources would be reduced.

With treatment placed under government control the municipalities could be relieved of their share of the treatment burden. This would be in accordance with the general trend to relieve the individual municipalities of the responsibility for health services of this type.[1]

A further advantage of this concentration of financial responsibility for treatment would be that the expenditure of treatment funds would be subject to direct political responsibility - one of the notable defects in the present system.

The desirability of altering the present organization of the program in Saskatchewan is indicated by the imperfections in the present organization as revealed, for the most part, in

1. In 1950 the Committee on Provincial-Municipal Relations found that the expansion of provincial activities in the field of public health and welfare had relieved the municipalities of financial responsibility in substantial measure, and that significant areas could be indicated in which financial burdens had been transferred from the municipalities to the province. See Report of the Committee on Provincial-Municipal Relations, 1950, Regina, King's Printer, 1951.

Chapters Four and Five which suggested that the principles of optimum resource allocation, financial efficiency (and stability) and democratic financial control were to some extent violated by the present method of organization.

In addition to these general advantages of the proposed scheme, it would remedy some of the weaknesses of the existing program as described in Chapter Three. As shown in that chapter, the problem of the recalcitrant patient is becoming an increasingly important issue. In accordance with the reasoning related above, this and associated problems appear to be insoluble so long as the League, with its antipathy for all things compulsory, is in control of the treatment program.

If the definition of the treatment function was understood to comprehend post-treatment services, the problem of rehabilitation could also be solved by making treatment the administrative and financial responsibility of the official health agency. As suggested in Chapter Three, it would appear quite undesirable to attempt an elaboration of the League's already complex revenue system so as to enable it to administer a comprehensive rehabilitation program itself. As the same time, so long as the treatment services are provided by the League it would appear to be difficult to institute a rehabilitation scheme under the administration of the health department because of the problems of coordination involved.

However, I believe that it would be desirable to leave the League in possession of those activities which it

presently finances out of voluntary contributions.

The fundamental justification for this suggestion is the belief that the success of the preventive functions does depend to a large extent upon the cooperation of organizations and individuals active in community affairs throughout the province. The ability to evoke such cooperation has been one of the League's most remarkable characteristics. Now insofar as this ability has been responsible for the continued independence of the League and other undesirable rigidities in the League's organization as described above, its disadvantages appear to outweigh its advantages. Once these dangers have been overcome, however, by transferring the administration and financing of treatment to the official agency, good use can be made of the League's special ability.

The danger of the League causing a misallocation of resources through its control of preventive work would be restricted to a sufficient degree by two factors. First, with treatment services being provided by the health department, the government would be in a position to influence the scope of the preventive program. By reducing treatment facilities, for example, an over-zealous search for new cases by the non-official agency could be discouraged.

A second deterrent to unjustified resource use by the non-official organization would be found in the fact that it would be directly dependent upon the contributors for its revenues. If it could not justify an extension of

its activities to the public it would presumably find itself lacking the required funds. It is realized, of course, that the effectiveness of this safeguard would depend entirely upon the rationality of the contributing public. That is, its effectiveness would depend upon the ability of the public to evaluate the relative virtues of the various appeals for funds presented to it. Whether rational or not, however, it cannot be denied that the distribution of resources brought about by this method of raising revenue would clearly reflect community choice.

What economic loss did result in spite of these safeguards would be more than offset by the efficiency of operation gained through the generally accepted ability of the non-official agency to attract the active cooperation of influential organizations and individuals within the community.[2] The value of this ability to the efficiency of the preventive program cannot be minimized.

The continued use of voluntary contributions to finance education, vaccination, case finding and the other elements of the preventive program described in Chapter Three would ensure continued public participation and interest in these activities. The performance of the voluntary funds since 1929 would suggest that there is little danger of them proving inadequate for the maintenance of the present low tuberculosis death rate. No certainty can exist in this respect, of course, without knowing whether it would be socially desirable to carry the campaign against

2. See Studies by Gunn and Platt, Cavins.

tuberculosis any further than it has been to date. It would appear that only the official health agency has the facilities to undertake a study of this problem.

Assuming, however, that such a study would not find it desirable to intensify the tuberculosis control program in the light of the social criteria suggested here, it may be concluded that the present level of voluntary contributions would represent at least an adequate allocation of resources to tuberculosis preventive work in future.

Again it is believed that the value of the public interest and cooperation encouraged by the appeal for such voluntary contributions would more than offset any possible loss connected with the raising of revenues by these means within the conditions imposed by the scheme proposed here.

Whether or not such a solution to the present imperfections in the anti-tuberculosis program in Saskatchewan does appear, this study would be of some value if it led to a general re-appraisal of the League's objectives by both the Government and the Board of Directors. There is no point, however, in such a re-appraisal if it is done in terms of past results and past methods. It is hoped that this study might suggest the need for re-appraisal in terms of present conditions and general social objectives rather than past successes and crusading fervor.

END

APPENDIX "A"

A NOTE ON MARGINAL RETURNS

By marginal returns is meant the increase in total returns to the particular program consequent upon the committment of one additional unit of resource to that program. It is assumed that such resources are capable of use in any other public or private employment. If the last unit of such a resource yields a greater marginal return to the community when employed in the anti-tuberculosis program than it would in any other use, the total benefit derived by the community from its available resources would not be a maximum, for by transferring an additional unit of resource to the anti-tuberculosis program more would be gained from this program than would be lost from the other uses by the transfer of resource.

On the other hand, if the returns from the last unit of resource committed to the anti-tuberculosis program were less than that from any other use, the transfer of a unit of resource from the anti-tuberculosis program would increase the total returns to the community because the transfer of a marginal unit of resource would take less from the returns to the anti-tuberculosis program than it would add to the returns from any other use.

Successive transfers of marginal units of resources in this latter case would tend to increase the marginal returns in the anti-tuberculosis program and to reduce marginal returns in the other uses in accordance with the principle of diminishing

returns. Optimum resource allocation would be achieved when the marginal returns to each use were all equal. At that point the community would be maximizing its gains from the employment of its available resources.

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