Alberta Doctors' Digest

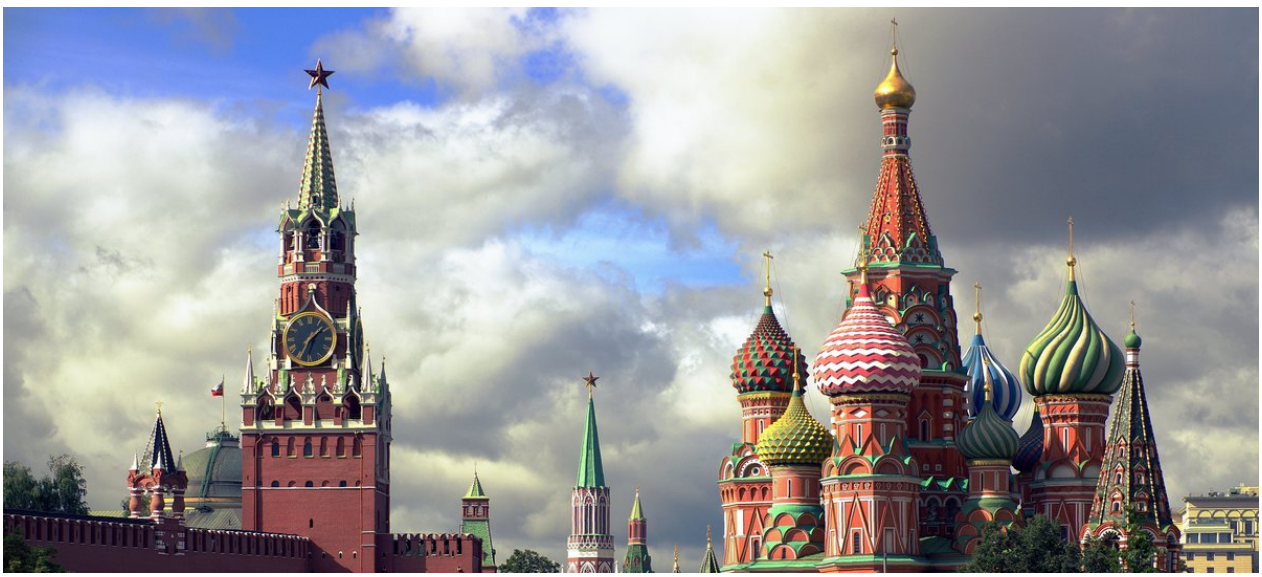
Where was Canadian Medicare made?

The recent book *Radical Medicine* by Esyllt W. Jones has quite captured my attention. In the well researched book, the author asserts the origins of Medicare in Canada were the result of “the ideas and people that came together in Saskatchewan in the 1940s and early 50s … [and] were part of a transnational … movement for greater health equality.” The origin was based on the Russian concept of polyclinics (health centers with salaried doctors), which moved across the Atlantic and became “the gold standard for health advocates on the political left.” Further, it contributed to the birth of medicare in Saskatchewan.

Confirmation for the first assertion is based on the Douglas government’s Sigerist Commission report released in October 1944. Validation of the second assertion comes from Jones’s observation that medicare “was endogenous to Saskatchewan, based fundamentally in local values and traditions.” Given their significance, these assertions deserve further examination.

Contrary to the author’s belief that the Russian approach was brought to Canada by Banting and Best in the 1930s and found fertile ground in Saskatchewan in 1944, Alberta physicians had already studied it years before. MLA Dr. W.A. “Tiny” Atkinson presented the concept to the Edmonton Academy of Medicine in April 1931. The minutes record: “[Dr. Atkinson] spoke of medicine of the future comparing the Soviet system, proposed state control methods and free service to all.”

At the June meeting, the Academy moved that “The AMA develop a province-wide committee to bring forward a scheme whereby the practice of medicine in Alberta could be rendered more medically efficient and economical.”



Contrary to the belief that the Russian approach to medicare was brought to Canada by Banting and Best in the 1930s and found fertile ground in Saskatchewan in 1944, Alberta physicians had already studied it years before (photo credit: Oleg Shakurov, Pixabay.com)

The approach was studied by the AMA who wanted improved access to health care in a health insurance program. By 1943, it also led to the CMA developing a set of principles for negotiating with governments on such a program. By 1945, the willingness to contribute to a health insurance program was already supported by 80% of Canadians.

How do these findings fit into the widely-held view that state medicine in Canada arose in Saskatchewan, and do they confirm why Saskatchewan led the way? An examination of the pre-1944 health milestones in Saskatchewan and Alberta should provide the answer, for the provinces were conjoined twins – born together in the Northwest Territories and separated in 1905. They had similar immigration and agricultural growth patterns. Their health care milestones unfolded similarly but with some important differences.

Medical contracts

The most fundamental difference in the two provinces came over medical contracts (retainers, stipends, or salaries). The AMA outlawed them in 1907 and deemed them unethical in 1922. Despite this stance, the Alberta government introduced stipends to keep physicians in the drought-stricken Palliser's Triangle in 1927 and provincial salaried doctors for northern Alberta in 1929. The total number of these doctors never exceeded 18. In Saskatchewan, Dr. Henry Schmitt signed the first municipal doctors' contract in the municipality of Sarnia in 1915. Popular, the number of contracts rose to a peak of 173 in 1950, covering almost 25% of the Saskatchewan population and ending only after the 1962 doctors' strike.

Hospitals

The first general hospital in the NWT was opened in Medicine Hat (now Alberta) in 1889 followed by the Calgary General Hospital and Holy Cross Hospital in 1890 and the Edmonton General Hospital in 1896, all before the first Saskatchewan hospital opened in Regina in 1901. The differential continued through WWI and beyond. In 1917, both provinces began a municipal hospital program, simultaneously, starting in the border town of Lloydminster.

MD licensing examinations and registration

In 1885, 45 physicians came west during the Northwest Rebellion in Saskatchewan. Deputy Surgeon-General Dr. Thomas Roddick realized, at least for military doctors, they were not registered, and he led the many-year movement to create a national exam and licensure system. The initiative stalled in 1907, so Alberta Drs. Robert G. Brett and George A. Kennedy endeavored to create a four-province Western Canadian Medical Council instead. The Saskatchewan Medical Association (SMA) reluctantly supported it. In 1909, Alberta and Manitoba physicians were successful in getting the CMA to revisit the concept, which established the Medical Council of Canada in 1912. Licentiates could be registered to practice in any province.

MD education

The University of Alberta began a three-year (of five) medical training program in 1913. It was extended to a full five-year course after the flu outbreak in 1918-19, and the new medical school opened in 1921. Specialist medical training commenced in Alberta in 1946. Prospective physicians came from Saskatchewan to finish their training in Alberta, especially after Saskatchewan began a three-year medical education program in 1926, a program not extended to a full MD until 1953.

Geographical differences

The large, arable Peace River country, with its dispersed population, could only support a few physicians in private practice. The Alberta government responded by creating the district nurse program (1919) and summertime travelling clinics that travelled to the north with a dentist (1921), University of Alberta Hospital-based doctors and nurses (1923) and a surgeon (1927).

Stable leadership

In 1927, the Regina Medical Officer of Health (MOH) Dr. Malcolm Bow accepted the Alberta deputy health minister position instead of the same one in Saskatchewan, and guided Alberta over the next 25 years. Alberta would have only three deputy ministers (1912-1961) and three health ministers (1923-1969) fostering a progressive health care agenda, particularly in public health.

Cancer care

The SMA formed their first cancer committee in 1929 and Saskatchewan established Canada's first cancer commission in 1930. The Alberta government made cancer a "notifiable disease" in 1922 and the AMA formed a cancer committee in 1931 with Deputy Minister Bow as the chairman. It was Alberta's Dr. John S. McEachern that convinced the CMA to establish a national control of cancer committee (now the Canadian Cancer Society) by 1938. While CMA president, he also fostered the 1935 King George V Fund, which raised $420,000. It became the foundation for the National Cancer Institute of Canada in 1947, under Saskatchewan's Dr. Allan Blair. At Dr. Blair's suggestion, the Alberta Cancer Society funded the first cancer medical research (McEachern) lab at the U of A – which opened in 1952. Free cancer care was initiated in Alberta in 1941, three years before it was introduced in Saskatchewan.

State medicine and the Hoadley Commission in Alberta

The United Farm Women of Alberta (UFWA) was formed in 1916 and strongly advocated for a public health department (formed in 1918) and the rural or district nurse program (started in 1919). Their president, Irene Parlby, declared publicly that medical care was a right (1918), and the government had a duty to provide it (1919). Elected in 1921, she was the Minister without Portfolio (1921-1935) with a focus on health and women's issues.

Health Minister George Hoadley would introduce the first specialist certification program in Canada in 1926, an initiative that stimulated the Saskatchewan triumvirate, led by Dr.

David Low, to petition the CMA to create the Royal College of Physicians and Surgeons, which it did in 1929.

After a third United Farmers of Alberta (UFA) motion to investigate state medicine in 1927, all parties in the legislature approved an inquiry into it in 1928. The inquiry concluded that a health insurance program was feasible.

At the September 1931 AMA convention, MLA Atkinson spoke eloquently of the work Hoadley had done in the health field but asked the province not to intervene any further into the practice of medicine. Months later, in February 1932, Hoadley appointed an all-party, eight-member commission to recommend the best method for making medicine and health services more available throughout the province and how to pay for it. In the AMA/CPSA brief to the Hoadley Commission, Drs. A. E. Archer and W. A. Wilson recommended a health insurance program covering doctors and hospitals.

Erstwhile, a UFA splinter group joined J.S. Woodsworth in the formation of the Co-operative Commonwealth Federation (CCF, now NDP) in Calgary in August 1932. Their Regina Manifesto in 1933 would enshrine the principle that health care should be as accessible as education.

In March 1933, the Hoadley Commission recommended a health insurance program with coverage of doctors and hospitals and added drugs and dentists, and a partial contribution to the cost by the provincial government. In the August 1935 election, every UFA legislative member was defeated by the new Social Credit government, and the *Alberta Health Insurance Act* died.

State medicine and the State Hospital and Medical League in Saskatchewan

The Saskatchewan government supported the municipal doctors program and supplemented doctors' income during the depression with relief funds. The SMA supported the concept of local health centers and contracted doctors so long as there was an opportunity for extra billing. In 1936, a citizen-based grassroots State Hospital and Medical League sought "to promote socialization, compile information and assist the government." Primarily a lay organization, in 1942 the League recommended an eight-point plan to create health districts and proposed a Russian-type model of local and regional clinics with the redistribution of doctors already on salary. In 1937, the CCF party began promoting the Russian concept of health centers with salaried doctors, while Sigerist recommended it in 1944.

Elected in 1944, Saskatchewan Premier (and Minister of Health) T.C. Douglas received the Sigerist recommendations, then initiated the Swift Current prepaid health insurance trial, introduced a provincial $5 per person tax in 1946 to build more hospitals, including a university hospital, and approved a full-degree-granting medical school. Douglas' hospital tax gave it control over all hospital expenditures. He also allowed the municipal doctors' program and the fee-for-service billing system to continue and declined to place doctors on salary. The health center concept lapsed after the 1952 election.

After 1945, Alberta would follow in lock step with the Saskatchewan health insurance decisions, but on a contributory or "Manningcare" funding basis. Interestingly, Alberta's longstanding Premier E.C. Manning (1942-1968) was originally from Saskatchewan.

Conclusions

- Canadian medicare is naturally divisible into two phases: pre-1945 (when state medicine was interpreted as a health insurance program in Alberta) and post-1944 (when universal funding was introduced to begin to pay for it in Saskatchewan). The most important issue to be addressed in both phases was the remuneration of doctors, either on a salary or a fee-for-service system paid for through an insurance program.
- The Russian polyclinic program (health center, salaried doctors) was considered in Alberta (in 1932) and rejected. It was entertained in Saskatchewan (1936-1944) and discarded by Premier Douglas in 1944.
- Milestones: Improving public health and health care access was a priority for the UFA government in Alberta even before their 1921-1935 tenure. There was little leadership in Saskatchewan after the municipal doctors' program began in 1915. For most of the major provincial and national health care milestones, Alberta was ahead of Saskatchewan until Douglas was elected in 1944.
- Alberta's state medicine deliberations (1927-1935) have no comparable discussions in Saskatchewan. They led Alberta to define state medicine as a fee-for-service health insurance program, which the AMA/CPSA and later the CMA supported.
- Douglas made a critical choice, choosing a hospital insurance program over putting doctors on a salary. He introduced the first "universal" $5 per person tax in 1946 to accelerate building 45% more beds in four years to catch up to Alberta, keeping control of it by providing 50% of the operating costs. Alberta did the same without the tax.

Does all this answer the question: "Where was Canadian Medicare made – Russia, Canada, Saskatchewan or Alberta?" It was made in Canada and the leading proponents were from Saskatchewan and Alberta. The seminal year – 1932 – deserves more research than it has so far received.

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