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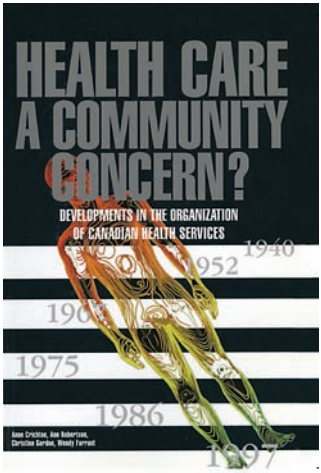

HEALTH CARE: A COMMUNITY CONCERN?
by Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant
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PART III

Canada's Publicly Financed Health Care System Evolves

CHAPTER 7

Developing Federal and Provincial Organizations for Providing Collectivist Health Services 1948–66[1]

Health Services in the Immediate Post War Years

It would have been possible to allow the Canadian health care system to evolve in the same way as the American system. In the 1930s private insurance schemes had been developed to facilitate prepayment of hospital and medical fees and these schemes had crept across the border.[2] However, Canada decided to pursue welfare state policies modelled on the British proposals for postwar reconstruction and to introduce a publicly funded collectivist health care system.[3] The *Report of the Advisory Committee on Health*

1 There is some repetition in this chapter from Chapter 2.

2 Routley (1967) has described the early prepayment schemes in Ontario and Shillington (1972) has shown the steady growth of medical care insurance between 1945 and the introduction of the Medical Care Insurance Act, 1966, implemented between 1968 and 1970.

3 Studies continued to be published in the postwar years which showed how far some provinces were behind others in their provision of health care. Three studies in Nova Scotia (Davidson and Davidson 1969; Leighton 1959, 1960; Canadian Council on Social Development 1972) identified community responses to poor working and living conditions, showing that adaptations to the stresses of daily life were not positive in that province.

The response of the Quebec reformers in the 1960s to the prospects of planning new health and social services shows that they, too, were concerned with the health of the poor. Two conflicting approaches to CLSC development, described by Lésémann ([1981] 1984), were both attempts to remedy social disintegration. The epidemiologists proposed that CLSCs should be set up where the

Insurance (Canada 1943a) reviewed the situation from a federal viewpoint as part of the welfare state plans and the government then encouraged its bureaucrats to develop conditional grant proposals to put to the 1945 Dominion-Provincial Conference on Social Reconstruction.

As discussed earlier these grant offers made at the dominion-provincial conferences of 1945–46 were not taken up at that time because of the hesitations of Ontario and Quebec to allow the federal government to move into the funding of social programs. They claimed their constitutional rights to control social affairs. But the federal government persisted with its offers, and in 1957 Ontario agreed to accept the federal proposals for funding hospital insurance and diagnostic services (Taylor 1978) while in 1963, a special agreement on cost sharing all social programs was reached with Quebec.

Development of Health Service Organization in Saskatchewan

While federal funding of health care programs was delayed, Saskatchewan had decided to bring in health care reforms at the provincial level.

In 1944 the Cooperative Commonwealth Federation (CCF) party was elected to power in Saskatchewan. Its primary objective was to introduce a publicly financed health care system and it began immediately to plan to introduce change. The Saskatchewan government brought in a consultant, Henry E. Sigerist from Johns Hopkins University, to advise it on how best to develop its plans (Roemer 1960). The public health officers had endeavoured to persuade the government to give priority to the development of primary care but the electorate made it clear that, beyond all else, people wanted protection from the high costs of hospital care.

Much of the early learning about health service planning in Canada was done in Saskatchewan where the government set up a planning commission separate from its existing administrative departments. The Saskatchewan government had hoped to get comprehensive financial support from Ottawa to develop a broadly based health care scheme all at once following the Rowell-Sirois recommendations (Canada 1940) but it was disappointed by the offers made at the Dominion-Provincial Conference on Social Reconstruction and the outcomes of this conference (Feather 1984). It had to accept incremental development as the only possibility.

Saskatchewan had a well-directed cabinet, clear about its direction and strong in its control. Although the Saskatchewan scheme could not be brought in as a total program from the start, the conception was one of a total health

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health status indicators were worst, while the social activists focussed on unstable poor communities in the large cities and proposed that the CLSCs should focus on community development.

care organization which would ensure that all citizens were able to get good medical care. The government had to make concessions to the electorate about priorities and to the doctors on whom they were dependent for technical services, thus it could not establish this total organization according to its rational plans but it tried hard to do so.

Sigerist advised the government to go along with the electors' priorities and so the introduction of hospital insurance was tackled first. A survey of existing hospitals was conducted and gaps identified (Wahn 1952) while plans were developed to raise money for operational costs from a head tax. A hospital insurance scheme was introduced in 1946.

At the same time the Saskatchewan government was endeavouring to ensure that medical care in the doctors' office would be provided when necessary. Before the war a number of rural communities had developed municipal doctor schemes. The government wanted to develop further schemes of this kind and established pilot regions in the Swift Current and Weyburn areas. Although these regional plans seemed to be very successful so far as the local people were concerned (Canada 1964) the idea met with great hostility from the doctors who did not wish to work on salary and be responsible to an elected board of management. Proposals for the development of two more regions which were subject to referenda were turned down in 1951 because the doctors persuaded the voters that it was not a good model of organization (Badgley and Wolfe 1967).

Despite growing hostility from the doctors in the province, the Saskatchewan government continued to plan for the introduction of medical care insurance which it was able to consider after the federal government provided matching grants for hospital insurance from 1957 onwards. A Medical Care Insurance Act was passed in 1962, precipitating a doctors' strike for twenty-three days. Then some compromises were worked out. Already the concept of salaried employment had been abandoned — doctors were to be paid fees for items of service — but there were struggles over the process of monitoring payments and the organization of community clinics (which had governing boards of community members). In the Saskatoon Agreement, reached with the help of an outside negotiator, it was accepted that the medical association would monitor payments, that these might be charged through insurance carriers, and that the boards of clinics would have a landlord–tenant relationship only — that they would not determine policy or management issues (Badgley and Wolfe 1967; Tollefson 1963).

In addition to these programs, the Saskatchewan government established a strong research department with good data banks — a model for all other provinces. It developed regional health services for community psychiatry in the 1950s, a provincial laboratory service, a subsidized pharmaceutical

scheme and dental care for children. It already had special cancer services as well as care for tuberculosis patients, which had been set up as public health services before the war. The province continued to investigate other areas of concern such as rehabilitation services and child health services, and gave a lead to all other provinces on what could be done to improve health care.

Pragmatism in Other Provinces and in the Federal Government

Elsewhere among the provincial politicians of this period, there was usually a pragmatic approach to picking up federal grants and the cabinets were subject to pressures from back-benchers to respond to local needs. Unlike Saskatchewan they did not stick to rational plans.

The electoral appeal of a provincially financed hospital insurance scheme led other provinces to copy the Saskatchewan model but they did not always understand how to control it effectively. While a head tax on the stable farming population of Saskatchewan was a good way to raise revenues in that province, it was not suitable for ensuring that the mobile loggers and miners of British Columbia paid their dues. In that province, hospitals tended to "cook the books" on patients' eligibility criteria when they arrived for crisis care and, in consequence, British Columbia's hospital insurance scheme did not pay its way at first. In 1952 newly elected Premier W.A.C. Bennett decided to abandon the collection of premiums and to finance the scheme from a provincial sales tax, thus moving away from the insurance principle.[4] By 1957 several provinces (British Columbia, Alberta, Newfoundland) had developed their own hospital programs (Taylor 1978).

Further Federal Moves

Unable to get acceptance of its proposals for the development of a federally supported health care insurance scheme at the Dominion-Provincial Conference on Social Reconstruction (Taylor 1978) the federal government did not give up. In 1948 it offered four National Health Grants: for provincial planning of health services, for hospital construction, and demonstration grants for innovations in public and mental health services. Saskatchewan was the only province with a health planning bureaucracy. The other provinces brought in consultants or set up committees to help develop their plans (Taylor 1953) though some used experienced public health officers to make forecasts (e.g., British Columbia 1952).

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4 Gradually most provinces have abandoned collecting premiums. British Columbia still collects them for medical care insurance and Alberta for hospital insurance but others now fund health care from general revenues (Crichton, Hsu and Tsang [1990] 1994).

In consequence, the health plans were not often carried out as they were written. There was much hospital building, for the back-bench MLAs who put pressure on governments to vary the plans did not look beyond the offer of construction grants to calculate operational costs. By the mid 1950s many provinces realized they needed federal help to continue to provide hospital services.

The federal government responded to their request for help in funding operational costs of hospitals by beginning a protracted negotiation with Ontario (Taylor 1978). (In order to pass an act the federal government had to have support of the majority of provinces and the majority of the population.) By this time the new Premier of Ontario was willing to accept federal funding for hospital insurance programs provided it could be on his terms — that is, that contributions to hospital insurance schemes should be optional not compulsory. Since it was assumed (correctly) that over ninety percent of Canadians would wish to be insured, the federal government gave way on this point and the Hospital Insurance and Diagnostic Services Act, 1957, was passed.

As discussed above, the grants, which now became available to Saskatchewan through this act, enabled that province to move towards bringing in medical care insurance. In 1961, the Canadian Medical Association, foreseeing that policies developed in Saskatchewan were likely to be adopted by other provinces, asked the federal government to set up a Royal Commission on Health Services. This commission reported in 1964, recommending that the federal government should go ahead with implementing a medical care insurance scheme. An act was passed in 1966 to bring in such a scheme but it was not implemented until 1968. However, all provinces had agreed to set up Medicare by 1970.

Although Saskatchewan had brought in other provincial programs such as Pharmacare (subsidized prescriptions for seniors and persons with disabilities) and children's dental care, the federal government decided that it would go no further with its grants-in-aid. Adding any other programs was to be left to provincial discretion. All provinces have added Pharmacare to their publicly funded programs but dental care remains in the private system except for limited provision under the school health service or in hospitals where oral surgery is provided (Stamm et al. 1986). Many provinces have private laboratories where the doctors are paid by the medical plans.

The emphasis was on gap filling. It was difficult to try to coordinate and streamline a system which was developed so incrementally and with so many interferences to the original plans (if there were any plans).

The delays in reaching agreement had unfortunate results for Canada. Grant-aided health care programs were introduced in a scattered way over

a long time period so that the first programs became overdeveloped while the other programs were still in the pipeline. Thus hospitals were overbuilt and took on work which could have been done in the doctors' offices while medical care was still privately funded.

By the end of the 1960s some federal politicians and bureaucrats were becoming concerned about the costs of the collectivist organization which had evolved. In the next chapter the questions which arose then will be considered.

Summary

The federal government wanted to bring in conditional grant aid for health and post-secondary education programs in 1945–46 but it was challenged on constitutional grounds. Meanwhile, Saskatchewan pioneered health planning but because of lack of resources it had to introduce services incrementally, and at first it followed the wishes of the electors to bring in free hospital services rather than primary care. An attempt to introduce regional programming was defeated in a referendum and when medical care insurance was introduced there was a doctors' strike. However, agreement with the doctors was reached after twenty-three days.

These defeats of government resulted in concessions to the medical profession which moved the organization of services away from an optimal collectivist model, though there were a number of successful innovations in the province such as a Saskatchewan data bank and provincial laboratory provision.

In other provinces there was no clear model of organization of collectivist health services. The politicians were pragmatists, looking for electoral advantages in introducing programs.

Nine provinces reached agreement with the federal government to accept matching grants for hospital insurance and diagnostic services in 1957. Quebec made an overall agreement with federal government in 1963 to provide health and social services similar to those of the other provinces provided it could decide on the policies. These delays in reaching agreement on funding resulted in overfunding of some programs while others were still in the pipeline and as a result, poor coordination of service provision and wastefulness in management resulted.