HSTC Bulletin
Journal of the History of Canadian Science, Technology and Medecine
Revue d'histoire des sciences, des techniques et de la médecine au Canada

hstc bulletin

Canadian Doctors and State Health Insurance, 1911-1918

C. D. Naylor

Volume 6, numéro 3 (22), septembre–september 1982

URI : https://id.erudit.org/iderudit/800142ar
DOI : https://doi.org/10.7202/800142ar

Aller au sommaire du numéro

Éditeur(s)

HSTC Publications

ISSN

0228-0086 (imprimé)
1918-7742 (numérique)

Découvrir la revue

Citer cet article

Naylor, C. D. (1982). Canadian Doctors and State Health Insurance, 1911-1918. *HSTC Bulletin*, *6*(3), 127–150. https://doi.org/10.7202/800142ar

CANADIAN DOCTORS AND STATE HEALTH INSURANCE, 1911-1918

C.D. Naylor*

(Received 12 January 1982. Revised/Accepted 15 October 1982)

The attitudes of Canadian doctors to state health insurance have varied considerably through the decades. However, professional perspectives on prepayment of medical bills have not changed in any random or capricious fashion. Instead, a multiplicity of specifically identifiable factors has modified the profession's viewpoint. In the 1920s, for example, medical incomes soared in every part of the nation despite a post-war recession during the early years of the decade.[1] Doctors were generally indifferent or hostile to the idea of health insurance. With the Depression came a flurry of interest in state intervention on the part of organized medicine, as medical incomes were slashed and members of the profession saddled with a substantial burden of charity work among the 'indigents' and unemployed.

The Canadian Medical Association (CMA) petitioned actively for 'Medical Relief' payments to doctors. Provincial divisions of the CMA took up the cry as well, with some associations going so far as to call forthrightly for the introduction of a state health insurance scheme.[2] Not surprisingly, 1934 saw the first official policy statement on government health insurance by the CMA. Prepared by the national body's Committee on Economics for the Annual Meeting in Calgary, this document understandably stressed the need for the medical bills of indigents and unemployed to be covered by the state. Enrolment should be compulsory for all below a certain income level who might be poor payment risks for the beleaguered doctors.[3] And in a 1937 amendment to the 1934 list of 'Principles' pertaining to health insurance, the CMA explicitly demanded mandatory means-testing by 'competent local authorities' to ensure enrolment by those whose income 'proves to be insufficient to meet the costs of adequate medical care.'[4]

While financial considerations were clearly one very important factor in determining medical attitudes to health insurance and shaping the official policy of organized medicine, many other elements came into play. A 1926 Québecois pamphleteer worried over the expansion of dispensaries for the treatment of tuberculosis, venereal disease and charity patients generally; for once the public took free medical care for granted, the doctor would be taken for granted also and his status would fall to that of 'un vil mercenaire.'[5] To such prestige concerns one could add more diffuse fears of lay control in any form. The profession had fought hard in the nineteenth

* Hertford College, Oxford, England.

century to win collective self-governance privileges, and the individual practitioner grew to enjoy a tremendous degree of autonomy. Certainly the official policy statements by the CMA between 1934 and 1965 reflected a fear that state health insurance would curtail the profession's independence.[6]

Finally one must note the impact of other less constant factors. Organized medicine in Canada viewed the organization of the National Health Service (NHS) of the United Kingdom with some alarm. It seems reasonable to suggest that the CMA's 1949 policy shift away from full-fledged state health insurance and towards a plan of government-subsidized enrolment in doctor-sponsored private insurance schemes reflected, in some degree, this heightened anxiety about state control. Internal demographics, too, played a role in conditioning medical responses. By the 1960s, two significant changes had taken place in the profession's structure: first, an increased number of specialists emerged, who had superior market power to the general practitioner and won greater billing freedom from the doctor-sponsored plans. Secondly, the generation which recalled the unpaid bills of the Depression was passing from positions of power in the profession. The new breed of medical politician took a high income as given, heard tales of woe from English doctors who had fled the NHS, and resented even the profession's own insurance plans as 'monoliths' which curtailed direct-billing and extra-billing by participating MDs.[7] Hence, the CMA moved towards an ideological alliance with the commercial insurance industry which continues to this day.[8]

Given, then, the complex concatenation of forces which has shaped professional attitudes to health insurance in general and medical care insurance in particular, analysis of the doctors' prepayment perspective just prior to and during World War I poses an interesting challenge. Material and ideal interests, along with internal and external variables, must be weighed.

Starting with Otto von Bismarck's 1883 Sickness Assurance Law for Germany, a variety of continental European countries initiated some plan for provision of medical and wage benefits to manual workers and other employees below a certain income level. Compulsory sickness insurance was legislated by Austria in 1888, by Hungary in 1891, Luxembourg in 1901, Norway in 1909 and Serbia in 1910. Despite this steady activity, the Canadian medical profession registered little or no reaction to the idea of state health insurance prior to 1911. Not until the innovation spread to Great Britain did it seem close enough to warrant commentary, and these early responses are best understood against a very brief sketch of the events surrounding Britain's National Health Insurance Act of 1911.

The British medical profession, in contrast to the Canadian profession, was sharply divided at the turn of the century. A class barrier of sorts separated the medical and surgical consultants from the general practitioners, the former being descended, as it were, from Royal College stock, while the

latter found their ancestry among the lowly apothecaries and before that, the trade-tainted Grocers' and Spicers' guild.[9] From the 1880s onwards, an increasing number of Friendly Societies and other fraternal organizations hired GPs on contract. The 'club doctors,' as they were called, found conditions of work for the consumer collectives to be less than satisfactory. Wages, often paid on a capitation basis, were rather low, the volume of patient visits high. Furthermore, the doctor could be dismissed if one or two of his several hundred lodge patients found grounds for dissatisfaction with his services. Conflicts between doctors and the fraternal organizations came to a head in the 1890s. Local medical societies were formed and boycotted some of the clubs, seeking higher wages and other improvements in the GPs' lot.[10] The profession was sufficiently over-crowded that lower-priced 'scab' doctors could usually be imported from other regions; and the consultants, who feared GP activism as portending a threat to their own status, were not always supportive of the medical societies' attempts to drive a better bargain with the lodgers.[11]

Despite its drawbacks, club work and contract practice was a meal ticket for many GPs. They could not really compete with the physicians and surgeons, who acted both as consultants and as primary care providers to the upper and upper-middle classes of British society on a fee-for-service basis. Thus, as Frank Honigsbaum notes:

> By the time NHI began, at least half the GPs in Britain - or some 10,000 out of 20,000 - were thought to be engaged in contract practice in one form or another and for a quarter of them, the number of patients involved was so large that the rates of pay offered had become crucial to their subsistence.[12]

Early interest in National Health Insurance on the part of the club doctors must therefore be understood as a means for them to escape the vagaries of contract practice.

Not surprisingly, the British Medical Association was split on the issue. The British Medical Association (BMA), formed in 1856, was actually the outgrowth of the Provincial Medical and Surgical Association, formed in 1832 to protect the interests of the apothecary-GPs. Consultants later joined the body, but saw themselves as 'scientists' in a learned professional association; the 'unionist' outlook of the club doctors was a source of internal squabbles.[13] Initial acceptance of National Health Insurance by the British Medical Association thus reflected an apparent victory for the GPs: freed of contract practice, they might improve their status within the profession and society at large.

The actual National Insurance Bill, however, was drawn up with only minimal consultation between the governing Liberals and the medical profession. Protests poured in on all sides, and David Lloyd George, then Chancellor of the Exchequer, courted the BMA unsuccessfully through lengthy negotiations. While

the doctors apparently had misgivings on several scores as their marriage to the state loomed ever closer, the size of the dowery appears to have been a major consideration. The government offered six shillings per head per year, which was about 50% more than what a BMA survey showed the average per patient per year to be in lodge or contract practice, but the BMA remained opposed.[14]

The Act nevertheless came into effect on 15 July 1912. It covered approximately one-third of the population for general practitioner services. Dependents were not included, but enrolment was compulsory for all manual workers between sixteen and sixty-five years of age, and for all non-manual workers with an income under 160 pounds per year - some 15,000,000 wage-earners *in toto*. In the autumn of 1912, the BMA organized a ballot and doctors voted almost six-to-one against serving under the Act. However, only half the eligible voters cast ballots, and any illusion of a united front was soon dispelled by the number of GPs who hastened to avail themselves of the Act's benefits. In January 1913 formal resistance ended when the BMA acknowledged that members would no longer be bound by earlier pledges to boycott the Act.

The opening salvo from Canadian organized medicine in support of the British profession came in the autumn of 1911 from the pen of Dr (later Sir) Andrew Macphail, the founding editor of the *Canadian Medical Association Journal* (CMAJ), and an outstanding literary figure of the period. It would be hard to imagine a more appropriate pairing of issue and editorialist, for Macphail was a thorough-going conservative with a strong suspicion of social progress and a disdain for measures which sought to move men from their appointed place in nature's hierarchy. His conservatism, while tempered by a sense of *noblesse oblige*, accordingly carried a darwinistic tinge; the latter may account for his admiration of free trade. Furthermore, S.E.D. Shortt has noted that for Macphail, 'Reverence for tradition and the moral dimension of life was coupled with hostility to the excesses of democracy and technological innovation.'[15]

George Bernard Shaw's play, 'The Doctor's Dilemma,' had been first produced in London in 1906 and published with a polemical introductory essay in 1911; Macphail in ironic counterpoint, entitled his editorial, 'The Patient's Dilemma':

> We have heard much of the doctor's dilemma. We are likely to hear more of the patient's dilemma, as the free play of the profession is impeded by unconsidered legislation. It is by freedom that medicine has attained to its high place, because the physician, being a free man, has chosen to be the servant of all.[16]

Macphail went on in this vein, extolling the virtues of medicine as a profession, deriding the Chinese for treating the physician as 'a kind of scavenger and nothing more,' and

stressing that 'the people are best served when the profession is at the high level whereat its founder placed it.'

After a side-swipe at contract practice, Macphail remarked: 'At this moment the profession in England is much disturbed over a piece of legislation, commonly called "The Insurance Bill," which aims to extend practice by contract to some nine million persons.' The profession, he maintained, need not fear; medical men were, in significant measure, now to be paid 'for doing what they have hitherto done for nothing.' But the public would suffer, for privately-endowed hospitals would tend to become state-funded institutions, 'and the spirit of charity will be replaced by a cold, official atmosphere which is not congenial to a member of a free profession.' With the best doctors gone, the students too might depart, taking away a stimulus to better quality care. An in Macphail's pessimistic vision, the mediocre doctors who had failed in private practice or lacked the courage to compete therein, would be the 'officials' who served in the hospitals: 'The rich will be the gainers and the last state of the poor will be worse than the first.'

The editorial, in truth, bears analysis badly, consisting as it does of unwarranted generalizations and conceptual inconsistencies. Shortt has suggested, however, that the power of Macphail's argument generally 'lay less in inexorable logic or even in his extensive knowledge of history and contemporary affairs than in his facility for the terse phrase.'[17]

Macphail returned to the topic in the *CMAJ* during the spring of 1912. Evidence was adduced for the contention that private philanthropists would be less favorably disposed towards the hospitals. Furthermore, 'the socialist doctors were also taking a hand:' they favoured a full-blown nationalized medical service, although 'opinion in the medical profession and amongst the general public is not yet ripe;' and felt 'the Act must inevitably lead to the public management and control of the voluntary hospitals.' All of this apparently confirmed Macphail's earlier fears and he repeated his warning about the deterioration in services available to the poor.[18]

In the ensuing months, however, Macphail was obviously given more information about the health insurance legislation and the stance of the British medical profession. With the July implementation date looming, it became clear that the BMA might well look more favourably on the Act if the capitation rates were increased. And meeting at Liverpool on 24 July 1912, the BMA had thrown down a challenge to Lloyd George: its members would not serve under the Insurance Act unless the capitation rate was increased from 8s. to 8/6 -- about double the average payment in private contract practice. In light of this trade union activity and, presumably, an awareness that British GPs did not share his view of National Health Insurance as an unmitigated evil, Macphail was forced to beat a rhetorical retreat. He did so with Shakespearean grace in September 1912, even as the British profession organized its plebiscite on health insurance.

Entitled 'Eating the Leek,'[19] Macphail's editorial in the *CMAJ* opened with a quote from 'Henry the Fifth' and went on to leave no doubt as to the analogy between Shakespeare's Fluellen and another Welshman, David Lloyd George. But whereas the previous comments on health insurance had been written with an overtone of brooding pessimism, the style of this editorial was lighter, the viewpoint more positive. Factual presentation and puckish commentary replaced the earlier philosophical musings.

Having disparaged the Chinese method of recompense in 1911, Macphail now suggested it was 'the logical outcome' of the profession's growing emphasis on prevention. The Chinese traditionally paid their physicians a fee for maintaining health; payment stopped if the patient fell ill, and the doctor sometimes went so far as to hang a special lantern outside his house to show his contrition.

> We can, indeed, go further and lay down that just as preventive medicine, as public medicine, is calculated not for the benefit of any particular individual, but for the well-being of the community at large, so, not the individual but the community must recompense the doctor, and the general practice of medicine must become a national service, endowed by the State.

Nor was this the end of the recantation. Macphail acknowledged Lloyd George's prescience, and wrote: 'It would be useless to deny that the Act, could it be carried out with the loyal cooperation of all parties, would do much to improve health conditions in the Old Country.' Cooperation, however, proved the *CMAJ* editor's keynote. Lloyd George had gone 'the wrong way to work,' failing to take into account the extent to which the medical profession of Great Britain was 'formed of free and independent individuals:'

> Had Mr. Lloyd George approached the profession in the first place, asking for advice regarding the scheme and regarding the scale of the capitation fee, matters would have been very different. There is not the least doubt but that the majority of the general practitioners of Great Britain would have entered cordially into the scheme; but it is a very different matter to be told by this Fluellen to eat his uncooked leek, willy nilly.

Macphail was therefore able to reconcile his love of free trade with BMA activism, for it was Lloyd George's high-handedness that had created 'their revolt;' 'pecuniary considerations' were secondary. This 'body of free and independent men' was accordingly rising 'in union' for good cause:

> The profession as a whole would rejoice to be delivered from the thraldom of the Friendly Socialists, and from the miserable rates which the struggle for existence makes it necessary

> to accept from those organizations. But it is one thing for a man whose whole education has taught him to rejoice in his freedom to accept a low wage in the open market, and quite another for him to be forced to accept a capitation fee without his wishes being considered.

Macphail's thoroughly developed world-view makes his commentary something of a special case. In 1913, following the collapse of BMA resistance to the National Health Insurance Act, other representatives of the Canadian profession made reference to the innovation. It is worth considering the context out of which these opinions arose with reference to some of the variables demonstrated at the outset of this essay.

First, contract practice never became as widespread in Canada as in the UK. Industries did occasionally hire MDs on a salaried basis: from Nova Scotia to British Columbia, there were mining and logging operations whose employees were guaranteed medical attendance. Lodge practice, too, was entrenched in some parts of the country, with Ontario in general, and Toronto in particular, standing out in this respect.[20] But whereas lodge practice had been roundly condemned by the leaders of the Ontario Medical Association in the 1890s, criticism of the lodgers was much less prominent over the next twenty years, perhaps because a smaller proportion of doctors relied on the clubmen for solvency.[21] There was, nevertheless, a concern in medical circles about inadequate remuneration of the general practitioner. This, according to common professional wisdom, was one reason for the spread of fee-splitting -- an arrangement whereby the referring GP received a kickback from the consulting surgeon.[22]

If the general practitioner was losing ground financially in comparison to the emerging specialists of one sort and another, the Canadian profession still did not contain the major class cleavages which characterized the British profession. Entrance to practice was through a single portal - the College of Physicians and Surgeons or its equivalent in the practitioner's province. Further standardization was afforded through the newly-created Medical Council of Canada. Unless credentials were held from Britain, or from the American College of Surgeons -- established during the period under discussion -- the specialist laid claim to his status simply through recognized post-graduate training and peer group acceptance. Indeed, American and British specialty credentials, while important imprimaturs, carried no legal weight in the Dominion.

To suggest, moreover, that most Canadian GPs of the period laboured near the poverty line would be an unfounded generalization. Data on income averages are available only for the years after the Great War, for federal taxation on personal earnings was not imposed until 1917. But it is undeniable that some non-specialists were doing very well by any measure.

Dr R.E. McKechnie, a British Columbia medical historian whose father was a prominent Vancouver practitioner, has recalled the doctor's pre-War 'Environment of Prosperity'[23] in what presumably is a childhood memory: The household cupboards were filled with 'English jams, oriental spices and other such delights,' and the cellars were 'stocked with French wines and champagnes and barrels of Eastern blue-point oysters shipped from the Maritimes.' To round out the 'creature comforts,' 'Oriental servants were available at a cost varying from ten to twenty-five dollars a month.' There were also rituals appropriate to a rising middle class:

> When Caruso of Madame Melba gave their concerts or Pavlova danced, the doctor dressed in his formal white tie and tails and, accompanied by his faultlessly gowned wife, attended the dinner that preceded the theatre, or the oyster suppers that followed.[24]

To sum up, the Canadian medical profession really had no special stake in health insurance. Consumer-sponsored prepayment arrangements did not cover a major portion of the populace, hence there was neither impetus for the doctors to seek alternative arrangements nor a pre-existing institutional framework which a government could utilize. Complaints about the level of GP fees and incomes surfaced sporadically, but the theme was not a dominant one.[25] Nor did the internal structure of the profession predispose to serious factionalization on issues related to prepayment.[26]

At the June 1913 Annual Meeting of the CMA, held in London, Ontario, H.A. McCallum began his presidential address by dealing with the profession's inadequate support for the national association:

> The splendid service of the British Medical Association to the profession of the British Isles, in dealing with the terms of Lloyd George's Insurance Bill, points out what an association can do for each individual member of the profession. The future outlook of Canadian medicine demands a strong association to confront legislation that would make us a despised arm of the Civil Service.[27]

McCallum suggested, however, that 'greater evils' might be in store for the profession 'than being brought under the pay and direction of the Canadian Civil Service.' At least this might help protect the public from its own 'giant credulity' -- an obvious reference to the popularity of osteopathy, chiropractic and Christian Science.

But the CMA President gave a stern warning as to the possibility of national health insurance or a state medical service:

> So long as a nation can elect a demagogue to its legislative halls, there is sure to arise the attempt. It may be in the very near future. Let us be armed to secure the most favourable terms.

> If four-fifths of the profession belonged to the Association, instead of one-fifth, as at present, no attempt could get under way to bring us into the service without our consent.[28]

Later that year, Dr Herbert J. Hamilton touched on British developments in a presidential address to the Toronto Academy of Medicine. Dr Hamilton favoured government support for diagnostic laboratories and research but could not approve of state health insurance. A 'National Medical Service' was definitely in the offing. The key to any such scheme, so far as Hamilton was concerned, lay in maintenance of the patient's choice of doctor, for the important rapport between practitioner and patient might thereby be safeguarded. This element of free choice was one redeeming feature of Lloyd George's National Insurance Act.[29]

Some of the above themes were taken up at the 1914 Annual Meeting by the Committee on Public Health Legislation, chaired by Dr D.G. Revell of the University of Alberta. The Committee suggested that the CMA and the Canadian Public Health Association liase to create a 'model' Medical Act and 'model' Public Health Act to be used in every province. This would enforce greater uniformity than the Canada Medical Act which had, after all, generated an inter-provincial registration mechanism but not guaranteed total standardization of requirements for practice. Such a project would foster unity in the profession, wipe out invidious 'provincialism,' and prove 'the best and surest way of dealing with such excrescences as osteopathy, chiropracty, so-called "Christian Science," and other evils:'

> The need for the proposed work is convincingly seen in the incongruous existing situation regarding osteopathy in the several provinces today;[30] or, again, in the history of recent events regarding medical practice in England. Preventive medicine is certain to be taken more and more under state control even in this country, and doubtless in time general and special curative medicine will be also. If we do not take our full part in shaping aright the coming changes, it will fare ill with our profession at some future time.[31]

But at the same Annual Meeting, another report was tabled which foreshadowed a minor split in the profession's ranks. The Public Health Section of the CMA had formed a Committee on Applied Sociology under the chairmanship of P.H. Bryce. This committee dealt with a number of issues at the interface of social welfare and public health, but opened its analysis with an acknowledgement that a new era had dawned. The old principles of political economy with their emphasis on 'individualistic competition,' best exemplified by John Stuart Mill's writings, should give way to 'a higher ideal, and that is that members of society should exist for the good of one another.'

It is perhaps not surprising that a committee of public health doctors should promulgate this sort of viewpoint. The practitioner dealt with diseases on an individual basis, seeing this

or that patient with this or that problem. The public health expert, in contrast, took a social engineering approach, emphasizing prevention rather than care and cure, and examining communities and institutions rather than individuals. Indeed, the committee went on to contend that the expansion of preventive medicine necessarily heralded more state intervention: 'Bismarck's Compulsory Insurance Act' and Lloyd George's British insurance legislation were logical outgrowths of this trend.[32] This latter stance approximates that of the Committee on Public Health Legislation.

Scarcely a month after the 1914 Annual Meeting, war broke out in Europe, and Canada followed Great Britain into the fray. As the conflagration spread, the organs of public opinion reflected a spirit of growing emphasis on selflessness and the common good, with anti-materialist sentiments also commonplace. But in December 1914, the *CMAJ* ran an article on 'Health Insurance and the Medical Profession'[33] which belied these developing changes in the *zeitgeist*, for the author, Dr A.R. Munroe of Edmonton, seemed most concerned with the potential benefits of health insurance to medical incomes.

Munroe pointed out that free clinics and other philanthropic institutions, along with fraternal organizations, were all oriented towards ensuring the provision of medical services for 'the sick of the poorer classes.' Noting events in Great Britain, he remarked: 'All we require in Canada or the United States is the right type of politician and it will be made the subject matter of legislation on this side of the Atlantic.' Various free dispensaries exploited the medical profession 'either in the name of charity or religion;' Mr Lloyd George was exploiting it 'in the name of politics.'

The scientific progress in medicine had not been matched by progress on 'the business side:' 'A fair percentage of patients pay us a full fee, a few pay us a partial fee, and more than a few pay us nothing at all.' About one-half of Great Britain's urban population had been covered by the National Insurance Act, and a similar percentage might well be covered by similar legislation in Canada. Until then, there was a significant income loss:

> We are living in an age when the "gold standard" determines one's station in society ... The day is past when the doctor is respected because of his profession alone, and most of us are guilty of valuing our practices by our cash receipts for the year. Therefore to be consistent we should welcome a method of converting this loss to gain.

The National Insurance Act nevertheless was flawed in Munroe's view. If something could be done 'to prevent the copying of such an act in this country,' 'there is no time like the present.' A National Medical Service was one solution, but Munroe had two objections. First, government administration was often unfair; 'and secondly, the change from our present status is too great.'

> We are living in a commercial age and, I believe, the solution to this problem will be arrived at by studying commercial methods . . . By accepting the good points of present insurance methods and supplying what is lacking to make it acceptable to the medical profession, we can arrive at a scheme that would guarantee the insured public medical, surgical, and hospital attendance, and guarantee the medical profession their fees.

Munroe's four-point plan for health insurance differed sharply from the National Insurance Act of Britain:

> 1) The services of the whole of the medical profession should be at the disposal of the whole public;
>
> 2) No one should be made the object of charity;
>
> 3) The average medical income should be increased;
>
> 4) The basis of reckoning from which the actuary obtains his rate of insurance to the public should be the medical schedule of fees.

From the above, it would certainly seem that health insurance was, as Munroe suggested, 'worth every man's while studying.'

Prior to and at the outset of World War I, the attitudes of Canadian doctors to health insurance, as represented in the writings and utterances of the profession's leaders and spokesmen, might be capsulized as follows: health insurance or state medicine was seen as inevitable, a fast-looming innovation which need not be disastrous so long as organized medicine brought its weight -- preferably an augmented weight -- to bear in shaping the relevant legislation. The British Insurance Act was seen as unsatisfactory; and given the travails of their UK counterparts, the Canadian profession's leaders were not eager to see a similar experiment tried in their nation. If state medical coverage came in the appropriate form, however, it could at least give doctors payment for services hitherto provided *gratis*, and might also limit the inroads of any irregular practitioners.

As already mentioned, the war brought a transformation in the attitudes of the Canadian public to a wide variety of social issues. The nation's populace inevitably came to be seen as a biological resource without which the war machine could not function. 'Organization, economy, efficiency are watchwords today in all civilized countries as never before in the history of mankind,'[34] wrote Macphail in the *CMAJ*. The 'belligerent nations' had heeded these watchwords 'early in the present struggle' for organizing their armies, navies and war industries; but 'it has been found necessary to apply the same principles in a wider sphere to include the resources and activities of the nation as a whole.'

Along with this emphasis on social engineering through use of the state apparatus went various inter-related sentiments. Anti-materialism was one: with so much at stake and so many making the ultimate sacrifice, personal acquisitiveness seemed especially mean-spirited. Anti-business attitudes[35] in particular were fuelled by the extraordinary profits and corrupt dealings of Canadian industries during the Great War. Finally, wartime collectivism generated a new sensitivity as to the plight of the poor and the labouring classes. It was, after all, the working class who supplied the majority of servicemen. And when Johnny came marching home, he might well expect -- or even demand -- some measure of social reform as a reward for his patriotic efforts.

In consequence, health insurance seemed feasible and desirable to a growing number of Canadians. However organized medicine paid no special attention to the question during 1915 and 1916. A great many MDs were overseas with the Medical Corps; in fact, the disturbance in the profession was such that no CMA Annual Meeting was undertaken for those two years. As the President of the Academy of Medicine put it in 1917:

> The war is making great demands indeed upon our profession. I do not know of any other profession, where similar incomes have been thrown to the winds at the call of duty, and yet we must be prepared to do still more.[36]

Moreover the organization and administration of the RCAMC was itself a contentious issue. One might say the profession had enough battles to fight without stirring up the health insurance hornets' nest.

But in 1917, when the nation and the profession had settled into the grim monotony of war, health insurance was once again a popular topic. The changed tenor of the times was reflected to some extent in the attitudes of medical spokesmen, for their perspective was less self-interested and more positive. Not unexpectedly, the public health doctors were most enthusiastic, an important phenomenon that would persist in enusing decades of state health insurance deliberations.[37]

Rising interest in health insurance must also be tied to British and American developments. A 1917 BMA survey confirmed what most observers had already surmised, namely that most GPs approved of the health insurance plan. Incomes on average had risen, and there was some call for extension of the scheme to cover dependents and hospital care.

Sparked by the British insurance legislation of 1911, Americans, too, had commenced serious study of health insurance. The prime movers were members of the American Association for Labor Legislation (AALL), a left-leaning group of social reformers who had been instrumental in encouraging the majority of states to adopt workmen's compensation acts during the years from 1908 to 1917. In 1912, a committee of the AALL had begun an examination of health insurance and two years later, armed with the relevant data and a Draft Bill, the Social Insurance

Committee members embarked on a national campaign.

Perhaps because American energies were not yet diverted to the Great War, the health insurance campaign gained considerable momentum and occasioned no small amount of controversy. Private insurance companies lobbied furiously against public insurance, but industrialists and labour leaders alike took a more supportive stance. In 1916 two state commissions reported favourably on the measure; these commissions were re-appointed in 1917 along with six new state commissions. Health insurance committees were set up by a wide variety of organizations, among them the American Public Health Association, the American Academy of Medicine, the National Conference of Charities and Corrections, and the New York Chamber of Commerce, to name but a few. The American Medical Association had a 'working committee' on the subject, with none other than I.M. Rubinow, the leading AALL campaigner, as its secretary.[38] While medical opinions were not invariably favourable, one enthusiast was nonetheless able to boast that 'Several medical societies, including the Pennsylvania State Medical Society and the State Medical Society of Wisconsin, and several public health associations have endorsed the principle of health insurance.'[39]

With this maelstrom of activity to the south, and an apparent endorsement from Britain's doctors, some Canadian MDs offered their own endorsement. One of them was Major J.W. McIntosh, a British Columbia MLA. An internist, former President of the Vancouver Medical Association, and a maverick Liberal who often talked of forming a Returned Soldiers' Party, McIntosh was to be a key figure in pushing the BC government to appoint the nation's first health insurance commission in 1919.[40] Already in the spring of 1917, McIntosh, calling for improvements in public health measures, informed his fellow MLAs that it was 'only a question of time before the workmen's compensation act would be extended to include sickness as well as accident.'[41]

On 27 June 1917, the Edmonton Medical Academy and Dental Association held a joint meeting at which it was decided that an educational committee should be established 'to organize a campaign of social reform.' Creation of a federal Department of Public Health was one priority. Health insurance was another:

> The committee is of the opinion that a good workable social or public insurance scheme would prove of invaluable assistance in reducing the number of cases requiring provincial or charitable assistance, and recommends that the same be put into operation at the earliest possible moment.[42]

That same month, Dr A.D. Blackader took a rather more conservative position in his presidential address to the CMA Annual Meeting.[43] Noting 'the many social and economic problems which are developing rapidly and threaten to affect seriously the standing of our profession and modify its activities,' Blackader warned against any tendency 'to develop an attitude of cloistered retirement from public affairs.' He quoted from the American medical literature on health insurance to

stress the imminence and importance of such legislation. Although in Canada 'thus far, very little attention has been given to a measure of this character,' a 'strong committee' should nevertheless be appointed by the Association to study and report on health insurance, including 'the means to be taken to safeguard the true interests of our own profession:'

> In England the physicians paid little attention to the measure, until prospective, or in some cases actual financial pressure led them to act, and then the opposition which they raised to many of its provisions led to a widespread impression that mercenary reasons and not a just appreciation of the beneficent workings of the bill influenced their action. Let us avoid such a possibility in Canada, and be prepared to consider the measure from every point of view, and perhaps even to further its advancement by our own action, for I feel assured that with broad and friendly consideration from the profession, the details of an insurance scheme can be arranged so as to secure entirely dignified terms for our members, and to accomplish mutual benefit for all parties.

But at the same annual meeting, an address was given that threw such caution to the winds; and predictably, the spokesman was a public health expert. Dr Charles J. Hastings, Toronto's Medical Officer of Health, had recently been honoured with the presidency of the American Public Health Association. At the CMA convention, he delivered a wide-ranging address on 'The Modern Conception of Public Health Administration and its National Importance.' Hastings reviewed developments in Europe and the USA, and made passing reference to 'the Right Hon. David Lloyd George, the most outstanding character in Great Britain to-day' - a rather striking contrast with Macphail's 1912 allusion to 'that strange, uncomfortable demagogue enthusiast.'[44] Stressing the interrelationships of sickness and poverty, Hastings contended that absenteeism due to sickness among the 2,400,000 wage workers of the Dominion led to an economic loss of more than $64,800,000 per year. This cost was independent of 'loss of life, funeral expenses, or loss through partial permanent disability, consequent upon certain forms of sickness, or of the sorrow and anguish.' Little wonder that Hastings enthused: 'A government system of health insurance can be adapted to this country, and when adapted, will prove to be a health measure of extraordinary value.'[45]

The fall of 1917 saw more official recognition of the movement. Dr J. Gibb Wishart, President of the Toronto Academy of Medicine, took aim against creeping commercialism in the medical profession, and reminded his colleagues that the war had brought 'a fresh outlook, an upsetting of accepted aspects of truth.' The 'unimportance of individuality' was apparent; the era of preventive medicine had dawned; already the care of school children and treatment of syphilis and tuberculosis were being 'assigned to the care of the state:'

> May these not be signs of the times that the day of the competitive physician and surgeon is over and that presently he must become a member of a panel and have removed from him the opportunity to exploit his experience for mere gain - that as his training is even now largely paid for by the state, so his employer hereafter may be that same body ... I am not a prophet, but let us not mistake, there are great changes coming.[46]

So far as the public health doctors were concerned, it seemed the changes could not come fast enough, for at the Sixth Annual Congress of the Canadian Public Health Association, held in Ottawa on 27 and 28 September, a symposium on health insurance was convened, the first such event in Canada. Three papers were presented. Dr Charles Hastings discussed 'The National Importance of Health Insurance,'[47] and two members of the Social Insurance Committee of the AALL made their inaugural trek northward to proselytize in Canada. Miles M. Dawson, a consulting actuary, offered an analysis of 'The Contribution of Health Insurance to Improvement of the Public Health,' detailing exactly how insurance might react upon patterns of medical care. And I.M. Rubinow, PhD, the AALL's full-time campaigner for health insurance, first outlined European and American developments, then systematically knocked down every conceivable objection to health insurance in an address that still sparkles brilliantly for the modern reader. Rubinow went to special lengths in demonstrating how little the Canadian medical profession had to fear a well-designed insurance measure, and by dwelling both on the flaws in the British arrangements and on the comparative strengths of the AALL Draft Bill, doubtless scored points even with the skeptics in his audience. He concluded with an appeal: 'Surely the medical profession cannot afford to be registered in opposition to this social reform.'[48]

Another American advocate found his way north that autumn. Professor Irving Fisher, a political economist at Yale, addressed a group of doctors at Toronto General Hospital on 6 November extolling the virtues of health insurance. Fisher pointed out the premium on human resources resulting from the war, and urged health insurance as both a reward to returned soldiers for their service and a means of breaking the vicious cycle of poverty and disease. Health education and 'individual hygiene' in particular would blossom under a sound insurance measure.[49]

The Toronto-based *Public Health Journal*, which had already reprinted one Rubinow paper in April 1917,[50] published in a single issue the texts of the addresses by Rubinow and Dawson to the health insurance symposium, and a reprint of a paper by Fisher previously published in the *American Labor Legislation Review*.[51] The *Journal* also ran an editorial on 'Health Insurance,' presenting the various reasons 'why health insurance is likely to come into the realm of practical politics in Canada, in the near future.' Apart from all its positive effects on public health, insurance 'will probably do much in the way of eliminating the competitive elements from medical practice and

make the physician's income much more stable.'

Whereas official spokesmen for organized medicine had tended to be supportive of the stance of the British profession, the editors of the *Public Health Journal* were tacitly disapproving:

> The great difficulty in developing legislation on the subject in other countries has been opposition from factions who believed their own particular interest to be endangered. This was particularly the case in Great Britain where opposition on the part of physicians was so active as to emperil the putting into force of Lloyd George's Act.

If international lessons were heeded, this should not occur in Canada. The 'underlying principles' of health insurance were sound; the doctor's role lay in 'seeing that their method of application is carefully worked out:'

> Since this type of legislation seems to be near at hand, the subject will be worthy of much study during the coming winter.[52]

Despite the flurry of attention in 1917, health insurance drew less discussion during the final year of the Great War. There is no obvious reason why this should be so. In the case of the *Public Health Journal*, it may have been the result of a broadening concern wtih overall social reconstruction, for a pink tinge was definitely discernable on the editorial side. As its editors wrote, 'generally speaking the ideas of business and those of public health are antagonistic.' Indeed, the business outlook was decried as 'immoral' and 'extremely dangerous;' 'passion for wealth' was the nation's 'greatest curse.'[53] In February 1918, the *Journal*'s editors remarked: 'Let us for one thing cease manufacturing railway millionaires and in place thereof develop a Federal Department of Public Health.' The Department should be

> one which would make certain that every Canadian present and future, enjoyed a maximum of good health, reasonable hours of labour, health insurance and other benefits which as citizens of a country of great natural wealth, we are entitled to.[54]

Later in the year, the *Journal* published the 'Resolutions on Reconstruction of the British Labour Party' together with a highly laudatory editorial. Calling the resolutions 'remarkable and essentially constructive,' the editors noted:

> The fact is that these proposals strike deeper at the roots of social unfairness than any government has dared - or desired to strike in the past. Radical perhaps they are - and therefore to be doomed forthwith by a large section of the selfish, luxury seeking class.[55]

The major professional event of 1918 was unquestionably the Canadian Medical Week, organized at Hamilton from 27 May to 1 June. In his opening address, CMA President Dr H. Beaumont Small made no mention of health insurance.[56] However Dr J.P. Morton, a Hamilton surgeon and President of the OMA, chose for his topic 'Medicine and Democracy;' and warned of 'the gradually changing relations between the medical profession and the State, for these may result, in the not distant future, in the enactment of a health insurance bill:'

> The cost of this so-called health insurance system would be divided between the patient, the firm, and the government. Hospitals and other properly equipped diagnostic centres would be established, where all necessary examinations for arriving at correct diagnosis would be carried out. The greatest gain of this plan would be the abolition of charity work, the very name of which has a stigma attached to it.[57]

In keeping with the idealistic tone of his entire address, Morton stressed that the abolition of charity was entirely for the good of the recipients; the financial advantages for doctors were never discussed. But while Morton painted a very rosy picture of health insurance, there was only one paper read on the topic at the week-long conference: Charles J. Hastings again took up the torch at a session organized by the Canadian Public Health Association and the Ontario Health Officers Association.[58]

Although the OMA President had been positively disposed, his First Vice-President and fellow Hamiltonian, Dr J. Heurner Mullin was not. Some months after the Canadian Medical Week, Mullin was invited to address a combined meeting of the St. Thomas and Elgin County Medical Societies on the topic of health insurance. Mullin suggested that some sections of the profession had 'fallen into disrepute' because of a failure on the part of many MDs to keep pace with scientific advances. Conditions of remote rural and city lodge practice contributed to this decline in standards. The public was bound to seek better arrangements; until then, rectifying the profession's weaknesses would prove a way of 'preparing for the struggle which is sure to come between the medical profession on the one hand and the legislators and their more or less expert advisors.'

Mullin acknowledged the benefits of health insurance, analyzed the various modes of remuneration, and outlined the provisions of the AALL Standard Bill which he praised as more satisfactory than 'anything presented in other countries.' Yet the OMA vice-President refused to accept the concept:

> Sickness in this country is still looked on as a personal misfortune and not as an economic calamity for which all members of the community are more or less responsible ... The central principle of our system in the government under democracy lies in the proposition that every man has a right to

> a full and complete individual liberty limited only by the liberty of every other man ... Why not give everyone a decent living and the money wherewith to pay for the needed attention supplemented if necessary by some insurance scheme?

Mullin concluded that better medical organization, better professional training and continuing education, and perhaps the setting-up of multi-specialty diagnostic clinics, could obviate any need for health insurance.[59]

Mullin's quasi-libertarian viewpoint stands in ironic contrast to the attacks on unbridled individualism and Canada's lack of 'social consciousness' which continued to appear from time to time in the medical literature.[60] Yet his outlook would prevail until the Depression kindled a broader enthusiasm for state intervention in the medical services marketplace. True, philosophy professor G.S. Brett had won 'an extremely sympathetic response'[61] from the seventy-five medical men from across the nation who attended the Round Table session on 'The Ethics of Commerce' at the Canadian Medical Week and were told: 'What we want to do is to root out the predatory ideas and plant in their place the conception of mutual responsibility.'[62] The discussants decried the Robin Hood method of billing required by the extant health care arrangements; they worried about the underpaid and over-worked rural doctor who lacked the wherewithal to take a holiday, let alone refresher courses. But the editors of the *Public Health Journal* were, in the final analysis, crying in the wildermess when they offered a solution in the autumn of 1918:

> National Health Insurance in England, at first bitterly opposed by the physicians, now meets with almost universal approval. It has meant in large measure state control of the medical profession in England. It has also meant that a more rational point of view has been adopted towards matters of health. It has in some degree divorced the medical profession from the "Ethics of Commerce." All of which is better for everyone concerned.[63]

EPILOGUE

November 1918 brought the Armistice; however, battles continued on the home front as labour militancy rose in the West. Accordingly it was not only utopian visions of a better post-war social order, but also the concrete need for legislative reforms to mollify working class unrest that brought health insurance into the realm of practical politics. British Columbia was first to act, an understandable occurrence since that province had been the stie of repeated clashes between organized labour and management, clashes moreover that devolved on a number of occasions into pitched battles between strikers and strikebreakers or their police allies.[64]

Major J.W. McIntosh, mentioned above, introduced the first health insurance resolution in the Legislature on 24 February 1919. Soon after, the House approved a resolution favouring

'early consideration by the Government of legislation with respect to State Health Insurance.' Facing pressure from post-war reconstruction committees, the Trades and Labour Council of Victoria, and sundry church, army and union deputations, the Liberal Cabinet decided to appoint a commission which would investigate health insurance and other reforms.[65]

Even before Premier John Oliver's Cabinet chose the commission members, the federal Liberals met to choose W.L. Mackenzie King as their leader. The social policy planks of the platform adopted at that August convention were reputed to be very much the work of the new leader. And among them was the cautious promise that, 'so far as may be practicable, having regard for Canada's financial position,' an 'adequate' sickness insurance scheme should be introduced by the federal government in co-operation with the provinces.

On 19 November 1919, the BC Social Welfare Commission was appointed. The commissioners held hearings at various centres in the province, and submissions ran heavily in favour of immediate action. But the medical profession proved less than enthusiastic. Dr George Hall, speaking on behalf of the Victoria Medical Society, indicated that his colleagues 'could favour health insurance academically;' however, any legislation on the pattern of the UK National Insurance Bill would be opposed. He suggested the province should wait to see how health insurance schemes in other nations worked out. There was, in any case, 'no immediate need' for it in BC. Hall concluded on a negative note:

> We as taxpayers are considering the financial aspect. Where are we to get the money to establish such a scheme? We do not want any ill-advised legislation on this matter.[66]

The Commission prepared four separate reports, dealing with mothers' allowances, maternity insurance, public health nursing, and health insurance. The health insurance document, last to be written, was not submitted until 18 March 1921. Dr T.P. Green, representing among other groups the medical profession, dissented from the highly positive verdict of his fellow commissioners, and refused to contribute to the report. It was, in any event, never made public. And by 1922, Premier Oliver, saddled with a substantial provincial deficit and an expensive new Mothers' Pensions program, opined that health insurance was a federal responsibility.[67]

So far as Canada's doctors were concerned, such buck-passing was all to the good. Incomes had risen; wartime sentiments were forgotten. And when CMA General Secretary T.C. Routley warned Saskatchewan doctors in 1923 that health insurance deserved serious consideration, the Secretary of the Saskatchewan Medical Society contended this was 'just a flight of imagination in Dr Routley's mind, and if he keeps quiet about it the country will never hear of it again.'[68]

NOTES

1. See the data on medical incomes in the 'Report of the Committee on Economics of the CMA, as presented at the Annual Meeting in Calgary, June 18-22, 1934,' especially p. 30. The report is available under separate cover in some libraries, but also was published as a supplement to the 1934 *Canadian Medical Association Journal* [CMAJ].

2. For a sense of shifting attitudes, see the review by R.S. Bothwell and J.R. English, 'Pragmatic Physicians: Canadian Medicine and Health Care Insurance, 1910-1945,' *University of Western Ontario Medical Journal* 47:3 (1976), 14-17. A comparison of relevant sections of that article with the account presented here will indicate that Bothwell and English have taken some minor interpretive liberties with their sources. On the impact of the Depression, see also the 1934 Economics Committee Report, 19-22 and 26-9.

3. The 'Enumeration of Principles' relating to health insurance is in the 1934 'Report,' 37-8.

4. 'Report of the Committee on Economics,' CMAJ 37 (Sept. 1937), Supplement, 21.

5. L.A. Gagnier, *Droits et Devoirs de la Médecine et des Médecins Canadiens-Français* (Montréal, 1926), 21-2.

6. Most of the CMA Policy Statements on health insurance from 1943 are conveniently gathered in appendices to B.R. Blishen's *Doctors and Doctrines: The Ideology of Medical Care in Canada* (Toronto, 1969). Blishen omits only the 1944 revision of the Principles on Health Insurance. Note that these canons had been originally drafted in 1934, and revised slightly in 1937 and 1942.

7. H. Shillington, *The Road to Medicare in Canada* (Toronto, 1972), 144-50, 182.

8. For a polemical overview of the present disputes, see C.D. Naylor, 'In Defence of Medicare,' *Canadian Forum* 62 (April 1982), 12-16.

9. Two studies are especially illuminating in understanding this historical division. At a professionalization level, J.L. Berlant's *Profession and Monopoly: A Study of Medicine in the United States and Britain* (Berkeley, 1975) helps to illustrate the tensions between the Royal College of Physicians, the surgeons, and the apothecaries. With respect to state arrangements in health care delivery, see F. Honigsbaum, *The Division in British Medicine: A History of the Separation of General Practice from Hospital Care, 1911-1968* (London, 1979).

10. Detailed accounts are found in J.L. Brand, *Doctors and the State* (Baltimore, 1965), 192-7; and P.H.J.H. Gosden, *The Friendly Societies in England 1815-1875* (Manchester, 1961), 138-49.

11. Honigsbaum, *op.cit.*, 14-15.

12. *Ibid.*, 13.

13. *Ibid.*, 14-15.

14. See the summary in J. Blanpain, *National Health Insurance and Health Resources: The European Experience* (Cambridge, Mass., 1978), 52-9.

15. S.E.D. Shortt, *The Search for an Ideal: Six Canadian Intellectuals and their Convictions in an Age of Transition, 1890-1930* (Toronto, 1976), 13-38. Quote is from p. 20.

16. 'The Patient's Dilemma, *CMAJ* 1 (Sept. 1911), 885-8.

17. Shortt, *op. cit.*, 17.

18. 'The Insurance Act,' *CMAJ* 2 (March 1912), 228-30.

19. 'Eating the Leek,' *Ibid.* 2 (Sept. 1912), 822-5.

20. Even in the late 1920s, Toronto was apparently inhospitable for Jewish GPs because of lodge practice; D. Eisen, *Diary of a Medical Student* (Toronto, 1974), 107 (note 27).

21. In the Toronto-based *Canadian Medical Review* VIII (July 1898), 8, Dr Button, the OMA President, noted that lodge practice was 'everywhere.' He added: 'With all my heart and soul I stigmatize the system as a rotten plank in the platform of gentlemanly dignity and independence.' There are other comments in the same volume of the *Review*, Cf. 51, 59-61, 94-5. These are typical of the period, but had tapered off to a great extent as little as five years later.

22. See, for instance, H.A. Bruce, 'Presidential Address,' *CMAJ* 2 (July 1912), 580-92. Speaking as OMA President, Bruce averred that 'the family practitioner is still receiving the same compensation as his predecessors of two or three generations ago.' He noted, too, that the Toronto Academy of Medicine had set up a committee on division of fees which resolved: 'That we agree that the attending physician has often been inadequately paid for his services.'

23. R.E. McKechnie, *Strong Medicine: History of Healing on the Northwest Coast* (Vancouver, 1972), 123-4.

24. *Ibid.*

25. Compared to the volume of income complaints during the Depression, the number is minimal.

26. It seems safe to say that the GP/specialist divide, although a source of anxiety from the latter part of the nineteenth century onwards, really became acute in

Canadian medicine only after World War II. The establishment of the College of General Practice in 1954, and its sponsorship of the first in-depth quality of care survey (K.C. Clute, *The General Practitioner* (Toronto, 1963) was part of a counter-movement to re-establish the stature of the family physician. The relations between GPs and specialists were most acrimonious in Quebec; see, for example, L. Joubert, *La Médecine est Malade* (Montréal, 1962), *passim*. This division allowed the establishment in Quebec of a variant of Medicare in which extra-billing was banned and 'opting-out' seriously constrained.

27. H.A. McCallum, 'President's Address,' *CMAJ* 3 (July 1913), 547-55. See also Macphail's synopsis in the same number.

28. *Ibid.*, 548. McCallum went on to address a variety of topics, among them, 'the miserable medical fees common to some districts of this country ... The righteous course for our profession to pursue is, while not distressing the deserving poor, to be careful not to put a premium on mere stinginess.' (553)

29. 'On Medical Education,' *CMAJ* 3 (Nov. 1913), 980-2, for Macphail's synopsis of Hamilton's comments.

30. Osteopathic degrees were recognized by some provinces, rejected by others. Ontario and Quebec doctors offered the toughest opposition to the osteopaths. Indeed, at the time of writing, graduates of American osteopathic colleges were still not allowed full practice privileges in Ontario.

31. 'Report on Behalf of the Committee on Public Health Legislation,' *CMAJ* 4 (Sept. 1914), 830-1.

32. 'Public Health Section: Report of the Committee on Applied Sociology,' *ibid.* 4 (Dec. 1914), 1123-4.

33. A.R. Munroe, 'Health, Insurance and the Medical Profession,' *ibid.* 1112-14. It is interesting that Munroe's article ran in the 'Res Judicatae' column of the *CMAJ* - a space normally reserved for scientific conundrums of current concern.

34. 'Medical Inspection of Schools,' *ibid.*, 7 (Jan 1917), 43.

35. There are numerous comments in this vein, some of which will be quoted below. See, for example, 'On Incomes,' *Public Health Journal* [*Pub. Health J.*] 9 (August 1918), 391-2; and 'Business and Public Health,' *ibid.* (May 1918), 245.

36. J. Gibb Wishart, 'Presidential Address,' *ibid.* (Nov. 1917), 282.

37. The relative enthusiasm of the public health doctors is noted by Bothwell and English, *op. cit.*

38. For the American scene, see I.M. Rubinow: '20,000 Miles Over the Land: A Survey of the Spreading Health Insurance Movement,' *Pub. Health J.* 8 (April 1917), 93-100. Also, I. Fisher, 'The Need of Health Insurance' *ibid.* (Dec. 1917), 328-36.

39. Fisher, *op. cit.*, 329.

40. A fuller account of events in BC will be presented in my Oxford thesis, 'The Canadian Medical Profession and State Medical Care Insurance, 1911-1966.'

41. 'In Brief,' *CMAJ* 7 (May 1917), 448-9.

42. 'In Brief,' *ibid.* (October 1917), 933.

43. A.D. Blackader, 'Presidential Address,' *ibid.* (July 1917), 577-88. The lengthy quote is from 587.

44. 'Eating the Leek,' *ibid.* 2 (Sept. 1912), 823.

45. C.J. Hastings, 'The Modern Conception of Public Health Administration and its National Importance' *ibid.* 7 (Aug. 1917), 684-703, in particular 698-9. See also the synopsis by Macphail, 736-7.

46. Wishart, *op. cit.*, 286.

47. I have been unable to locate a transcript of this address, which apparently was not published. As Hastings was doubtless involved with the *Public Health Journal*, it may be a reflection of his modesty that the other papers given at the symposium were published in the *Journal*, but his was not.

48. M.M. Dawson, 'The Contribution of Health Insurance to Improvement of the Public Health,' *Pub. Health J.* 8 (Dec. 1917), 313-17; and I.M. Rubinow, 'Health Insurance, the Practice of Medicine and Public Health' *ibid.*, 318-27.

49. See the brief report in the *CMAJ* 7 (Dec. 1917), 1110-11.

50. See note 38, above.

51. *Ibid.*

52. 'Health Insurance,' *Pub. Health J.* 8 (Nov. 1917), 308-9.

53. 'Business and Public Health,' *ibid.* 9 (May 1918), 245.

54. 'A Federal Department,' *ibid.* (Feb. 1918), 92.

55. 'The British Labour Party,' *ibid.* (Sept. 1918), 443.

56. H.B. Small, 'Presidential Address,' in *The Canadian Medical Week* (Toronto, 1918), 1-5.

57. J.P. Morton, 'Medicine and Democracy,' *ibid.*, 7, 13, 14.

58. Again, I have been unable to find a transcript of Hastings' address. It was not among the selected papers published under OMA auspices in the volume above. However both the *CMAJ* and the *Public Health Journal* list it among the papers scheduled for the first two days of the conference, under the title 'Health Insurance.'

59. J. Heurner Mullin, 'Are We Ready for Health Insurance?' *Pub. Health J.* 9 (Sept. 1918), 402-11.

60. For a classic statement of this sort, see F.N. Stapleford, 'The Present Social Outlook' *ibid.* (May 1918), 231-3.

61. 'Editorials,' *ibid.* (Aug. 1918), 390-1.

62. G.S. Brett, 'The Ethics of Commerce,' *ibid.*, 336.

63. See note 61, above.

64. For a capsule account, see I. Abella, 'The Canadian Labour Movement, 1902-1960,' (Canadian Historical Society, Ottawa, 1975), 4-14.

65. M.G. Taylor, 'The Saskatchewan Hospital Services Plan,' (PhD thesis, UC, Berkeley, 1948), 15-17.

66. On the terms of reference for the commission, see the *Victoria Daily Colonist*, 20 Nov. 1919, in particular the comments by E.S.H. Winn, chairman of the body on the Victoria hearings, and Dr Hall's statement, see the *Victoria Daily Times*, 14 Jan. 1920. I am grateful to Professor M.G. Taylor of York University for providing the latter reference, which corrects a typographical error in his PhD thesis, 17, n.1.

67. See D.L. Matters, 'A Report on Health Insurance: 1919,' *B.C. Studies* 21 (Spring 1974), 28-32. Also, see *British Columbia Legislative Journal* 4 Dec. 1922, 127.

68. Cited by Bothwell and English, *op. cit.*, 14.