The Co-operative Commonwealth Federation, Health Care Reform and Physician Remuneration in the Province of Saskatchewan, 1915-1949

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ABSTRACT

This thesis examines the origins and development of medical care insurance in the province of Saskatchewan with respect to physician remuneration from 1915 to 1949. In particular it seeks to determine why the Co-operative Commonwealth Federation(CCF) government of T. C. Douglas did not follow the recommendations of its Health Services Planning Commission(HSPC) for the establishment of a state salaried medical service based on the province's extensive system of municipally employed salaried physicians. Its purpose is to provide a clearer understanding of how and why fee-for-service payment became entrenched in Saskatchewan, the birthplace of Canada's national medical care system.

The decision of the Douglas government not to implement the 1945 HSPC proposals for a salaried general practitioner service was made in the context of an alleged Saskatchewan CCF party commitment to salary remuneration and support for salaried medicine from the province's municipal doctors. This thesis assesses the validity of the various hypotheses and explanations in the established historical accounts of this policy decision and weighs them against empirical evidence. The evidence includes previously unstudied primary sources from the Saskatchewan Archives Board and the Archives of the Saskatchewan Medical Association and the College of Physician and Surgeons of Saskatchewan.

It is concluded that the CCF did not establish a salaried medical service in Saskatchewan as recommended in the 1945 HSPC proposals because: neither the party or the government was committed to salary remuneration; the policy of the Douglas government was to provide medical services to the people of Saskatchewan as rapidly as possible

with the co-operation of organized medicine; and the medical profession, including the province's salaried municipal doctors, was fervently opposed to being placed on salary.

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CHAPTER 1

INTRODUCTION

The Saskatchewan Co-operative Commonwealth Federation(CCF) government of 1944-1964 is recognized for its profound influence on the development of Canada's medical care insurance system, commonly referred to as Medicare. As the first provincial government to provide comprehensive, universal coverage for medical services, the CCF proved the feasibility of a nation-wide medical insurance scheme, and both prepared public opinion and formulated the political demands that led to the implementation of medicare by the Federal government in 1966. Moreover, the Saskatchewan Medical Care Insurance Plan served as the model for the national medicare programme.

This instrumental role of the CCF in the evolution of Canadian medicare, coupled with the ferocity and high drama of the doctors' strike in 1962, has overshadowed interpretations by many historians that the medical insurance plan implemented in Saskatchewan in 1962 was not what the CCF had intended or advocated when it came to power in 1944. In his classic study of the Saskatchewan CCF, *Agrarian Socialism: The Co-operative Commonwealth Federation in Saskatchewan*, S. M. Lipset states that the "party leaders originally envisaged a medical system in which all doctors would work on a salaried basis...."[1] Frequently based on Lipset's work, subsequent accounts of the evolution of health insurance in Saskatchewan and Canada often cite a Saskatchewan CCF commitment to a salaried medical service.[2] For example, C. David Naylor in *Private Practice and Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966* notes the following:

> The party's avowed intention of setting up a salaried state medical service worried the SCPS[Saskatchewan College of Physicians and Surgeons] which, from the 1930s on, had endorsed only "state-aided Health Insurance on a reasonable fee-for-service basis."[3]

There are historians who make no reference to a CCF resolve to replace fee-for-service(ffs) payment with the salary method, but these accounts do not challenge the general assertion found within the works of Lipset, Naylor and other scholars.[4]

The 1962 doctors' strike has also overshadowed what existing historical accounts of the step-by-step development of medical care insurance in Saskatchewan from 1944 - 1962 indicate was a less dramatic, but equally formative, conflict concerning physician remuneration in 1945.[5] Indeed, at a glance, it would appear that the CCF may have initially sought to implement a state salaried medical scheme when it came to power in 1944.

Stan Rands, for example, notes in *Policy and Privilege: A History Of Community Clinics In Saskatchewan*, "after the election of 1944, some of the early actions of the new CCF government seemed to indicate that radical policies could be expected."[6] First, the CCF appointed an internationally renowned expert on the Soviet health care system and a staunch advocate of salary remuneration, Dr. Henry E. Sigerist of Johns Hopkins University, to chair a survey of health care services in Saskatchewan. His report, submitted October 4, 1944, recommended salary remuneration.[7] Then in early 1945, the CCF government's Health Services Planning Commission(HSPC), a small group of professionals personally selected by the Premier and Minister of Public Health, T. C. Douglas, devised a medical services plan for rural Saskatchewan that envisaged the expansion and development of the province's municipal doctor system into a salaried general practitioner service. This plan was in turn presented to, and considered by, the HSPC Advisory

Committee, comprised of representatives of organized medicine and the general public, on March 2, 1945. These initiatives may have seemed like the first phase of a strategy to implement a state salaried medical service in Saskatchewan. However, a survey of existing scholarship indicates that within a year of unveiling the 1945 HSPC proposals, the government had clearly relinquished any plans it may have had to establish a provincial medical care plan with payment for physician services on a salary basis.

Organized medicine was adamantly opposed to the establishment of a state salaried medical service. SCPS representatives confronted the Premier at a private meeting March 21, 1945, registering their objections to the HSPC proposals. Existing accounts maintain that Premier Douglas and the Cabinet considered implementing the HSPC proposed salaried medical care scheme in the face of the strong opposition of the medical profession,[8] but in subsequent negotiations with the doctors during 1945 Douglas, in Naylor's words, "gave way" to the medical profession.[9] Jacalyn Duffin and Leslie A. Falk in "Sigerist in Saskatchewan: The Quest for Balance in Social and Technical Medicine," quoting Mindel C. Sheps of the HSPC Planning Commission, write:

> The HSPC issued a memorandum in favour of centralized government control and physician payment by salary, but the College of Physicians objected and, after "delay and temporizing," she wrote, "that[issue] was settled just the way the doctors wanted it...in the direction we didn't want them to go."[10]

According to Malcolm G. Taylor in *Health Insurance and Canadian Public Policy: The Seven Decisions that Created The Canadian Health Insurance System*, the 1945 HSPC proposals and the attendant friction constituted the CCF government's "first confrontation" with the medical profession.[11]

Historians agree that the CCF government of Tommy Douglas did not follow the 1945 HSPC recommendations for the establishment of a salaried medical service in rural Saskatchewan.[12] Two health policy initiatives undertaken by the CCF in 1945-1946 are identified as indicating the government's rejection of the HSPC proposals. First, following negotiations with the Saskatchewan College of Physicians and Surgeons(SCPS) during the Spring and Summer of 1945, Premier Douglas sent a letter to the SCPS that historians of Saskatchewan medicare tend to agree precluded the establishment of a state salaried medical service.[13] According to Douglas' widely-quoted letter of September 19, 1945, the SCPS would have "unrestricted jurisdiction over all scientific, technical and professional matters" and would be able to determine "the general character of the agreement and arrangements whereunder the profession will provide medical services."[14] Naylor notes that with this letter "Douglas had clearly abandoned the party's commitment to a salaried medical service under department of health auspices."[15] Similarly, Malcolm G. Taylor states that with this letter, SCPS official Dr. Lloyd Brown "happily observed that the new government now stood for health insurance rather than [salaried] state medicine."[16]

Second, in early 1946, in the Swift Current Health Region, the first of several health regions organized in the province during the CCF's first term in office, the provincial government assisted the regional health board in setting up a medical services plan for its 50,000 residents. Physicians were paid on a ffs basis.[17]

This thesis explores the apparent transformation of CCF health care policy during the Douglas government's first term in office(1944-1948). In particular, it seeks to determine why the CCF government of Tommy Douglas did not follow the HSPC recommendations for a salaried

medical scheme. The significance of this policy decision in the evolution of public health insurance in Canada was succinctly articulated by Malcolm G. Taylor:

> What if Premier Douglas had acted on the advice of his Health Planning Commission to introduce a medical care program, with general practitioners paid by salary.... Had that policy option been implemented, it is obvious that, in some parts of Canada, at least, the design of the delivery system might well have been vastly different.[18]

Indeed, some contemporary scholars maintain that the CCF concessions to organized medicine in 1945-1946 led to and entrenched ffs payment in Canada's medical care system.[19] For example, Katherine Fierlbeck in "Canadian Health Care Reform and the Politics of Decentralization" writes:

> While the original Saskatchewan blueprint for public health care envisioned salaried doctors, the medical organizations refused to sanction the scheme unless they maintained their professional autonomy through a fee-for-service system. Physicians in Canada are thus essentially private contractors rather than state employees....[20]

Despite its importance, this crucial decision and the conflict over physician remuneration in 1945 has been discussed only in passing by historians of Canadian medicare.

Historians offer three interpretations about why the CCF did not follow the 1945 HSPC recommendations for a salaried medical service in rural Saskatchewan. The first is that organized medicine's opposition and their threat that the HSPC salaried medical scheme would compel doctors to leave Saskatchewan and deter others from coming to the province induced the Douglas government to reject the HSPC proposals. For example, Malcolm G. Taylor states:

> As the Premier and the Cabinet weighed the situation and assessed the opposition of the College, it was concluded that the over-riding concern was the severe shortage of physicians in Saskatchewan, augmented by the warnings of the College that the introduction of a system as radical as that proposed by the commission would not only deter many doctors from coming but cause others to leave. This threat appears to have been the dominating factor affecting many of the Government's decisions.[21]

Lipset in *Agrarian Socialism* adds:

> The Saskatchewan government was faced with the possibility that the socialization of medicine would cause a large number of doctors to leave the province. Members of the government feared that they would then be blamed for the consequent decline in medical standards and services.[22]

Second, David C. Naylor in *Private Practice, Public Payment* maintains that Premier Douglas' "concern was to implement programs of health services as amicably and rapidly as possible."[23] Naylor suggests that this factor, coupled with SCPS opposition and its threat that the HSPC plan would both cause doctors to leave and discourage immigration, exacerbating the province's existing doctor shortage, led to Premier Douglas' concessions to the medical profession in 1945.[24]

A third interpretation is offered by Lipset in *Agrarian Socialism*. Lipset suggests that the HSPC proposals were not implemented because the people of Saskatchewan did not desire a state salaried medical service. Lipset argued that the HSPC proposals were not implemented because a) the electorate did not understand or demand qualitative changes in medical care, and b) there was a lack of organized pressure groups that supported qualitative changes:

> The Saskatchewan government, however, is not backed by an electorate that understands or demands qualitative changes in medical care. The people wanted greater and cheaper quantities of the kind of service they already had. The farmers supported "state" medicine, but to them the term meant state payment of medical care, free medicines, free hospitalization, prepayment of medical costs, and medical care of pensioners and indigents....The pressures of groups opposing social change must be counterbalanced by other powerful groups. The lack of major groups in Saskatchewan opposing the well-organized medical profession has been a large factor in the success of that group.[25]

Lipset concluded:

> Thus, government officials are faced on one hand with the popular demand for any kind of state medicine on the one hand, and, on the other, with the threat of sabotage by physicians unless the plan of their organized profession is put into practice. The compromise of the basic goals of reform of medical practice naturally followed.[26]

This thesis will test the aforementioned interpretations in the established historical accounts of the Co-operative Commonwealth Federation and the development of medicare in Saskatchewan.

In order to accurately assess physician opposition to the HSPC proposals, Chapter 2 of the thesis examines the Saskatchewan medical profession's position regarding physician remuneration, with a particular emphasis on the municipal doctor system. Malcolm G. Taylor's account of the Premier's pivotal meeting with the SCPS negotiating committee on March 21, 1945, suggests that the province's salaried municipal doctors were not opposed to the HSPC proposals. Taylor intimates that the municipal doctor representative on the negotiating committee, Dr. R. K. Johnston, was not against a salaried system in rural Saskatchewan:

> The committee accepted subsidy of doctors in remote areas, but opposed grants which could or might be used "as a means of coercion to force a salaried system of medical care in rural areas." There was one discordant voice in the College delegation, that of Dr. R. K. Johnston, a municipal doctor. He reported, as chairman of the Municipal Doctor Committee, that in a survey he had conducted, seventy-one municipal doctors "were almost 100 percent for a practice consisting of municipal contract work[salary] and outside practice[fees for major surgery], and that on the whole they favoured the municipal work as it was now operated." But his voice was lost in the committee committed, as it was, to fee-for-service.[27]
> (note. brackets by Taylor)

Dr. C. Stuart Houston, in contrast, states in the *Canadian Medical Association Journal* that the HSPC plan "at once alienated the salaried municipal doctors, for it would deny them any right to private practice or to attend any one from beyond a rigid area boundary."[28]

According to Lipset, in 1944, the residents of 101 of 303 rural municipalities, 60 villages and 11 towns with a combined population of 200,000 people received medical services from municipal doctors working on a salaried basis.[29] In view of the extent of salaried medical practice in Saskatchewan in the 1940's, official SCPS opposition may have been less of an obstacle to the establishment of a salaried

medical scheme than existing scholarship suggests, and may even have been surmountable. Hence, a study of the medical profession's opposition to the HSPC proposals must include careful consideration of the views of the municipal doctors.

Were the province's municipal doctors, as a review of the available literature suggests, entirely removed from private medical practice with the exception of the major surgery they provided on a ffs basis?[30] Did the municipal doctor prefer salary remuneration over ffs payment? Finally, were the municipal doctors favourable to a salaried medical scheme as proposed by the HSPC in 1945?

SCPS policy towards physician remuneration is also explored in this second Chapter. Taylor states that the "Commission[HSPC] members, and presumably, the premier, were unprepared for the immediate and negative response from the College" to the 1945 HSPC proposals for the establishment of a state salaried medical service.[31] This was because a SCPS brief of March 1943 concerning a post-war medical services plan stated that "We think the scheme can be combined with something equivalent to the Municipal Doctor Plan, with payment on a combined salary and fee basis."[32] What exactly did the SCPS mean by this statement? What precisely was SCPS policy towards salary remuneration and the municipal doctor system? Chapter 2 attempts to answer these questions through an analysis of SCPS records, files of the Health Services Board (a tripartite medical, rural municipality, and provincial government body set up to regulate the municipal doctor system), as well as the *Saskatchewan Medical Quarterly*, the journal of the Saskatchewan College of Physicians and Surgeons. The hypothesis put forward by Taylor and others that physician opposition caused the CCF government to reject the 1945 HSPC salaried medicine proposals is then assessed.

Chapter 3 provides an account and analysis of the submissions to three government-appointed inquiries into health services in 1943-1944. The purpose of this third chapter is to explore Lipset's interpretation that the Douglas government did not follow the 1945 HSPC recommendations because it was not backed by an electorate that supported the establishment of a state salaried medical service. In order to test Lipset's hypothesis, Chapter 3 attempts to determine the nature and extent of public support for a salaried medical scheme before the CCF came to power in 1944. To this end, the medical care policy positions of various lay organizations are examined. Special emphasis is placed on the Saskatchewan Association of Rural Municipalities (SARM), in Taylor's words, "one of Saskatchewan's most powerful political forces, representing as it did 302 rural municipalities";[33] and the State Hospital and Medical League(SHML). According to Taylor, the SHML was a confederation of voluntary and governmental organizations including homemakers clubs, fraternal societies, church and farm organizations, the Saskatchewan Teachers Federation, co-operative groups, 120 rural municipalities, six cities, twenty-four towns and fifty-six villages.[34] Naylor states that both the SHML and SARM supported the CCF salary remuneration policy.[35] These endorsements may suggest that there was significant public support for the establishment of a salaried medical service in Saskatchewan during the 1940's.

Chapter 3 also clarifies how the different lay organizations, political parties, and the medical profession understood the various terminologies in common usage in Saskatchewan for pre-paid medical services plans. These terms include "state medicine," "socialized medicine" and "health insurance." A review of the available literature suggests that the general public, political parties and the doctors

defined and utilized these terms differently. For example, Lipset states that the farming community supported state medicine, but to them the term meant free medical services,[36] rather than a state salaried medical service, as was understood by the medical profession and the HSPC.

Chapter 4 begins with a review of CCF health care policy from the 1937 until the party assumed office in 1944, with the objective of both determining and clarifying the nature of the party's commitment to salary remuneration. Lipset was the first to ascribe such a commitment to the CCF health reform plans. In *Agrarian Socialism*, he cites the "Handbook to the Saskatchewan CCF Platform and Policy," issued in 1937, to illustrate a CCF commitment to salaried medicine:

> The physicians favored health insurance under which they would continue to practice exactly as they did under private medicine, except that they would send their bills to the state instead of to the patients. The CCF, however, has long maintained that health insurance was no solution to the problem of adequate medical care. A pamphlet issued by the party in 1937 makes this position clear.[37]

Stan Rands, in *Privilege and Policy*, also cites the 1937 CCF policy booklet:

> This document declares that there is a great need for state or socialized medicine, that the health needs of the people will not be met by simple arranging for payment while the present system of practice continues, and that if we are to have prevention as well as treatment, the state must necessarily assume control. This statement makes it clear that the provincial party at the time saw medical insurance as inadequate, and sought an overall policy administered by a health plan with the professionals, including physicians, on salary.[38]

Donald Swartz also contends that such a commitment was reiterated in the party's 1944 election platform in which historians agree the party pledged to introduce "socialized medicine."[39] For example, he states in "The Politics of Reform: Public Health Insurance In Canada" that:

> The CCF had never advocated health insurance; the party's program called for "socialized medicine," which included salaried physicians working in publicly owned clinics and hospitals with some measures of popular control.[40]

Rands argues further, in support of his contention that the CCF promised to implement a salaried medical service during the 1944 provincial election, that the "party program [1944] declared in categorical terms that no insurance scheme can do the job."[41]

However, McLeod and McLeod's account of Tommy Douglas as Minister of Public Health in *Tommy Douglas: The Road to Jerusalem* suggests that, as the 1944 Saskatchewan provincial election approached, the CCF leadership was not irrevocably committed to salary remuneration. According to McLeod and McLeod, the CCF executive of Tommy Douglas and Clarence Fines "agreed in 1943 to the outlines of a medicare system...."[42] But the "question of whether doctors should work on salary or receive a fee for each service provided was left open."[43]

Did the CCF assume office in 1944 undecided in terms of how physicians ought to be paid in a province-wide pre-paid medical care scheme? Was the CCF as committed to a salaried medical scheme as many scholars contend? How exactly did the CCF define "socialized medicine" prior to and during the 1944 provincial election? CCF policy documents from the late 1930's up until and during the 1944 election are examined in Chapter 4 in order to answer these questions.

After reviewing the health care policies of the CCF party, Chapter 4 proceeds to provide an historical account, and an accompanying analysis, of the Douglas government's health care initiatives up until the unveiling of the HSPC salaried medical scheme. The controversial appointment of Dr. Sigerist to the Health Services Survey Commission(HSSC) is examined, as well as his final report. The negotiations of the CCF government's medical care plan for old age pensioners and other social assistance beneficiaries is also explored, and the significance of the government's acceptance of ffs payments is discussed. Throughout this period the pronouncements of Premier

Douglas and government officials are examined to determine the CCF government's health care policy. Was the CCF government of T. C. Douglas planning and preparing to implement a state salaried medical service?

Chapter 5 begins with a description of the 1945 HSPC proposals, with an emphasis on how the CCF health planners envisaged the implementation of a salaried medical service. This is followed by an account of the March 2, 1945, meeting of the HSPC advisory committee. Did the lay representatives on the HSPC advisory committee support the HSPC recommendations for a salaried medical service? The SCPS' meetings with the government are then revisited, from the Premier's initial confrontation with the SCPS negotiating committee March 21, 1945, until Douglas' widely-quoted letter of September 19, 1945. This examination will test Naylor's interpretation about why the HSPC recommendations for the establishment of a state salaried medical service were not implemented. Naylor writes:

> By this time the SCPS had already recognized one important fact: T. C. Douglas was a politician – not a planner. As such, his concern was to implement programs of health services as amicably and rapidly as possible. Leaders of the college repeatedly bypassed the HSPC and members of his staff to negotiate with Douglas directly, thereby winning a variety of concessions. Given the province's chronic shortage of doctors, a point of special concern to Douglas was the SCPS'S warning that sweeping changes in the provincial health care system might drive practitioners out of Saskatchewan and discourage immigration. The extent to which Douglas gave way is indicated in a letter dated 19 September 1945....[44]

The establishment of the Swift Current Medicare Care Plan is then explored to determine how it came about that ffs remuneration was instituted in this experimental medical care plan. Public reaction to this departure from the 1945 HSPC proposals is detailed as a further test of Lipset's contention that the Saskatchewan electorate did not support the establishment of a salaried medical service.

In addition, the CCF efforts to improve and expand the municipal doctor system via financial grants are examined. According to Duane

Mombourquette in "An Inalienable Right: The CCF And Rapid Health Care Reform, 1944-1948" the SCPS supported this initiative:

> The HSPC's proposals for salaried doctors working in rural health centres met with strong condemnation from the medical profession.... the College wanted medical practice based on a fee-for-service method of payment not Local Health Centres with salaried positions.... Faced with this strong opposition...the government shifted the thrust of its efforts to improving the municipal doctor system. This had been advocated as an appropriate first step by Sigerist and also had the approval of the College of Physicians and Surgeons and the old Health Services Board.[45]

MacLeod and MacLeod, in contrast, state that the SCPS was opposed to the expansion of the municipal doctor system:

> Henry Sigerist had written that the municipal doctor plans, a form of local medicare, already formed "the backbone of all medical services in the province" in 1944, and he recommended that the plans be extended and developed. The College of Physicians and Surgeons opposed the idea and by putting pressure on its members, made it almost impossible for them to pursue careers as municipal doctors on salary.[46]

The possibility is explored that this initiative was the first step in a CCF strategy to introduce a salaried scheme at a later date.

Chapter 6 presents a concluding assessment of the various hypotheses set out in Chapter 1. It attempts to provide a comprehensive explanation of why the CCF did not establish a salaried medical service in rural Saskatchewan as recommended in the 1945 HSPC proposals.

Endnotes:

[1] Seymour Martin Lipset, *Agrarian Socialism: The Co-operative Commonwealth in Saskatchewan* (Berkley: University of California Press, 1950), p. 288.

[2] Donald Swartz, "The Politics of Reform: Public Health Insurance In Canada," *International Journal of Health Services*, Vol. 23, No. 2 (1993), p. 225; Stan Rands, "The CCF in Saskatchewan" in Donald C. Kerr ed. *Western Canadian Politics: The Radical Tradition* (Edmonton: NeWest Press, 1981), p. 61; Stan Rands, *Privilege And Policy: A History of Community Clinics in Saskatchewan* (Saskatoon: Community Health Co-operative Federation, 1995), p. 98; Aleck Ostry, "Prelude to Medicare: Institutional Change and Continuity in Saskatchewan, 1944-1962," *Prairie Forum*, Vol. 30, No. 1 (Spring, 1995), pp. 101-103.

[3] David C. Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966* (Kingston and Montreal: McGill-Queens University Press, 1986), p. 136.

[4] Malcolm G. Taylor, for example, is silent on this issue.

[5] Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created The Canadian Health Insurance System* (Montreal: McGill-Queen's University Press, 1978), pp. 245-250; Naylor, pp. 139-142; Lipset, p. 293.

[6] Rands, *Privilege And Policy*, p. 99.

[7] *Ibid*; Jacalyn Duffin and Leslie A. Falk, "Sigerist in Saskatchewan: The Quest for Balance in Social and Technical Medicine," *Bulletin of the History of Medicine*, 70, (1996), p. 675.

[8] Taylor, p. 248.

[9] Naylor, p. 140.

[10] Duffin and Falk, p. 666.

[11] Taylor, pp. 245-250.

[12] Lipset, p. 293; Taylor, pp. 248-250; Naylor, pp. 140-141.

[13] Taylor, p. 250; Naylor, pp. 140-141.

[14] Taylor, pp. 249-250.

[15] Naylor, p. 141.

[16] Taylor, p. 250.

[17] Naylor, p. 142; Lipset, p. 293.

[18] Taylor, p. 417.

[19] G. Gray, *Federalism and Health Policy* (Toronto: University of Toronto Press, 1991), p. 35.

[20] Katherine Fierlbeck, "Canadian Health Care Reform and the Politics of Decentralization," in Christa Altenstetter and James Warner Bjorkman ed. *Health Policy Reform, National Variations and Globalization* (London, United Kingdom: Macmillan Press Ltd, 1997), p. 26.

[21] Taylor, p. 248.

[22] Lipset, p. 296.

[23] Naylor, p. 140.

[24] *Ibid.*

[25] Lipset, p. 297.

[26] *Ibid.*

[27] Taylor, p. 246.

[28] C. Stuart Houston, "The early years of the Saskatchewan Medical Quarterly," *Canadian Medical Association Journal*, Vol. 118 (May, 1978), pp. 1127-1128.

[29] Lipset, pp. 288.

[30] Naylor, p. 163; Taylor, pp. 246-247.

[31] Taylor, p. 245.

[32] *Ibid.*

[33] Taylor, pp. 84-85.

[34] *Ibid.*, pp. 85-86.

[35] Naylor, p. 136.

[36] Lipset, p. 297.

[37] *Ibid.*, p. 289.

[38] Rands, *Privilege And Policy*, p. 98.

[39] Rands, "The CCF in Saskatchewan," p. 61.

[40] Swartz, p. 225.

[41] Rands, "The CCF in Saskatchewan," p. 61.

[42] Thomas H. McLeod and Ian McLeod, *Tommy Douglas: The Road to Jerusalem* (Edmonton: Hurtig Publishers, 1987), p. 148.

[43] *Ibid.*

[44] Naylor, p. 140.

[45] Duane Mombourquette, "An Inalienable Right: The CCF And Rapid Health Care Reform, 1944-1948," *Saskatchewan History*, Vol. 43, No. 3 (1991), pp. 105-106.

[46] McLeod and McLeod, p. 150.

CHAPTER 2

MUNICIPAL CONTRACT PRACTICE & PHYSICIAN REMUNERATION IN THE PROVINCE OF SASKATCHEWAN: 1915-1945

Introduction

When the CCF came to power in Saskatchewan in 1944, a substantial number of the province's physicians were already remunerated on a salaried basis. According to a "Medical Manpower Survey" of the province of Saskatchewan conducted by the Canadian Army Medical Corps(CAMC) during the Second World War, in 1943, of the 408 practising physicians in Saskatchewan, 130(31.7%) were on full-time salaries and 63(15.3) were on part-time salary. As noted by the authors of the report, "this unusually high proportion of salaried physicians" was "due to the widespread adoption in the rural areas of the municipal doctor scheme."[1] Indeed, by the early 1940's more than a half of the province's rural-based general practitioners were essentially salaried employees of the governing bodies of rural municipalities, villages and towns. It was through an extension and development of this indigenous medical care system that the Douglas government's Health Services Planning Commission(HSPC) envisaged the establishment of a salaried general practitioner service in rural Saskatchewan.

This chapter seeks to determine if indeed the municipal doctor system, and in particular the municipal physician, was as conducive to the establishment of a salaried state medical service in Saskatchewan as it would appear, particularly in terms of physician support for such a project. The first section of this chapter provides a brief description of the municipal doctor system, with a particular emphasis on the scheme's private practice element. A second section consists of

an account and analysis of physician opinion and SCPS/SMA policy towards the municipal doctor system and physician remuneration in general.

The findings will be used to address the particular questions concerning the municipal doctor system set forth in Chapter 1. Were the municipal doctors entirely removed from private practice with the exception of major surgery rendered on a ffs basis? Did the municipal doctor prefer salary remuneration over the ffs method? Were the municipal doctors favourable towards a salaried medical scheme along the lines of the HSPC proposals? What exactly was organized medicine's position on municipal contract practice and salary remuneration in a provincial medical services plan?

Saskatchewan's Municipal Doctor System

As Joan Feather notes in "Early Medical Care in Saskatchewan," in the early 1900's:

> Fee-for-service practice was the mainstay of prairie medicine but it could only attract a physician where there were enough patients to support a practice and where patients could afford to pay the doctor's fees. Unfortunately, these conditions could not be met in all rural areas.[2]

The limitations of ffs remuneration gave rise to Saskatchewan's salaried municipal doctor system in rural Saskatchewan between 1915 and 1930.[3] As the system expanded during the 1930's, the scheme was adopted in areas where private practice was still viable, including some of the most densely populated and prosperous farm regions in the province.[4]

By 1943, one year before the CCF came to power in Saskatchewan, the residents of 106 rural municipalities or parts of rural municipalities,[5] 65 villages and 8 towns received general medical services, including minor surgery and maternity care, from municipal doctors. These 179 communities had a combined population of 204,788

persons, 22.8% of entire 1941 population of 895,992 persons and approximately 32% of the rural population. Nine of the 106 rural municipalities with medical care schemes remunerated physicians on a ffs basis. The remaining 97 agreements with rural municipal councils and all of the 73 contracts with villages and towns paid participating physicians a straight salary for general practitioner services.[6] In 1943, seventeen of these agreements permitted the doctor to collect deterrent fees of $1.00 to $3.00 for initial house calls (two doctors were allowed to charge $10.00); ten included fees ranging from $3.00 to $7.00 for maternity cases; four permitted fees of $2.00 to $5.00 for fractures; and four agreements "allow the doctor a fee from the patient for certain other services."[7] Sixty-three of 179 rural municipalities, villages and towns with municipal medical care plans also provided coverage for major surgical procedures; twenty-nine surgical contracts were on ffs basis.[8]

According to the 1943 CAMC survey these schemes involved 113(salaried) doctors, just over a half of the province's 213 rural-based general practitioners.[9] Seventy-three were on a full-time basis, with a contract with one or more rural municipalities. Forty physicians were on a part-time basis, with a contract with a part of a municipality, village or town. In 1941 the populations of the villages with municipal doctors plans ranged from 56 to 466 persons, with an average of 192 persons; the populations of the 5 towns with municipal medical schemes ranged from 387 to 1033 persons, with an average of 509 persons.[10] Accordingly, most town and village municipal doctor contracts would therefore not be considered full-time appointments. Part-time municipal doctors are best considered private practitioners with salaried contracts.

At a glance the 1945 HSPC proposals for the establishment of a state salaried medical service in rural Saskatchewan, modelled as they were on the existing municipal doctor system, appear as a continuation of the status quo for the province's full-time municipal physicians, with the exception that they would no longer be paid for major surgery on a ffs basis. This perception ignores the important but unacknowledged fact that, from the scheme's inception, the majority of full-time municipal doctors engaged in extensive private practice. That practice consisted of both general medical care and major surgery, in addition to the surgical care they provided to the residents of their contracting municipality on a private ffs basis. The municipal doctors referred to this private income as "outside practice."[11]

This additional private income was derived from two sources. First, all contracts with rural municipalities permitted private practice in the villages and towns situated within its geographical boundaries.[12] Second, municipal physicians both accepted cases from, and engaged in private practice, outside the borders of the contracting municipality. This was despite the fact that many of the plans established after 1937 were based on a model agreement (circa 1936-1937),[13] introduced by the Health Services Board(HSB),[14] stipulating that the municipal doctor was:

> To give his whole time and attention as a practising physician to the service of the Municipality during such employment and not to practise his profession outside of the Municipality or with respect to patients outside of the Municipality, except in some case of emergency....[15]

The model agreement also prohibited the collection of extra fees for house calls, maternity cases and minor surgery, with the exception of unnecessary calls to the home for which the doctor was allowed to collect $2 and a mileage charge.[16]

The municipal doctors were opposed to this restriction on their private practice privileges, and in the early 1940's sought to have it eliminated via a new model contract devised by Dr. J. J. Collins, a salaried municipal doctor, that strengthened and enhanced the scheme's private practice provisions.[17] Accordingly, the HSB and the Department of Health were informed that the "the physician should be allowed to practise in territory adjacent to the municipality without prejudice."[18] A special committee of the SCPS met with the provincial government and the HSB several times in late 1942 and early 1943 to discuss Dr. Collin's model contract, which had been approved by the College May 20, 1942.[19] The Deputy Minister of Health, Dr. Davidson, was "to draft a clause including the changes that would meet with the approval of both organizations."[20] However, it was not until the CCF came to power that the aforementioned restriction on private practice was eliminated. In the interim, this restriction appears to have had a marginal impact on the municipal doctors' private income. Dr. Collin's 1941 report calling for the removal of this impediment to the municipal doctors' private practice activities suggests that this restriction was neither adhered to by the majority of municipal doctors, nor enforced by municipal councils.[21]

Clearly some municipal doctors' earnings consisted almost entirely of their salary contracts. Municipal physicians in localities surrounded by other physicians on contract, and who did not perform major surgery or did so on a salary basis appear to have been completely removed from private medical practice. For example, in 1937, the municipal doctor for the rural municipality of Sarnia, whose contract of $4000 included three villages and provisions for major surgery reported to the HSB that he had "practically no private patients as I am surrounded by municipal doctors. And I do major

operations."[22] However, for many municipal doctors a substantial portion of their income was derived from private medical practice, as a SCPS survey undertaken in 1944 indicates.

At the SCPS Annual General Meeting September 18-20, 1944, Dr. R. K. Johnston, a salaried municipal doctor, reported that of the 71 physicians who replied to a questionnaire he had drafted and sent to all the municipal doctors in the province, 69 stated that they supplemented their salaries with private practice on a ffs basis. Johnston's survey also demonstrated that 70 of the 71 doctors would not be content if their incomes were restricted to their present salary. A majority of these same physicians were satisfied with their present income, i.e. municipal contract plus private practice.[23] This suggests that ffs practice was quite substantial.

According to an earlier survey conducted by Dr. J. J. Collins in 1941, 30% of the average municipal doctor's gross income of $5302.00 was earned privately.[24] One may presume that as the rural economy improved during the war, the average municipal doctor's income increased.

The monetary value of some municipal doctors' private practices appears to have exceeded their municipal contracts. For example, in a submission to the 1944 Sigerist Commission, the rural municipality of Tisdale stated that the private earnings of its municipal doctor in 1939 surpassed the remuneration of his salary of $4000.00 per annum:

> We might also add that in addition to having rendered the above services to our residents, we believe we are sufficiently well-informed to state that this doctor also rendered services to patrons under private practice that would give him more than equal that of his contract.[25]

In this context the municipal doctor cannot be equated to a salaried civil servant as envisaged in a state salaried medical service. The proceedings of the Saskatchewan Legislature's Special Select Committee on Health and Welfare(1943-1944) underscores this fact:

Mr Valleau [CCF]:

> While we recognize there are many disadvantages, which are due to the economic conditions prevailing in the districts, would you say these men [Municipal Doctors] are in the category of civil servants?

Dr. Gareau [SCPS]:

> Definitely not. Also, municipal doctors have to do a lot of private practice. Otherwise good men wouldn't stay in those districts. As far as your municipal scheme is concerned, we are all for it, but think it could be improved.[26]

The extent and magnitude of this private practice must be considered in examining municipal doctor opinion towards contract practice and other medical services schemes, particularly a system that entailed the placing of general practitioners on a straight salary with no private practice privileges.

Private Practitioners and Municipal Contract Practice

Private physicians appear to have been opposed the municipal contract practice from its inception. During his surveys of the municipal doctor scheme during the summers of 1929-1930, C. Rufus Rorem observed that:

> Private physicians in Saskatchewan on the whole express disapproval of the system, but allege that in rural areas it may be the only way to assure the continued presence of a medical practitioner.[27]

However, as the municipal doctor scheme expanded during the 1930's to densely-populated and prosperous areas where private medical practice was still economically viable, organized medicine sought to both restrict and eliminate municipal contract practice. At the Twenty-seventh Annual Meeting of the Saskatchewan Medical Association (SMA), August 20, 1934, President G. H. Lee declared in his address to the assembled physicians that:

> This system should be reserved for providing medical services for those communities, and those only, in which, because of local conditions, medical services could not well be provided in any other way. Such conditions would be where settlement is very sparse, and the amount of work done would not assure a practitioner of an adequate living on any other basis of remuneration.[28]

Dr. Lee went on to suggest that "perhaps the solution [to municipal contract practice] could be found in a system of State Health Insurance."[29]

The utility of a province-wide health insurance scheme as a means of eliminating municipal contract practice was first brought to the profession's attention in early 1933 by the SMA Special Committee on Health Insurance, chaired by Dr. S. E. Moore, a private practitioner. At a Special General Meeting, February 28, 1933, Dr. Moore presented his committee's recommendation and proposal for the establishment of province-wide health insurance scheme on a ffs basis as an alternative to the municipal doctor system.[30] In a supplement to the report, concerning the municipal doctor question, the Special Committee noted that: "if the Health Insurance Plan was adopted then there would be no call or requirement for or engaging of any particular one as municipal physician...."[31]

In the months ahead, the Special Committee's recommendation that the SMA approach and obtain the support of the provincial government and various lay organizations in the province for the establishment of a compulsory, contributory health insurance scheme on a ffs basis was endorsed by the profession. Less than a year earlier, the Council of the SMA had rejected the concept of a province-wide health insurance scheme, blaming Canadian Medical Association officials for the public's interest in state health insurance, or "state medicine" as it was often referred to in the early 1930's.[32] It would appear that opposition to an expanding municipal doctor scheme contributed to this policy shift.

The elimination of the municipal doctor system also appears to have been the impetus behind SCPS support for a provincial obstetrics plan put forward by Dr. F. H. Coppock of Rosthern at the 1935 SMA/SCPS

Annual Meeting, September 24-25, 1935. Dr. Coppock, a rural-based private practitioner, was a staunch opponent of the municipal doctor system.[33] His proposal called for the rural and urban municipalities to jointly finance all maternity cases in the province. One of the benefits cited by Dr. Coppock for such a medical care scheme was:

> nearly every Municipal Doctor would receive sufficient remuneration from this obstetric service to enable him to tear up his contract and continue to practice in the same district without being subjected to dictation, interference, or unfair dismissal.[34]

Noting that it "would help solve the Municipal Doctor question,"[35] the SMA/SCPS Joint Special Legislative Committee endorsed Dr. Coppock's maternity grants scheme at a Committee meeting January 15th, 1936.[36] Dr. Coppock's plan was presented to various lay organisations and the provincial government, but like the 1933 SMA health insurance proposal, it would appear that the provincial government was unwilling to provide the necessary financing.[37] The lack of government support most likely befell the Regina District Medical Society(D.M.S.)1938 resolution(approved by the majority of physicians in attendance at the 1938 SCPS annual meeting)and subsequent proposal calling for the replacement of the municipal doctor system with a ffs contributory health insurance scheme in rural Saskatchewan, financed jointly by the Municipal, Provincial and Federal Governments.[38]

In 1939 the members of the Regina D.M.S. also established the first doctor-controlled medical insurance plan in Saskatchewan. In response to efforts of a group of Regina citizens to establish a medical co-operative staffed by physicians on salary,[39] but also fearing that the medical "profession as a whole may of necessity become...the servants of groups of lay-people and municipal bodies,"[40] the Regina D.M.S. set up Medical Insurance Incorporated(MSI). Modelled after Dr. J. A. Hannah's Toronto-based Associated Medical Services,[41] M.S.I. remunerated physicians on a ffs basis, and offered its lay membership

choice of doctor. M.S.I. restricted its operations to Regina in its inaugural year, but the Regina D.M.S. aspired to extend the scheme into rural Saskatchewan.[42]

To this end, the SCPS successfully lobbied the provincial government to amend, in early 1940, the Municipalities Act to allow municipal councils to engage the services of physicians on a ffs basis.[43] As well, the Municipal Medical and Hospital Services Act was amended to permit groups of physicians, such as M.S.I., to enter into medical services agreements with municipalities.[44] Although M.S.I. did not enter into any agreement with a rural municipality for general practitioner services until after the CCF had came to power in 1944, the aforementioned amendments permitted the establishment of municipal doctor plans on a ffs basis. Indeed, in his 1941 report to the SCPS on the municipal doctor system, the president of M.S.I, Dr. Lloyd Brown recommended that municipal physicians obtain ffs contracts.[45] By May of 1944, 10 rural municipalities were paying their doctors on a ffs basis for general practitioner services.[46]

This Regina D.M.S. initiative coincided with the 1941 survey mentioned previously by Dr. J. J. Collins, a salaried municipal doctor, concerning physician opinion towards the municipal doctor system, health insurance, and "state medicine," which the SCPS defined as a medical care system in which all physicians would be salaried civil servants. Concerning private practitioner opinion of the municipal doctor system, Dr. Collins reported that "the non-contract doctors were in general averse to Municipal medicine."[47] However, his survey also indicated significant support for salaried state medicine among the province's private practitioners, albeit exclusively among rural-based physicians:

> What system of practice is the choice of the physician?....The Rural Doctors[private practitioners]also favoured private practice although many of the older men expressed preference for State Medicine and the younger men for Health Insurance. In the case of the Municipal Doctors, private practice seemed to be the type of practice of choice, but Municipal and State Medicine had many followers and Health Insurance a few. Of the Rural Doctors a large percentage favoured State or Municipal Medicine, while neither of these systems found one supporter in the Urban centres.[48]

In terms of what medical care system was most suitable to Saskatchewan according to medical opinion, Dr. Collins stated:

> In the Rural centres the doctors were reasonably unanimous in declaring private practice to be no longer feasible and in the case of the Municipal Doctors they were unanimous in this regard. The Municipal Doctors believed the Municipal system to be most suitable while the men in private practice believed State Medicine to be the most suitable with Health Insurance and Municipal Medicine having their sponsors. In summarizing we may say that where private practice is no longer feasible, then, for Urban centres, Health Insurance is the most suitable system while for Rural localities Municipal or State Medicine is to be preferred to Health Insurance. This is the consensus of opinion of the doctors intimately acquainted with their territory.[49]

These responses may suggest that rural-based private practitioner support for state medicine was to a large degree, contingent upon whether or not private medical practice was feasible.

Official SCPS policy with respect to state medicine, health insurance and municipal contract practice and, in turn, physician remuneration within a provincial medical services plan in post-war Saskatchewan took shape in the early 1940's beginning at meeting March 18, 1942, called specifically to deal with these issues.[50] The physicians in attendance re-affirmed SCPS support for "state-aided health insurance on a reasonable fee-for-service-rendered basis."[51] In doing so, the SCPS simultaneously rejected a scheme of salaried state medicine for the province.

This initiative was motivated by a presentation, on the eve of March 18, 1942, to the Regina D.M.S. by the Secretary of the Canadian Medical Association, Dr. Routley, on the contributory health insurance proposals of the federal Department of Pensions and National Health. Developed in close consultation with CMA officials,[52] the federal draft

legislation envisioned a health insurance programme financed by individual premiums, employer contributions and government subsidy. In terms of physician remuneration, doctors would be paid by salary, capitation, ffs or a combination thereof, as determined by the "Provincial Commission."[53] Dr. Routley encouraged the SCPS to officially endorse contributory health insurance as envisioned in the forthcoming federal proposals.

As recommended by the Regina D.M.S., the Council of the SCPS set up a "committee on health insurance," initially comprised entirely of private practitioners, to study the federal proposals and prepare SCPS policy with respect to the implementation of the federal scheme in Saskatchewan.[54] Accordingly, the health insurance committee set to work preparing an official remuneration policy. In the interim, however, the SCPS submitted a brief to the Saskatchewan Legislature's Select Special Committee on Social Security and Health Services that contained a position on payment of doctors.

As Malcolm G. Taylor notes in *Health Insurance and Canadian Public Policy* the SCPS brief stated that:

> While we are firmly of the opinion that any scheme of health insurance should in general provide for the patient a free choice of his medical attendant where practicable, and services should be paid for on a reasonable and agreed fee for services rendered basis, we do think the scheme can be combined with something equivalent to the present Municipal Doctor plan, with payment on a combined salary and fee-for-service basis.[55]

Nevertheless, salary remuneration for general practitioner services was only acceptable to the SCPS leadership in sparcely settled areas with a population insufficient to maintain a doctor on a ffs basis:

> Point 15 of the Canadian Medical Association health insurance principles attached hereto provides that the contract-salary service be limited to areas with a population insufficient to maintain a general practitioner without additional support from the insurance fund.[56]

Strict adherence to such a policy would entail the dismantlement of the salaried municipal doctor system and the re-introduction of ffs in the

densely-populated and more prosperous rural areas, as a Liberal member of the Select Special Committee pointed out to the SCPS delegation:

> Dr. Danielson (Liberal):
>
> In Saskatchewan a large number of municipalities place the medical doctor on salary and yet they are some of the most advanced districts in the Province. Would you suggest that be done away with and have it only in places where poor roads are and in far-out districts? I think we have 100 municipalities in the Province that are in the hospitalization schemes. I know in my own district that there are some doing that and it is just as progressive a part of the province as any. Would it be your suggestion that the municipalities would discontinue that practice and go in on a "pay" or "fee" basis?
>
> Dr. Gareau (SCPS):
>
> Well, we have not any definite decision on that.
> That is something that would have to be worked out.[57]

Dr. Danielson's query and Dr. Gareau's evasive response reflected the popularity of the salaried municipal doctor system in rural Saskatchewan.

During the summer of 1943 the SCPS "Central Health Insurance Committee" completed and sent to all members of the medical profession two resolutions with respect to physician remuneration in provincial health insurance scheme. The first resolution called for ffs remuneration, and combined salary/ffs "contract arrangements similar to present Municipal Doctor schemes" in areas of the province where ffs payment alone was not viable.[58] A second called for the "Capitation System[to] be eliminated entirely from any Health Scheme in Saskatchewan."[59]

This resolution was re-submitted to the Health Insurance Committee for further study after the SCPS General Meeting, September 16-17, 1943, "refused to deal with the resolution."[60] The Health Insurance Committee, in turn, after failing to arrive at an agreement at a meeting January 30, 1944, appointed a subcommittee on remuneration to consider the resolution.[61] In addition, the subcommittee was to draft

a response to a request from the government-appointed Saskatchewan Reconstruction Council(SRC)for a "clear statement of where the College stands on the question of methods of remuneration."[62] The SCPS had previously submitted its brief to the Saskatchewan Legislature's Select Special Committee on Social Security and Health Services to the SRC with a note that since its presentation "we have seen no reason to change our views."[63] The SRC noted that the CMA in its brief to the Federal government-appointed Advisory Committee on Health Insurance, chaired by John J. Heagerty, stated its "acceptance, in principle, of both fee-for-service and capitation fee methods of payment, not even going definetly(sic) in favor(sic)of the former...."[64] The SCPS was asked if a "panel system, or even payment by salary, be more acceptable, if adequate provision were made for leave of absence for post-graduate and research work."[65]

It is worth mentioning here that at the SCPS annual meeting of September 1943, Dr. C. J. Houston of Yorkton presented a ffs contributory health insurance scheme to the Central Health Insurance Committee that he devised together with Dr. R. A. Dick of Canora(also a private practitioner). Like the earlier SMA/SCPS and Regina D.M.S. proposals, this medical care plan envisaged the discontinuation of salaried municipal doctor practice. In thinly-populated areas where ffs alone could not provide a physician with an adequate income, instead of municipal contract, doctors would be paid a subsidy to supplement their ffs earnings.[66]

The remuneration subcommittee recommended ffs for both urban and rural Saskatchewan, with municipal contract as an "alternative plan" in rural areas, noting that "Under present conditions, these two plans are frequently combined-even those doctors on contract supplement their

earnings by fee-for-service."[67] The subcommittee considered this recommendation to be a rejection of the capitation method.[68]

A minimum salary of $6000 was recommended for municipal doctors for general practitioner services, with services exceeding this amount to be paid on a ffs basis. The committee suggested that surgery rendered by municipal physicians be on a ffs basis.[69]

Although the remuneration committee indicated a preference for ffs outside of "sparsely settled and remote areas" where only the salary method would "retain a medical man,"[70] unlike the SCPS brief to the Select Special Committee on Social Security and Health Services, it did not explicitly recommend that salary remuneration be confined to areas "with a population insufficient to maintain a general practitioner without additional support from the insurance fund,"[71] as set forth in the CMA principles on Health Insurance.

The remuneration subcommittee recommendations were officially approved by the SCPS as part of the "conclusions of the Central Health Insurance Committee," at its 1944 annual meeting September 18-20, 1944.[72] In the interim, they were submitted to the SRC along with the following reply to a query concerning the SCPS views towards the formation of group practice clinics:

> In Saskatchewan there is the municipal system of doctors, which is giving an excellent service, and if "the gaps are filled" and if adequate salaries are provided so that the municipal system of doctors will retain its excellent men and attract others, a most efficient service will be available.[73]

These submissions appear to have given the SRC the impression that the SCPS was agreeable to a substantive municipal doctor system in rural Saskatchewan within a ffs provincial health insurance plan:

> ...the fee-for-service method of payment is the one generally recommended by the College of Physicians and Surgeons. Exceptions are doctors in institutions, and doctors in areas where the number of patients is not sufficient to support a doctor on this basis. They would also approve a modified scheme for rural districts of hiring doctors on a salary basis for general practice with extra fees for surgery and special services.[74]

The subcommittee's endorsement of salaried municipal contract practice, without any qualifications, and the omission of the CMA/SCPS principle that salary remuneration be confined to areas where ffs was not feasible may have been due to the influence of R. K. Johnston, a salaried municipal doctor, and R. G. Ferguson, specialist(salary) and father of Saskatchewan's world renowned anti-tuberculosis programme.[75] Both physicians, late appointments to the SCPS Central Health Insurance Committee, served on the remuneration subcommittee. In a letter to subcommittee chairman Dr. J. A. Valens(private practitioner) outlining his views on physician remuneration in a provincial medical care scheme Dr. Ferguson indicated that he was not opposed to salary remuneration for general practitioner services in the heavily populated areas of rural Saskatchewan.[76]

As we shall see, R. K. Johnston's fervent and vocal support for salaried municipal contract practice, coupled with the fact that Johnston practised in one of the most prosperous farm districts in the province, would suggest that he, also, would not be in agreement with the CMA/SCPS principle that salary municipal doctor contract should be restricted to sparsely-settled and isolated areas of the province. These views may explain the leadership's concerns with respect to professional unity, as well as complaints by private practitioners that there were too many salaried doctors on the SCPS' Health Insurance Committee(see Chapter 4, p. 85).

The SCPS briefs to both the Saskatchewan Legislature's Select Special Committee on Social Security and Health Services and the Saskatchewan Reconstruction Council were presented to the Health Services Survey Commission chaired by Henry E. Sigerist, the third government-appointed inquiry into health services in 1943-1944.

Municpal Doctors and SCPS Policy

Despite the SCPS official stance towards municipal contract practice, many municipal physicians appear to have been content with this form of medical practice. For example, in the March 1938 edition of the *Canadian Doctor*, R. K. Johnston, a salaried municipal doctor, stated:

> At recurrent intervals articles appear in our journals referring to Municipal Contract Practice, and so far, any that I have seen have spoken strongly against such practice. The remarkable part of this to me is that all that has been written against Municipal Contract Practice has been written by doctors who have never held a municipal contract....It has been my custom to for some years, while attending medical conventions or district medical meetings, to contact other Doctors whom I knew to be on Municipal Contract, to get their views and without one exception they have all told me they considered it to be the ideal form of practice, patient and doctor both considered....While the method of obtaining a municipal contract has at times been unfair and has proved a hardship to a doctor who was already giving good services to the district, and while the contracts should be made to conform more to a standard and passed on by a committee representative of our own profession before being accepted by the doctor; still I do not feel that I am unethical in accepting a municipal contract....[77]

Dr. J. J. Collins' 1941 survey also suggested significant support for the municipal doctor system:

> The district or municipality being satisfied, our problem is to determine whether our municipal doctors are satisfied. With some qualifications one might say that they are. Such remarks as these are quite clear on this point, - "I like the system very much. Have been a Municipal Doctor for three years and am perfectly satisfied with my contract."– "Thoroughly satisfied after twenty-one years in Municipal practice." Others though voicing no great complaint desire some modification to it.[78]

However, the replies to Dr. Collins' questionnaire suggest that a majority of these physicians preferred a totally private ffs system:

> What system of practice is the choice of the physician?...In the case of the Municipal Doctors, private practice seemed to be the type of practice of choice, but Municipal and State Medicine had many followers and Health Insurance a few.[79]

In terms of health insurance, as noted above, Dr. Collins reported that there was a question as to its feasibility in rural Saskatchewan.

The particular concerns and interests of the municipal doctors with respect to a provincial medical services plan were manifest at the SCPS "special meeting" of March 18, 1942, when Dr. Lloyd Brown,

President of the Regina D.M.S, moved that the college endorse "state-aided health insurance on a reasonable fee-for-service-rendered basis."[80]

However, as recorded in the Minutes:

> Dr. J. J. Collins, Ituna, believed that there were many viewpoints on this question and many things to be considered, as although this motion is to be the view of all the doctors in Saskatchewan, yet there were 20% already in State Medicine. This proposal was based on three parties contributing, one being the Government, another the employer, which would be satisfactory for the urban people but not for the rural regions where there are mostly farmers, and that this would have to be a provincial or a municipal matter for the raising of funds. He did not think that the men present were prepared or had given much serious thought to be able to give an intelligent vote also that there were less than 10% of the professional men at this meeting.[81]

Another salaried municipal physician, Dr. MacDonald of Ceylon, "agreed with Dr. Collins that it was impossible to work on an insurance plan as yet."[82] Further discussion suggested support for salary remuneration among the municipal doctors:

> Dr. Abrasom[municipal doctor] was questioned whether he would prefer a salary, and he replied in the affirmative.[83]

However, Dr. Brown's assertion that the resolution before the meeting could be "passed without prejudicing the position of municipal doctors as it is left wide open as to local conditions and this was kept in mind when drawing up the resolution"[84] appears to have assuaged the concerns of the salaried doctors; when Dr. Brown's resolution was put to a vote, it carried unanimously.[85]

The apparent support for contract practice among the municipal doctors was both affirmed and forcefully conveyed to the province's private practitioners by R. K. Johnston at the SCPS Annual General Meeting September 16-17, 1943. Johnston's address may suggest that many municipal physicians disagreed with CMA/SCPS policy that in a national or provincial health insurance programme salaried contract practice should be restricted to the sparsely populated and

economically depressed areas of the province where ffs remuneration was not feasible:

> (b) Dr. R. K. Johnston of Eston reviewed health insurance from the viewpoint of the municipal doctor: "...I have contacted many of the Municipal Doctors to get their views, and without one exception, they have told me they consider Municipal Practice to be the ideal form of practice, patient and Doctor considered....The Doctor feels free to carry out whatever treatment he may consider best, as only loss of time has to be considered. Eston is one of the most prosperous farming districts in the province; the Municipal doctor scheme was not introduced there as a direct relief measure...so I feel that Health Insurance can be worked equally satisfactorily for both health services...Many of you will not agree with what I have said, however, no subject is well dealt with until it has been well discussed."[86]

Although Dr. Johnston indicated support for the salaried municipal doctor system, it is important to emphasize that he would not support a straight salaried system in the rural areas:

> ...At present municipal contracts allow Doctors to engage in outside practice. I would not concur in any plan of Health Insurance which would take away the element of competition or limit the Doctor in the scope of his practice....[87]

These latter sentiments appear to have been representative of the province's municipal physicians. In a summary of the comments received from the 71 municipal doctors who responded to R. K. Johnston's 1944 "questionnaire re Health Insurance," Johnston reported that the "Municipal Doctors are not in favour of [salaried] State Medicine."[88] In addition, although "fairly well satisfied with this form of practice (municipal contract plus private practice)," the respondents preferred ffs remuneration by 60 to 11.[89] A survey conducted by the Central Health Insurance Committee in early 1944 also revealed that the majority of municipal physicians preferred ffs remuneration:

> The replies from the municipal men so far agree substantially that any plan should be state-aided contributory health insurance with control in the profession on medical matters. In the matter of remuneration there is some difference of opinion, although the tendency seems to be for a fee-for-service.[90]

The average municipal doctor was not simply a salaried physician. Some municipal physicians' earnings consisted almost entirely of their salary contracts. Municipal doctors surrounded by other municipal medical care plans and who did not perform major surgery, or did so on

salary, relied on salaries. But for many doctors a substantial part of their income was on a private ffs basis. This private income consisted of both general medical care and major surgery from within(villages and towns) and outside the borders of the contracting municipality. The private income of some municipal doctors was equal to or exceeded their annual salaries. In this context the municipal doctor cannot be equated to a salaried civil servant as envisaged in a state salaried medical service.

The municipal doctors attached great importance to both their private income and private practice privileges, as evidenced by their efforts in the early 1940's to strengthen and enhance the scheme's private practice provisions via the introduction of a new "model" contract.

Several surveys of municipal physician opinion undertaken in the late 1940's also indicated that the vast majority of the province's municipal doctors supported and desired the continuation of municipal contract practice that both included and permitted a significant amount of private practice. In terms of a province-wide medical services scheme, in the early 1940s, many municipal doctors and rural-based private practitioners believed that contributory health insurance on a ffs basis, as advocated by the SCPS, was not financially feasible in many areas of rural Saskatchewan. In this context, many municipal doctors wanted to be able to continue to earn a living on a combined salary and ffs basis as municipal doctors or otherwise within a province-wide health insurance scheme. They did not, however, support the establishment of a salaried medical service.

The province's private practitioners were opposed to the salaried municipal doctor system from its inception. Beginning in the early 1930's organized medicine sought to have the municipal doctor scheme

eliminated via the establishment of a province-wide ffs contributory health care plan or a maternity care program. As early as 1934 the SCPS presidency declared that municipal contract practice should be reserved only for communities where, because of local conditions, medical services could not be provided in any other way. This viewpoint was submitted as SCPS policy in the college's submission to the 1943-1944 Special Select Committee on Social Security and Health Services. This policy was re-iterated, albeit it would appear with more flexibility, in the SCPS submission to the Saskatchewan Reconstruction Council in 1944. However, there was support among the province's salaried municipal doctors for the preservation and extension of the contract scheme beyond the poor and sparsely populated areas where ffs remuneration could not retain the services of a physician.

The province's salaried municipal doctors clearly were not the embryo of a state salaried medical service. Nonetheless, as we shall see, the municipal doctor system was the basis of a conviction and hope among some residents in Saskatchewan that a salaried medical service could be established in this sparsely populated prairie province of Western Canada.

Endnotes:

[1] Saskatchewan Archives Board, Regina (hereafter SABR), Records of the Health Services Survey Commission (hereafter HSSC) file 34, "Medical Man Power Survey, M. D. #12, Statistical Report," (circa 1943), p. 14.

[2] Joan Feather and Vincent L. Mathews, "Early Medical Care in Saskatchewan," *Saskatchewan History*, Vol. XXXVII, No. 2 (Spring, 1984), p. 50.

[3] For an account of the development of the municipal doctor system in Saskatchewan see C. Rufus Rorem, *The "Municipal Doctor" System In Rural Saskatchewan* (Chicago, Illinois: The University of Chicago Press, 1931); Feather and Mathews, *supra*, pp. 47-52; C. Stuart Houston, "Saskatchewan's municipal doctors: a forerunner of the medicare system that developed 50 years later," *op. cit.*, pp. 1642- 1644; Malcolm G. Taylor, *Health Insurance and Canadian Public Policy*, *op. cit.*, pp. 70-71.

[4] R. K. Johnston, "We Like Municipal Contract Practice!" *Canadian Doctor*, (May, 1938), p.19; *Saskatchewan Medical Quarterly* (hereafter SMQ), Vol. 7, No. 1 (December, 1943), pp. 14-16.

[5] A rural municipality is a rural geographical unit of local government consisting of 6 to 12 townships, each township being an area of six miles square. It does not include incorporated towns and villages within its boundaries. During the 1940s, the majority of 302 rural municipalities in the province were made up of nine townships or eighteen miles square, containing on average 2100 residents. Each rural municipality was administered by an elected council of one reeve and six councillors, with powers similar to those vested in the council of a village, town or city. R. G. Ferguson, "Report of Committee On Economics," Vol. 2, No. 4 (October, 1938), p. 16; Dr. R. O. Davison, "Municipal Medical Services In Saskatchewan," *SMQ*, Vol. 5, No. 3 (August, 1941), p. 12.

[6] Saskatchewan Archives Board, Saskatoon (hereafter SABS), Records of the Health Services Board (hereafter HSB), file 2, "Health Services Board: Municipal Medical Services," circa 1943, pp. 1- 4, 10-13; Health Services Board Submission to Select Committee of the Legislative Assembly of Saskatchewan re. Social Welfare etc., Regina, March 28, 1943, pp. 4-5.

[7] SABS, HSB, file 2, "Health Services Board, Municipal Medical Service, Rural Municipalities," (circa 1943-1944), pp. 2-3.

[8] SABS, HSB, file 2, "Health Services Board: Municipal Medical Services," (circa 1943), pp. 3, 10-11.

[9] SABR, HSSC, file 34, "Medical Man Power Survey, M. D. #12, Statistical Report," (circa 1943), Table 3.

[10] *Ibid.*

[11] See, for example, Johnston, *supra*, pp. 17-19; *SMQ*, Vol. 7, No. 1 (December, 1943), pp. 14-16.

[12] Davison, *supra*, p. 13.

[13] In 1943, the Health Services Board reported that 76 of the 106 rural municipalities or parts there of with municipal doctor plans had adopted the principles of the model contract. SABS, HSB, file 2, "Health Services Board, Municipal Medical Services, Rural Municipalities," p. 1.

[14] The Health Services Board was established in 1934 to oversee and regulate the municipal doctor system. The Board was comprised of equal representatives from the SMA/SCPS, the Saskatchewan Association of Rural Municipalities, and the provincial government.

[15] SABR, Papers of Dr. John Michael Uhrich (hereafter Uhrich Papers), file 13.2, "Model Municipal Physician Agreement: Memorandum for Dr. Davison," 15 May 1942.

[16] SABS, HSB, file 2, "Municipal Medical Services of Saskatchewan, May 1941," p. 2.

[17] At a SCPS meeting March 18, 1942, Dr. J. J. Collins presented a new model salary municipal doctor contract that he devised with the aid of a survey of municipal doctor opinions undertaken in 1941. This new contract strengthened and augmented the existing Health Services Board model contract private practice provisions. First, physicians would contract with the municipality for 300 as opposed to 365 days of service. For services rendered on the 65 days not covered by the 300-day contract, Sundays, statutory holidays and several days of vacation, the physician would be paid on a fee-for-service basis. Second, the model contract explicitly stated the physician's right to engage in private practice outside the confines of the contracting municipality. Third, municipal physicians would collect fees for all out of office calls, maternity cases ($5.00), and travelling expenses. This model contract, which Dr. Collins claimed was a "representation of the average viewpoint of the municipal doctors," was approved by the SCPS May 20, 1942. Dr. J. J. Collins, "A Proposal for Modification of the Municipal Doctors Contract and Suggested New Model Contract," *SMQ*, Vol. 6, No. 1(April, 1942), pp. 15-26.

[18] SABR, Uhrich Papers, file 13(2), "Model Municipal Physician Agreement: Memorandum for Dr. Davison," 15 May 1942.

[19] *SMQ*, Vol. 6, No. 2 (August, 1942), pp. 12-25.

[20] *SMQ*, Vol. 6, No.1 (April, 1943), pp. 17-18.

[21] Dr. J. J. Collins, "A Proposal For Modification of the Municipal Doctor Contract: And Suggested New Model Contract," *supra*, pp. 15-16.

[22] SABS, HSB, file 5, C. S. MacLean to Dr. Davison, 19 February 1937.

[23] *SMQ*, Vol. 8, No. 4 (December, 1944), p. 18.

[24] J. J. Collins, "State Medicine, Health Insurance and Hiring Municipal Doctors," *SMQ*, Vol. 5, No. 4 (December, 1941), p. 21.

[25] SABR, HSSC, file 12, "Rural Municipality of Tisdale, HSPC re. Brief on Medical Services, Sept 15, 1947," p. 4.

[26] SABR, HSSC, file 30, "Relevant Material in Proceedings of Select Special Committee on Social Security and Health Services," (unpaginated).

[27] Rorem, *supra*, p. 74.

[28] SMA/SCPS, Saskatchewan Medical Association, "Twenty–seventh Annual Meeting, August 20th, 1934," p. 2.

[29] *Ibid.*, p. 3.

[30] SMA/SCPS, "Annual Meeting, September 22nd, 23rd and 24th 1932 And Special General Meeting, Saskatoon Saskatchewan, February 28th, 1933," pp. 25-26.

[31] *Ibid.*, p. 31.

[32] SMA/SCPS, College of Physicians and Surgeons of Saskatchewan, *Annual Report*, September 1932, pp. 20-1.

[33] Frank H. Coppock, "The Menace of Contract Practice," *Canadian Doctor* (March, 1938).

[34] SMA/SCPS, "Minutes of the 28th Annual Meeting of the Saskatchewan Medical Association and the College of Physicians and Surgeons, September 24th, 25the and 26th, 1935," p. 8.

[35] SMA/SCPS, "Minutes of Meeting of the Joint Special Legislative Committee," 15 January 1936.

[36] *Ibid.*

[37] SMA/SCPS, "Minutes of the Annual Meeting of the Saskatchewan Medical Association and the College of Physicians and Surgeons of Saskatchewan, September 22, 1936," pp. 5-6.

[38] *SMQ*, Vol. 2, No. 4 (October, 1938), p. 22; *SMQ*, Vol. 3, No. 1 (January, 1939), pp. 6-8. The Regina D.M.S passed and introduced a similar resolution to the 1935 SCPS annual meeting. SMA/SCPS, "Minutes of the 28th Annual Meeting of the Saskatchewan Medical Association and the College of Physicians and Surgeons, September 24th, 25the and 26th, 1935," pp. 3-4.

[39] Robin Badgley and Samuel Wolfe, *Doctors' Strike: Medical Care and Conflict in Saskatchewan* (Toronto: Macmillan of Canada, 1967), pp. 16-17.

[40] *SMQ*, Vol. 3, No. 4 (November, 1939), p. 22.

[41] *Ibid.*, p. 16.

[42] *Ibid.*, p. 17.

[43] SMA/SCPS, file "Medical Services Incorporated Regina," Dr. G. K. Lindsay to Hon. R. J. M. Parker, Minister of Municipal Affairs, 28 February 1940; Davison, "Municipal Medical Services In Saskatchewan," *supra*, pp. 12-13.

[44] *SMQ*, Vol. 5, No. 1 (January, 1941), p. 6.

[45] Dr. J. L. Brown, "Hiring Municipal Doctors," *SMQ*, Vol. 5, No. 4 (December, 1941), pp. 25-26.

[46] SABS, HSB, file 2, "Municipal Medical And Hospitalization Schemes, May 1, 1944."

[47] J. J. Collins, "State Medicine, Health Insurance and Hiring Municipal doctors," *supra*, p. 13.

[48] *Ibid.*, p. 16.

[49] *Ibid.*, p. 17.

[50] SABR, Uhrich Papers, file 18(4), A. W. Argue to the members of the College of Physicians and Surgeons of Saskatchewan, 2 March 1942.

[51] *SMQ*, Vol. 6, No. 1 (April, 1942), pp. 46-47.

[52] Naylor, *Private Practice, Public Payment, op. cit.*, pp. 102-107.

[53] *SMQ*, Vol. 7, No. 2 (August, 1943), p. 12.

[54] *Ibid.*, pp. 29-30.

[55] SMA/SCPS, The Council of the College of Physicians and Surgeons of Saskatchewan, "Submissions To The Select Committee of the Legislative Assembly of Saskatchewan, March 1943," p. 4.

[56] *Ibid.*, p. 5.

[57] SABR, HSSC, file 30, "Relevant Material in Proceedings of Select Special Committee on Social Security and Health Services," (unpaginated).

[58] *SMQ*, Vol. 7, No. 7 (December, 1943), p. 19.

[59] *Ibid.*

[60] SMA/SCPS, file 2-9-4, "Bulletin #3 of the Central Health Insurance Committee," February 1944.

[61] *Ibid.*

[62] *SMQ*, Vol. 8, No. 2 (June, 1944), p. 10.

[63] *SMQ*, Vol. 8, No. 1 (March, 1944), p. 9.

[64] *SMQ*, Vol. 8, No. 2 (June, 1944), p. 10.

[65] *Ibid.*

[66] *SMQ*, Vol. 7, No. 3 (December, 1943), pp. 27-31. There is no evidence in the Saskatchewan Medical Quarterly or the holdings of the SCPS/SMA Archives to suggest that this plan was ever officially endorsed by the SCPS; however, in September of 1944 Dr. Houston informed the Sigerist Commission that the SCPS annual meeting of September 1943 passed a "vote of approval" with respect to this fee-for-service health insurance scheme. SABR, HSSC, file 12, Dr. C. S. Houston to Dr. Mindel Sheps, 6 September 1944.

[67] *SMQ*, Vol. 8, No. 2 (June, 1944), p. 8.

[68] *Ibid.*

[69] *Ibid.*, p. 9.

[70] *Ibid.*, p. 8.

[71] SMA/SCPS, The Council of the College of Physicians and Surgeons of Saskatchewan, "Submissions To The Select Committee of the Legislative Assembly of Saskatchewan, March 1943," p. 4.

[72] *SMQ*, Vol. 8, No. 3 (December, 1944), pp. 9-10.

[73] *Ibid.*, p. 14.

[74] Saskatchewan Reconstruction Council, *Report of the Saskatchewan Reconstruction Council*, (Regina: King's Printer, 1944), p. 174.

[75] C. Stuart Houston, *R. G. Ferguson: Crusader against Tuberculosis*, (Toronto: Hannah Institute & Dundurn Press, 1991).

[76] SMA/SCPS, file 2-9-6, Dr. R. G. Ferguson, "Remuneration of Physicians," circa 1944.

[77] Johnston, *supra*, pp. 17-19.

[78] J. J. Collins, "State Medicine, Health Insurance and Hiring Municipal Doctors," *supra*, p. 18.

[79] *Ibid.*, p. 16.

[80] *SMQ*, Vol. 6, No. 1 (April, 1942), p. 46.

[81] *Ibid.*, p. 52.

[82] *Ibid.*, p. 54.

[83] *Ibid.*, p. 53.

[84] *Ibid.*, p. 52.

[85] *Ibid.*, p. 53.

[86] *SMQ*, Vol. 7, No. 1 (December, 1943), pp. 14-16.

[87] *Ibid.*, p. 16.

[88] *SMQ*, Vol. 8, No. 4 (December, 1944), pp. 17-18.

[89] *Ibid.*

[90] SMA/SCPS, file 2-9-4, "Bulletin #2 of the Central Health Insurance Committee," p. 1.

CHAPTER 3

THE POLITICS OF HEALTH CARE REFORM IN 1940's SASKATCHEWAN: HEALTH INSURANCE VERSUS STATE MEDICINE

Introduction

The "medical crisis" of the 1930's engendered broad public support for the establishment of a provincial medical services plan in Saskatchewan that remained long after the hardships of the depression had ended.[1] The health care debate in the 1940's, both prior to and after the CCF came to power, was not therefore about whether there should be a provincial or national medical services plan, but rather what form it ought to take. In this context, three government-appointed inquiries into health services and post-war reconstruction conducted extensive public opinion surveys with respect to provincial medical services in 1943-1944: the Select Special Committee on Social Security and Health Services; the Saskatchewan Reconstruction Council; and the Health Services Survey Commission.

This chapter will attempt to ascertain and assess the level of support for salary remuneration among the general public via an examination of the submissions to these inquiries. This chapter also documents the conflict between the State Hospital and Medical League and organized medicine over the direction of health care reform in Saskatchewan. The findings of this chapter will facilitate a test of Lipset's hypothesis that the CCF government of Tommy Douglas did not follow the 1945 HSPC recommendations for a salaried medical service because of the lack of public support for such a scheme. First, this chapter clarifies how the terms "state medicine," "health insurance"

and "socialized" medicine/health services were understood and utilized in Saskatchewan.

State Medicine, Health Insurance and Socialized Medicine

During the 1930's the terms "state medicine," "health insurance," and "socialized" medicine/health services were all used loosely and interchangeably in Saskatchewan to denote a province-wide medical services scheme.[2] However, by the early 1940's, a consensus emerged among the medical profession, politicians, the press, and the plethora of lay organisations interested in health care reform that the establishment of a universal medical service scheme in the province entailed a choice between two distinct types of medical services schemes:

(1)health insurance, with costs met from a fund created by personal contributions and state subsidy, the doctors paid by fee-for-service, capitation or by salary.

(2)state medicine, a non-contributory system financed entirely by taxation from general government revenues, in which members of the medical profession would be salaried civil servants.[3]

In this context, the term "socialized" medicine/health services was seldom used, with the important exception of the Saskatchewan CCF(see Chapter 4.) Indeed, that term is virtually non-existent in the briefs, proceedings and reports of the Special Select Committee on Social Security and Health Services and the Saskatchewan Reconstruction Council. The few examples of its application in the 1940's suggest that socialized medicine/health services was used as a generic term for a medical services plan providing universal coverage, either in the form of contributory health insurance or state medicine. For example, the introduction of the first edition (December 1943) of the SCPS' "Bulletin" states that the object of this new communication is:

> To keep the medical profession in Saskatchewan in touch with the development and turn in events dealing with socialized medicine, be it in the form of Health Insurance, or State Medicine.[4]

Prior to the 1940's, it would appear that only the leadership of organized medicine in Saskatchewan understood and defined "state medicine" as entailing a salaried medical service,[5] predicated on their knowledge that the only national non-contributory medical care scheme in operation in the world, at that time, was that of the Soviet Union. And in that country physicians were remunerated on a salary basis. On the other hand, throughout the 1930's, and as late as the early 1940's, the term "state medicine" was used by the general public, the press, politicians and individual doctors (in the public sphere) to denote, and as a synonym for, medical care schemes with varying degrees of state involvement, including a contributory health insurance scheme. For example, Dr. Uhrich, who would become the Minister of Health after the 1934 provincial election, in announcing the Saskatchewan Liberal party's commitment to "state medicine" in January of 1934 clearly envisaged a contributory health insurance scheme:

> Any system of state medicine, of course must be built upon a sound and practical foundation and the ideal plan, based upon the experience of other countries would appear to be one wherein the Dominion government the provincial government and the people as individuals will contribute to a state health insurance fund.[6]

Moreover, Dr. Uhrich's ffs contributory health insurance plan, which the Liberal government pledged to implement once the province's finances improved, was referred to by himself and the press as a scheme of "state medicine" at its unveiling in early 1935.[7] It was not until the late 1930's that Uhrich no longer referred to his contributory health insurance scheme as "state medicine." According to the *Leader Post*(Regina), Uhrich told the Legislature in March of 1939:

> As far as state medicine was concerned that was practised only in Russia, said Dr. Uhrich. He favoured a contributory health insurance plan along the lines of the British Columbia scheme and Saskatchewan's present contribution to health insurance, on the basis of the B. C.

> Scheme to which the B. C. government contributes, would mean $17, 000, 000 available for health insurance services.[8]

As such, one must exercise caution in attributing support for a particular type of medical services scheme, let alone a salaried medical service, to organizations such as the Saskatchewan Association of Rural Municipalities (SARM) and the Saskatchewan Association of Urban Municipalities (SUMA), even though throughout the 1930's they passed resolutions calling for the provincial government to implement state medicine.[9] Indeed, it would appear that physician remuneration did not become an issue of public debate with respect to a province-wide medical services scheme until the 1940's.

Organized Medicine and the State Hospital and Medical League

Both contributory health insurance and salaried state medicine had their advocates and detractors who sought to influence government policy and public opinion as to which of the two schemes should be implemented on a province-wide basis.

From the outset of the medical crisis of the 1930's, the leadership of organized medicine in Saskatchewan was opposed to state medicine. At the Saskatchewan Medical Association(SMA) annual meeting, September 10-11, 1931, the President Dr. A. McLurg warned:

> Unless we can meet the problem we demand to have solved there is no doubt a solution will be found in the nature of state medicine. State Medicine should be the last resort.... It will prove destructive to individual initiative on the part of the physician. It will cause a lessening of responsibility, a lowering of professional standards and reduce a great profession. We owe to our profession and to ourselves the duty of finding a substitute that will be just as universal in its application and that will be just as effective but at more reasonable costs and more in line with the traditions of our profession....[10]

Accordingly, in 1932 a Committee on Health Insurance was established. And in 1933 the SMA endorsed, and began to actively seek public and state support for, a ffs contributory health insurance scheme.[11] As

Naylor notes, this initiative was undertaken in order to entrench "existing practice patterns instead of 'state medicine.'"[12]

In its first foray into directing lay opinion with respect to medical services policy the SMA achieved immediate success. At a meeting initiated by the SMA, June 6, 1933, representatives from the departments of Municipal Affairs and Public Health, the Saskatchewan Hospital Association, SARM, and SUMA endorsed the principle of compulsory contributory health insurance.[13] And in 1935 the Minister of Health, Dr. Uhrich, unveiled a ffs contributory health insurance plan (identical to the 1933 SMA scheme) that the provincial government promised to implement as soon as the province's finances improved. However, the efforts of organized medicine to direct the popular movement for state-financed medical care under the umbrella of the State Hospital and Medical League(SHML) met with failure.

The SHML had been established in the city of Prince Albert, Saskatchewan on April 24, 1936. Convinced that the Liberal Government of Jimmy Gardner simply lacked the will to fulfil its 1934 election promise to introduce a provincial medical care program, League founder Alderman C. L. Dent of Prince Albert brought together a multitude of private citizens, farm, labour, and church organizations, co—operative groups and municipal governments that were, in the League's words, interested in "socialized medicine or state control of health."[14] The League's stated goal was to set up a "united front" to devise, implement and promote the establishment of a provincial medical and hospital scheme.[15]

The Chairman of the SMA Health Insurance Committee, Dr. S. E. Moore, recognizing the potential threat to the interests of organized medicine posed by the SHML, warned the SMA that:

> ...should this young organization grow and become attached to any one state scheme of its own accord then the profession will be forced to do as directed, by the laity, rather than direct in a scheme with the medical view point.[16]

Accordingly, as part of the SMA's on-going initiative to direct the popular movement for a provincial medical services plan towards a scheme congruent with the interests of organized medicine, Dr. Moore attended the meetings of the SHML in order to, in his words, "give guidance" to this organization.[17]

Meanwhile, in accordance with a resolution passed at the joint annual meeting of the SMA and SCPS September 22, 1936, the voluntary SMA was merged with the SCPS.[18] Thereby the SCPS became the only medical body in Canada with the dual function of both regulating the profession in the public interest and overseeing the interests of organized medicine.[19] As Mombourquette notes, this initiative occurred one month after a group of doctors issued a circular letter recommending amalgamation in order to confront the "many...serious problems...standing at the door of the profession(e.g. Health Insurance, State Medicine, etc.)...."[20]

Dr. Moore was elected President of the SHML at its first annual Convention, October 15, 1936, and served on the Board of Directors along with the Presidents of the United Farmers of Canada, Saskatchewan Section(UFCSS)and SARM.[21] However, the League's membership eventually rejected a ffs contributory health insurance plan devised and promoted by Dr. Moore.[22] Dr. Moore was subsequently replaced as President by Dr. Setka, a Prince Albert-based general practitioner who supported salary remuneration.[23]

At the SHML's fifth annual convention, October 8-9, 1940, delegates endorsed the League's "Eight Point Plan of State Medicine for Saskatchewan," which envisaged a system of group practice clinics staffed by full-time salaried personnel.[24] As an immediate step towards

its plan for the establishment of a province-wide salaried medical service, the SHML lobbied the provincial government to extend the municipal doctor system "with all necessary provincial aid, financial and otherwise, to include all municipalities of the province as well as all the hamlets, villages, towns and cities and other organized areas."[25]

Throughout the early 1940's the League continued to expand its membership base and to acquire support for its health care proposals. At the League's annual convention, October 13-14, 1942, the executive declared that 296 organizations had affiliated with the League during 1942, an increase of 100 affiliations over the previous year.[26] And by early 1943 each of the League's proposed health care districts had an executive committee organized to administer and help implement the "Eight Point Plan."[27]

It was in this context that Dr. Lloyd Brown, chairman of the SCPS' "Publicity Committee" and President of the Regina District Medical Society, advised that, because of the "urgency of the situation," there be "no further delay" in launching the SCPS' so-called "education campaign" to point out to the public "the advantages of Health Insurance on the one hand, and the dangers of State Medicine on the other."[28]

Between December 1942 and March 31, 1943, the residents of Saskatchewan were inundated with newspaper and radio advertisements such as the following:

> "HOW IS PATIENT NO. 29H406 today..." You don't want to be given a number when you're ill, do you? You don't want to be one of thousands in a card index. You don't want to be treated impersonally. State Medicine might mean all this. But Health Insurance protects you. Health Insurance permits you to consult the doctor of your choice...HEALTH INSURANCE is recommended by YOUR DOCTOR... ASK HIM ABOUT IT.[29]

The SHML responded with its own radio campaign during this period. It consisted of a series of addresses prepared and delivered by the

League's executive and senior officials of its affiliated organizations such as the UFCSS, Saskatchewan Wheat Pool, and the Saskatchewan Teachers Federation.[30] SHML speakers maintained that the SCPS' objections to state medicine were merely a facade for their opposition to salary remuneration:

> What the College of Physicians Surgeons really dreads is the idea of private practitioners being required to work on a salary basis, no matter how high, the same as our municipal doctors and those operating in our sanitaria and mental institutions.[31]

These opposing public relations campaigns corresponded with the public hearings of the Saskatchewan Provincial Legislature's 1943 Select Special Committee on Social Security and Health Services.

The Select Special Committee on Social Security and Health Services and the Saskatchewan Reconstruction Council: State Medicine or Health Insurance?

On March 2, 1943, Liberal Premier William J. Patterson appointed a bipartisan committee of 25 Liberal and CCF MLAs, chaired by B. D. Hogarth, to enquire into "practical measures of further Social Security and Health Services for Saskatchewan by itself or in conjunction with the Government of Canada...."[32] Over a period of five weeks, the committee heard representations from 38 organizations representing "a typical cross-section of the people of the province."[33] An additional four organizations, including the Saskatchewan Association of Urban Municipalities (SUMA), submitted their views via written briefs.

During the hearings, the group of MLAs first sought to discern from each delegation before the committee which of the two contending medical care schemes they desired, a non-contributory scheme financed exclusively by the state from general taxation (state medicine), or a health insurance scheme funded by individual contributions. Once an organization's preference had been established, the committee's questions were primarily directed at ascertaining and exploring what

form of contribution and/or taxation the various organizations envisaged. The committee did not extract from the various delegations their preferences with respect to how doctors ought to be paid. Indeed, a careful perusal of the proceedings reveals that with the exception of the SCPS' appearance before the Committee, at which time the MLAs (particularly the CCF) questioned the doctors with respect to their opposition to the salary method, there was little discussion concerning physician remuneration during the hearings. Questions of finance were the Committee's main concern and focus.[34]

According to a summary of the submissions, prepared by the Inter-Sessional Committee,[35] the chief proponents of state medicine were the SHML, UFCSS and the Women's Section of this organization.[36] These organizations were opposed to a contributory scheme because, in their view, it did not provide protection for low-income groups, make adequate provision for preventive services, nor, as a perusal of the submissions and oral testimony of SHML and UFCSS will indicate, facilitate a re-distribution of physicians.[37] To the suggestion that the government could assume the premiums and or personal taxes of those unable to contribute to the health insurance fund, the SHML stated it was opposed to a scheme that would oblige the less fortunate to accept charity. It should be noted in connection with the SHML and UFCSS objections that the supporters of contributory health insurance put great stress on the need for preventive services and a solution to the physician shortage in rural Saskatchewan.

The following lay organizations favoured contributory health insurance: SARM, Saskatchewan Homemakers' Clubs, the Bishops, Clergy and Laity of the Catholic Church of Saskatchewan, the Provincial Executive of the Trades and Labour Congress of Canada, the Saskatoon

Trades and Labour Council and the Moose Jaw Trades and Labour Council, the Medical Co-ops and the Catholic Hospital Conference.[38]

It is worth emphasizing SARM's preference for contributory health insurance over state medicine:

> ... prior to 1940 Resolutions were adopted at our Annual Conventions requesting the Government of the Province to inaugurate a system of State Medicine. Since then the feeling has grown that contributory Health Insurance was desired rather than State Medicine, and this resulted in the passing of the Municipal Medical and Hospital Services Act, 1939.[39]

SARM recommended that health services be financed by a "direct personal tax on the individual and contributions by the Provincial and Dominion Governments."[40]

The aforementioned Municipal Medical and Hospital Services Act, permitted health services to be financed through a personal tax on the individual. Prior to this legislation, all [rural] municipal doctor plans were financed by a direct levy on property. As Dickinson notes in "The Struggle For State Health Insurance: Reconsidering the role of the Saskatchewan Farmer," the "farmers were interested in shifting the tax burden for health care from the property base to the individual/family unit."[41] SARM's position may have reflected a concern that if a non-contributory scheme was adopted in Saskatchewan, the farmer would bear an unequal taxation burden.

The membership of the six Railway Transportation Brotherhoods was divided with respect to these two systems of medical care.[42] Based on this summary, the Inter-Sessional Committee concluded that "the preponderance of opinion voiced before the 1943 Committee favoured contributory Health Insurance as against State Medicine."[43]

With respect to physician remuneration, although the Special Committee's *Final Report* suggests support for the salary method among the advocates of both state medicine and health insurance,[44] a careful examination of the actual submissions to and proceedings of the 1943

Committee reveals that only the SHML and the SCPS indicated their preferences with respect to how physicians ought to be paid. The SHML contended that "the fee for service custom does not encourage the preventive aspect of health services,"[45] and insisted that all physicians be placed on salary.

In addressing the differences in opinion with respect to physician remuneration, the Inter-Sessional Committee noted that, owing to the province's geography, whatever scheme was established "must take cognizance of, and continue where necessary some at least of the municipal schemes already in existence, in which the salary principle is well established."[46] Accordingly, the Committee stated that "there would appear that there is room for both methods of remuneration."[47]

Although the Inter-Sessional Committee made no specific recommendation with respect to how physicians should be paid, it recommended that that "the Commission appointed to administer the scheme take up with the College of Physicians and Surgeons the matter of a reduction in the Schedule of Fees."[48] This statement suggests that the Committee was resigned to ffs in whatever scheme was eventually established, with the exception of the outlying areas of low population density.

It is worth noting here, with respect to the Inter-Sessional Committee recommendation concerning a reduction in the SCPS fee-schedule, that the 1942 annual SARM convention approved a resolution to the effect that the provincial government "enquire into the workings of the College of Physicians and Surgeons...with special regard to the high fees set."[49] Dr. Uhrich, Minister of Public Health, was informed by the Secretary of SARM that:

> In support of the above Resolution it is alleged that the fees of Medical Practitioners, particularly for major operations, are excessive and beyond the paying ability of the average individual requiring these services.[50]

Indeed, at a SCPS meeting March 18, 1942, one physician warned the College that its latest proposed fee-schedule and payment demands "would drive the people to State Medicine...."[51] As we shall see, this perception that SCPS fee-schedules were exorbitant was brought to the attention of the Saskatchewan Reconstruction Council(SRC), which held public hearings in 1943-44.

The SRC was established by the provincial government October 20, 1943, for the purpose of "formulating a co-ordinated post-war reconstruction and rehabilitation plan" for Saskatchewan.[52] To this end, the Council accepted submissions and heard representations from interested parties on all aspects of post-war development, such as agriculture, education, housing etc, including health and medical services. Of the many representations, a total of 26 lay organizations outlined their views, however briefly, on a provincial medical services plan, or the delivery of health services to a certain class or group of individuals. Of these representations, only five indicated their preference with respect to physician remuneration in either a written submission, oral presentation, or during a cross-examination by the Councils' public hearing committee. The UFCSS and the Saskatchewan Teachers' Federation, for example, both of which supported the creation of a salaried medical service, confined their briefs primarily to agriculture and education issues and did not convey their support for salaried state medicine to the commission.

Besides the SHML, the Regina Mutual Medical Benefit Association (a lay-controlled medical co-operative) was the most insistent that ffs should be eliminated:

> Our members also consider that the professional groups providing the services should be paid on a salary or per capita basis and that the present fee-for-service basis should be discontinued.[53]

The Emerald Revekah Lodge #22 100F of North Battleford, contending that the "doctors charges of today are too exorbitant," stated that they wanted physicians to be paid "fair not extreme" salaries and work an eight hour work day.[54] The minutes of the North Battleford Teachers' Federation's appearance before Council suggests that this organization also envisaged a state salaried medical service.[55] The Saskatoon Mutual Medical Benefit Association, maintaining that ffs was not conducive to preventive medical practice,[56] stated it was opposed to ffs unless there was a drastic reduction in the SCPS fee-schedule.[57]

In terms of financing, seven organizations indicated their preference for a contributory health insurance scheme: R. M. of Mantario, #262; both the Saskatoon and Regina Mutual Medical and Hospital Associations; the Saskatoon Local Council of Women; the Railway Transportation Brotherhoods; and the Saskatoon and Prince Albert Rehabilitation Councils.[58] In addition, the Melfort Reconstruction Committee stated that it was preparing for the implementation of the Dominion Health Insurance Scheme (contributory); and the Regina Local Council of Women endorsed the provincial government's health insurance (contributory) proposals.[59] Five organizations indicated their support for a non-contributory system of state medicine, as opposed to health insurance: Rural Municipality of Weyburn, UFCSS, SHML, Connaught Home and School Association, and the Saskatchewan Teachers' Federation(North Battleford Local).[60] The SRC would report its findings in August, 1944, after the CCF came to power.

The Special Select Committee on Social Security and Health Services released its *Final Report*, on March 31, 1944.[61] Noting that federal monies would be required for whatever scheme was implemented in the province, and that Ottawa had opted for a contributory format, the Committee stated that its decision between state medicine and

contributory health insurance had been "more or less determined for it;" and, as such, "it became no part of their task to state a preference for State Medicine or Health Insurance."[62] The Committee recommended that the Legislative assembly "endorse the principle of health insurance for all the people of Saskatchewan,"[63] and set up a commission along the lines outlined in the federal proposals to both prepare for and administer the anticipated Federal scheme. Should the federal legislation be delayed, as an interim measure, the Committee recommended an extension and further study of existing municipal medical and hospital schemes with the view of making them compulsory in all municipalities and local improvement districts in the province.[64] Accordingly, on March 31, 1944, the Liberal government introduced "A Bill Respecting Health Insurance,"[65] which provided for the appointment of a commission to administer the proposed federal plan.

The latest draft of the proposed federal Health Insurance Act, devised with close consultation with the CMA, envisaged a contributory health insurance scheme financed by 1) 12$ registration fee; 2) a personal income tax levy; and 3) a contribution from the Federal Government.[66] The contentious area of physician remuneration, whether on ffs, capitation or salary, was left to the provinces to decide. Curiously, the *Final Report* of the Special Select Committee on Social Security and Health Services did not discuss, let alone make any recommendations concerning physician remuneration. It is also worth noting, in the context of the Saskatchewan CCF supposed commitment to a salaried medical service, that the CCF members on the Committee did not submit a minority report recommending salaried physicians.

The SHML was a vocal critic of the proposed federal health insurance legislation in its various drafts during 1943-1944. Concerning the first draft legislation, the SHML declared that:

> the main feature of the Draft Bill is to create a collection agency for the Medical Profession, as no limit for medical services is established and no salary basis proposed.[67]

The Saskatchewan Teachers' Federation(STF), an affiliate and strong supporter of the SHML, attacked the 1944 draft legislation on similar grounds. At a meeting of the STF Provincial Council in early 1944, the Secretary of this organization, J. H. Cumming, stated the following:

> It's easy to see why the medical profession supports the heath insurance scheme. They wrote the bill. The whole thing would be a grand collection agency for the medical profession. We won't get state medicine under health insurance. There is no provision for adequate hospitalization or for adequate medical services, for diagnostic and remedial treatments, but it does provide for the same fee-for-service that we now have.[68]

Mr. Cumming's comments were made in connection with the adoption of a resolution that called for council to request that the SHML lobby the provincial government to establish a system of state medicine, and that similar pressure be placed on the federal government to take a similar action.[69]

The federal proposals were also criticized by the Saskatchewan CCF, albeit apparently not with respect to physician remuneration. Mr. O. W. Valleau, the CCF's chief representative on the Special Select Committee of the Legislature on Health Services, objected to the proposed administration of the federal plan,[70] but "he could not vote against the bill because of the urgency of health insurance."[71] Subsequently, the Liberal's Health Insurance Act passed unanimously and received royal assent April 1, 1944, in the final days of the last session of the Legislature. Thereafter, the 1944 provincial election campaign began in earnest.

Within eight weeks of the CCF's decisive victory, the Social Reconstruction Council(SRC) submitted its *Final Report*. The SRC acknowledged the "strong representations [that] were made with respect to state medicine," but concluded, "after due consideration," that a recommendation for the immediate establishment of state medicine "as

opposed to the [proposed Federal] Plan for health insurance would not be warranted."[72] Several factors were cited "in reaching this conclusion": 1) the province "could not hope to finance a complete system of state medicine"; 2) it appeared that federal assistance was contingent upon the acceptance of the Dominion health insurance plan; 3) the "lack of administrative experience in this field...necessary for success"; and 4) the "very strong professional opposition to state medicine."[73] Accordingly, the SRC endorsed "state-aided health insurance"(the SCPS' terminology for contributory health insurance).[74] In terms of physician remuneration, the SRC recommended that all doctors be paid on a ffs basis except in areas where this would result in a shortage of doctors.[75] In these areas, the [health insurance] Commission should guarantee a minimum payment to the doctor sufficient to assure his services."[76] These recommendations were essentially the physician remuneration policy of the SCPS.

Health Services Survey Commission

Public opinion with respect to health care delivery in Saskatchewan was canvassed yet again in the relatively short period of 1943-1944 following the 1944 provincial election. This time various organizations and private citizens submitted briefs and made oral presentations to the CCF-appointed Health Services Survey Commission(HSSC), which held public hearings in September of 1944.

Of the three inquiries into health services in Saskatchewan in 1943-1944, the HSSC received the most submissions. A large and diverse number of local government, farm, and citizen organizations of various orientations, as well as trade unions, appeared before the Committee.

Twenty-four individual rural and urban municipalities and several umbrella organizations,[77] such as SARM, seven trade unions; the

province's four medical services co-operatives, two agriculture organizations, and four, what the HSSC referred to as, "citizens' organizations" submitted briefs to the Commission.[78] A further three lay organizations of various orientations, the Saskatchewan Hospital Association, Saskatoon Constituency Association(CCF) and the Saskatchewan Old Age Pensioners' Association outlined their views on a provincial medical services scheme.

Of these organizations, the following indicated their preference for a contributory health insurance scheme: (1)SARM; (2)M. S. Anderson, Reeve of Mckillop; (3)R. M. Pittville; the (4)Regina,(5)Saskatoon and (6)Melfort Mutual Medical Benefit Associations(Medical Services Co-operatives); (7)"local unions #43, #100 and #186 of the Canadian Brother hood of Railway Employees and other Transport Workers of Regina, Saskatchewan;"(8) Canadian Daughters League; and (9) the Provincial Council of Women;and (10) the Saskatchewan Hospital Association.[79] In addition, the Moose Jaw & District Labour Council appears to have favoured a system of state medicine, but felt that contributory health insurance must be established as a first step towards this objective.[80]

The following organizations indicated their preference for a non-contributory scheme of state medicine, and or voiced their support for the SHML's "Eight Point Plan" for state medicine: (1)SHML; (2) R. M. of Big Quill, no. 308;(3) R. M. of Connaught;(4) Prince Albert Mutual Medical Benefit Association(Medical services Co-operative);(5) UFCSS;(6) Saskatchewan Federation of Agriculture, "representing the organized Producers and Consumers' Co-operatives" and the UFCSS;(7) Regina Trades and Labour Council; (8) Saskatoon Trades and Labour Council; 9) Saskatoon Constituency Association(CCF); and (10) the Saskatchewan Old Age Pensioners' Association.[81]

The position of the Joint Legislative Committee of the 6th Railway Transportation Brotherhood is noteworthy for its neutrality with respect to debate between state medicine and health insurance. The trade union's contention that the general public was indifferent may be suggestive:

> These are known as State Medicine, or Health Insurance Plans and while there is a wide divergence of opinion between the proponents of the two systems we find the average laymen is indifferent and unconcerned as to the various principles advocated, but is only concerned with the portion of a system of Medical Care that will meet with its particular needs. We have therefore adopted a neutral position with the advocates of these systems.[82]

In terms of physician remuneration, all ten of the aforementioned advocates of state medicine indicated their support for a salaried medical service in their briefs by voicing their support for the SHML's proposals and/or stating directly that the doctors should be placed on salary. For example, the Regina Trades and Labour Council stated that:

> It would seem to us that the best approach the government cam make to medical service, is through the medium of salaried doctors operating in evenly distributed health centres throughout the Province. As you are undoubtedly aware this is similar to a plan which has been proposed for the Commonwealth of Australia, and has been suggested by the Saskatchewan State Hospital and Medical League.[83]

The Saskatchewan Federation of Agriculture noted in its brief that it supported the Canadian Federation of Agriculture's state medicine proposals, "which would eliminate the fee for service system."[84] But in the meantime it "endorsed the representation and program submitted to this commission by the State Hospital and Medical League."[85]

Several proponents of contributory health insurance also advocated the discontinuation of ffs remuneration. The Regina, Saskatoon and Melfort Mutual Medical Benefit Associations, like the SHML, all maintained that ffs remuneration was not conducive to preventitive medicine. For example, the Melfort co-operative stated that:

> Fee-For-Service is a detriment to the practice of preventive or curative medicine: it is an incentive to unnecessary surgery, while a per-capitation is an incentive to preventive medicine and makes possible a vastly improved health service.[86]

In an addendum to the SCPS' brief to HSSC by Dr. J. F. C. Anderson, took exception with these claims:

> The College deplores such statements as "the Medical Profession is not concerned with preventive care," and that "Fee For Service Cannot Support Preventive Health Services."[87]

The Regina and Melfort co-operatives recommended that doctors be placed on salary or capitation. The Saskatoon Mutual Medical Benefit Association, despite its position that ffs could not support preventive health services, did not make a similar recommendation.[88] However, on October 4, 1944, the Saskatoon medical co-operative, with an enrolment of 2000 persons, launched a campaign to obtain a membership of 5000 that it believed would be required to support a group practice clinic with a staff of 6-9 salaried doctors.[89] The co-operative's failure to obtain discounts from the SCPS and the co-operation of many Saskatoon doctors for its modest reimbursement plan appears to have been the impetus for this initiative.[90]

A memorandum supported by "local unions #43, #100 and #186 of the Canadian Brotherhood of Railway Employees and other Transport Workers of Regina, Saskatchewan," recommended contributory health insurance with doctors "remunerated on a fee-for-service basis(the only lay organization to do so in all three public inquiries)."[91] The remaining supporters of contributory health insurance, including SARM, did not state their position on physician remuneration.

Although SARM does not appear to have had an official policy with respect to physician remuneration, an account in the *Saskatchewan Medical Quarterly* of a SCPS/SARM meeting in early 1944 may suggest that this organization was congenial to ffs payment:

> A committee of the Council met the Executive of the Association of Rural Municipalities in Regina early this year. Much good came of this meeting. A definite basis of understanding was reached. We found them highly favourable to a contributory health scheme. They were

> appreciative of the services being rendered the people of rural areas in these trying times and were willing to stand for fair returns for services rendered.[92]

The Commissioner of the HSSC, Dr. Henry Sigerist, submitted his report to the government of T. C. Douglas on October 4, 1944. Unlike the two previous government-appointed inquiries into health services in Saskatchewan, Sigerist did not debate the merits of, or make a recommendation with respect to, state medicine and contributory health insurance. For the cities, he recommended "a system of compulsory health insurance, the details of which would have to be worked out."[93] In rural Saskatchewan, the municipal doctor system should be extended. He made no recommendation as to how these schemes should be financed, i.e. general revenues or direct taxation/premiums. In terms of physician remuneration, Sigerist endorsed the salary method, but he did not call for the medical profession to be placed on salary(see Chapter 4, pp. 91-92).[94]

In the early 1940's a consensus emerged in Saskatchewan that the establishment of a provincial medical care plan entailed a choice between two distinct medical schemes, distinguished by their financial make-up and to a lesser extent how physicians would be paid: 1) contributory health insurance funded by personal contributions (premiums or a direct personal tax) and a state subsidy; and 2) state medicine, a non-contributory scheme financed exclusively by the state from the consolidated revenue fund raised through general taxation in which the medical profession would be salaried civil servants. Curiously, a ffs non-contributory-scheme, i.e. state medicine on a ffs basis, such as contemporary Canadian medicare, does not appear to have been envisaged. It was assumed that if medical services were funded from general government revenues doctors would be paid by salary.

Salaried state medicine was supported by a broadly-based, well-organized and vocal popular movement for a provincial medical services plan under the umbrella of the State Hospital and Medical League. So strong was this movement that the SCPS launched a comprehensive and sophisticated public relations campaign to counter this perceived threat to its interests.

With the exception of the Select Special Committee on Social Security and Health Services, which observed that a "preponderance of opinion favoured contributory health insurance as against state medicine," the submissions to the three public inquiries into health services in the province in 1943-1944, demonstrated the solid, province-wide support for the establishment of a state salaried medical service in Saskatchewan. A total of ten organizations indicated their support for salaried state medicine to the HSSC, equalling the number of groups that submitted briefs in favour of contributory health insurance. Moreover, these endorsements of salaried state medicine included the two agriculture organizations that appeared before the commission, the United Farmers of Canada, Saskatchewan Section and the Saskatchewan Federation of Agriculture, "representing the organized Producers and the Consumers' Co-operatives."[95] These endorsements call into question the validity of Lipset's imputation that the "farmers supported 'state' medicine but to them the term meant state payment of medical care...[and not a state salaried medical service]."[96]

Although there appears to have been broad support for both contending health care systems, SARM's preference for contributory health insurance over state medicine may suggest that there was also considerable support for the establishment of a contributory health insurance plan as opposed to a scheme of state medicine. An examination of SARM briefs to the three inquiries into health services

in 1943-1944 suggests that this organization did not have an official physician remuneration policy. However, a SARM communication with the SCPS in early 1944 may suggest, as College officials inferred, that it was congenial to ffs payment.

In this context, it is worth noting that the SHML claimed that it was strongly "supported in the municipal field by the Urban and the Rural Municipal Associations."[97] In view of SARM's health care positions, perhaps public support for the League's policies was not as strong as the SHML claimed. Moreover, SARM's definite endorsation of contributory health insurance as opposed to state medicine challenges the League's contention that it represented and spoke for the "great majority of the citizens of Saskatchewan."[98] Nevertheless, the SHML clearly commanded a great deal of support for its "Eight Point Plan," as evidenced by the significant number of organizations of varying orientations and stature - rural municipalities, farm, labour and citizens' groups, e.g. the Saskatchewan Pensioner's Association, that indicated their support for this programme to the HSSC.

Endnotes:

[1] The drastic fall in the price of wheat that followed the collapse of the New York stock exchange in October 1929 devastated Saskatchewan's agriculture-based economy. Depressed grain prices coupled with severe drought in some regions of the province rendered many individuals and families in both rural and urban Saskatchewan unable to afford life's necessities, including basic medical care. Under these conditions the existing physician shortage in rural Saskatchewan became even more acute, as an ever-growing number of country doctors, unable to secure a living, abandoned their practices to re-establish in the cities and more prosperous localities within and outside the province. In order to prevent a major exodus of medical personnel, in November of 1931 the provincial government authorized the newly established Saskatchewan Relief Commission to issue grants of $40 to $75 per month to rural-based doctors in relief areas as an incentive to continue practising. But this initiative did not ease the cost of medical care to the general public. Consequently, throughout the Great Depression of the 1930's, a plethora of lay organizations and individual citizens lobbied the provincial government to establish some kind of provincial medical care plan. Feather, "From Concept to Reality: Formation of the Swift Current Health Region," *Prairie Forum*, Vol. 16, No. 1 (Spring, 1991), p. 64. Taylor, Malcolm G. Taylor, *Health Insurance and Canadian Public Policy, op. cit.*, pp. 73-75. For an account of the personal hardships borne by the patient and country doctor in 1930's Saskatchewan see Jacalyn Duffin's description of the contents of Dr. Hugh MacLean's "Medical Services During the Depression" file in "The Guru and the Godfather: Henry Sigerist, Hugh MacLean and the Politics of Health Care Reform in the 1940s Canada,"*Canadian Bulletin of Medical History*, Vol. 9 (1992), pp. 199-202.

[2] See for example, "Party Leaders Give Strong Support To State Medicine League Program: Outline Views On Its Development," *Western Producer*, 22 October 1936.

[3] Saskatchewan Archives Board, Regina (hereafter SABR), Records of the Legislative Assembly Office Unpublished Sessional Papers, LXVII, 1, Select Special Committee on Social Security Briefs and Exhibits, 1943 – 1944 (hereafter USPSSC), file 40, "Suggested Agenda for Committee to Enquire into Legislation Relations Relating to Social Welfare," p. 1; Select Special Committee on Social Security and health Services, "First Report of the Select Special Committee re Social Welfare, etc," *Saskatchewan Legislative Journal*, April 12, 1943, Appendix., pp. IV-V; Select Special Committee on Social Security and Health Services, *Final Report*, (Regina, 1944), p. 10; Saskatchewan Reconstruction Council, *Report of the Saskatchewan Reconstruction Council*, (Regina: King's Printer, 1944), pp. 168-174.

[4] *Saskatchewan Medical Quarterly* (hereafter *SMQ*), Vol. 7, No. 3 (December, 1943), p. 5.

[5] Archives of the Saskatchewan Medical Association and the Saskatchewan College of Physicians and Surgeons (hereafter SMA/SCPS) College of Physicians and Surgeons of Saskatchewan, *Annual Report* (September 1932), p. 22; Saskatchewan Medical Association and the College of Physicians and Surgeons, *Annual Report* (1936), p. 12.

[6] "State Medicine, Insurance, Assured by Liberals; Says Uhrich," *Leader Post*, 22 January 1934.

[7] J. M. Uhrich, "PUBLIC HEALTH AND STATE MEDICINE: Speech Delivered by the Honourable J. M. Uhrich in the Budget Debate in the Legislative Assembly of Saskatchewan, January 28, 1935," *Journal of the Saskatchewan Legislature*, Session 1934 - 1935, p. 19; "State Medicine Plan For Future Told by Uhrich: Scheme Seen as Solution for Sask. Medical Problems by Health Minister," *Leader Post*, 29 January 1935; "Editorial: State Medicine for Saskatchewan Favourable," *Leader Post*, 9 March 1945.

[8] "Public Health Improves, Says Uhrich," *Leader Post*, 8 March 1939.

[9] For example, at its Annual Convention in January 1936, SARM overwhelmingly endorsed a resolution calling for the Federal and provincial governments to implement "state medicine" at the earliest possible date. Taylor, *supra*, p. 74.

[10] SMA/SCPS, Saskatchewan Medical Association, *Annual Report* (1931), p. 7.

[11] SMA/SCPS, College of Physicians and Surgeons of Saskatchewan, *Annual Report* (September, 1932) p. 21.

[12] Naylor, *Private Practice, Public Payment, op. cit.*, p. 66;

[13] Taylor, *supra*, p. 74.

[14] SABS, Pamphlet Collection, "Saskatchewan State Hospital and Medical League, Second Addition," 30 September 1936.

[15] *Ibid.*

[16] Saskatchewan Medical Association and the College of Physicians of Surgeons, *Annual Report* (1936), p. 12.

[17] SMA/SCPS, "Minutes of Annual Meeting: Saskatchewan Medical Association and the College of Physicians of Surgeons: September 22nd, 23rd, 24th, 1936," p. 14.

[18] *Ibid.*, p. 11.

[19] Taylor, *supra*, p. 241.

[20] Duane Mombourquette, "A Government and Health Care: The Co-operative Commonwealth Federation in Saskatchewan, 1944-64." M. A. Thesis, University of Regina, 1990, p. 36; Saskatchewan Archives Board, Saskatoon (hereafter SABS), Records of the Health Services Board (hereafter HSB), file 14, circular letter to all doctors from the "Committee for the Group" of physicians who studied the medical situation in Saskatchewan, 28 August 1936.

[21] "State Medicine Urged for Saskatchewan," *Leader Post*, 16 October 1936; "State Medicine League in First Convention Decides to Urge Plans upon Govt," *Western Producer*, 22 October 1936.

[22] "Social Service Council to Aid State Medicine Scheme," *Regina Star*, 28 May 1937.

[23] SABS, Pamphlet Collection, "Saskatchewan State Hospital And Medical League, Fourth Annual Convention, Saskatoon, Sask., October 20, 1939," p. 6.

[24] SABS, Pamphlet Collection, "Report of the Fifth Annual Convention of the State Hospital and Medical League, Saskatoon, October 8th and 9th, 1940," p. 9.

[25] University of Regina Library, Special Collections (hereafter URLSC), "Brief for Submission to the Government of the Province of Saskatchewan, October 15, 1943, State Hospital and Medical League," cited in The State Hospital and Medical League, *The Case For State Medicine*, (1944), p. 8.

[26] SABS, Pamphlet Collection, "Report of the Seventh Annual Convention of the "State Hospital And Medical League, Odd fellow's Hall, Saskatoon, Oct. 13th & 14th, 1942," p. 1.

[27] Feather, *supra*, p. 65.

[28] *SMQ*, Vol. 6, No. 2 (August, 1942), p. 44; Vol. 5, No. 4 (December, 1941), pp. 30-32.

[29] SMA/SCPS, file "Publicity Committee," Sample of advertisements placed in the *Leader Post* (Regina), *Saskatoon Star Phoenix*, *Moose Jaw Times*, and *Prince Albert Daily Star*.

[30] URLSC, J.H. Wesson (President, Saskatchewan Wheat Pool and Vice-President, Canadian Federation of Agriculture) A Review of "Health on the March": A Pamphlet issued by the Canadian Federation of Agriculture, radio address delivered over CKBI and CJRM, March 28, 1943; Geo. R. Bickerton (President, United Farmers of Canada) "The Wealth of Health," radio address delivered over CJRM and CFQC, May 2, 1943; Mrs. Mabel Bradely (President, United Farm Women, Regina) "State Medicine and its Possibilities: A Call to Action," radio address delivered over CKBI and CJRM, February 23, 1943; Jas. H. Cumming (Secretary, Saskatchewan Teachers' Federation, Saskatoon), "Unwarranted Expense and Tragic Toll of Unorganised Medical Care," radio address delivered over CJRM and CFQC, March 7, 1943. Cited in The State Hospital and Medical League, *The Case For State Medicine,* (1944).

[31] URLSC, P. G. Makaroff, K. C., Saskatoon, "The Municipal Doctor, Health Insurance, Co-operative Insurance And Other Alternatives," radio address delivered over CJRM and CFQC, February 21, 1943. Cited in The State Hospital and Medical League, *The Case For State Medicine*, (1944), p. 24.

[32] *Saskatchewan Legislative Journal*, March 2, 1943.

[33] Select Special Committee on Social Security and Health Services, "First Report of The Select Special Committee re Social Welfare, etc," *Saskatchewan Legislative Journal*, April 12, 1943, Appendix, pp. IV-V.

[34] SABR, Records of the Health Services Survey Commission (HSSC), file 30, "Relevant Material in Proceedings of Select Special Committee on Social Security and Health Services,"(unpaginated).

[35] The Select Special Committee was unable to complete its task before the end of the 1943 session of the Legislature. An inter-sessional Committee was appointed to continue the inquiry after prorogation and report to the reconstituted Select Special Committee early in the next session of the Legislature to the end that a "Final Report" could be tabulated. Select Special Committee on Social Security and Health Services, "First Report of The Select Special Committee re Social Welfare, etc," *Saskatchewan Legislative Journal*, April 12, 1943, Appendix, p. VIII.

[36] SABR, USPSSC, file 39, "Inter-Sessional Committee on Social Security and Health Services: Report to Select Special Committee on Social Security And Health Services Session 1944," p. 4.

[37] *Ibid.*, pp. 5-6; SABR, HSSC, file 30, "Relevant Material in Proceedings of Select Special Committee on Social Security and Health Services, "(unpaginated).

[38] SABR, USPSSC, file 39, "Inter-Sessional Committee on Social Security and Health Services: Report to Select Special Committee on Social Security And Health Services Session 1944," p. 5.

[39] SABR, USPSSC, file 6, "Recommendations To The Select Committee Of The Legislative Assembly of the Saskatchewan Legislature re Social Welfare Etc. by The Saskatchewan Association of Rural Municipalities," p. 2.

[40] *Ibid.*, p. 4.

[41] Harley Dickinson, "The Struggle for State Health Insurance: Reconsidering the Role of Saskatchewan Farmers," *Studies in Political Economy*, 41 (Summer, 1993), p. 147.

[42] SABR, USPSSC, file 39, "Inter-Sessional Committee on Social Security and Health Services: Report to Select Special Committee on Social Security And Health Services Session 1944," p. 5.

[43] *Ibid.*

[44] Select Special Committee on Social Security and Health Services, *Final Report*, (Regina, 1944), p. 10.

[45] "A Petition of Rights And A Bill of Health By E. R. Powell: Submitted by Mr. E. R. Powell, State Hospital & Medical League, March 15, 1943," p. 5.

[46] SABR, USPSSC, file 39 "Inter-Sessional Committee on Social Security and Health Services: Report to Select Special Committee on Social Security And Health Services Session 1944," p. 13.

[47] *Ibid.*, p. 14.

[48] *Ibid.*, p. 23.

[49] SABR, John Michael Uhrich Papers, file 18(4), J. J. McGurran, Secretary SARM, to J. M. Uhrich, 27 March 1942

[50] *Ibid.*

[51] *SMQ*,, Vol. 6, No.1(April, 1942), p. 42.

[52] Saskatchewan Reconstruction Council, *Report of the Saskatchewan Reconstruction Council*, p. 9.

[53] SABS, Records of the Saskatchewan Reconstruction Council (hereafter SRC), file 6.4, "Brief Presented to the Saskatchewan Reconstruction Council by the Regina Mutual Medical Benefit Association Limited, March 10th 1944," p. 4.

[54] SABS, SRC, file 4, Emerald Rebekeh Lodge #22 100F, March 24, 1944, 3: 00 P.M. (Proceedings).

[55] SABS, SRC, file 4, North Battleford Teachers' Federation, March 23, 1944, 4:00 P.M. (Proceedings).

[56] SABS, SRC, file 7.2, "[Brief of] Saskatoon Mutual Medical and Hospital Benefit Association Ltd., Friday, January 21, 1944."

[57] SABR, HSSC, file 31,"Report of the Saskatchewan Reconstruction Council (Part XI) Health and Medical Services," p. 212.

[58] SABS, SRC, file 6.4, "Brief Presented to the Saskatchewan Reconstruction Council by the Regina Mutual Medical Benefit Association Limited, March 10th 1944;" file 7.1, Saskatoon Local Council of Women; file 7.2, R. M. of Mantario; "[Brief of] Saskatoon Mutual Medical and Hospital Benefit Association Ltd., Friday, January 21, 1944; Saskatoon Rehabilitation Council; file 5, Prince Albert Rehabilitation Council.

[59] SABS, SRC, file 6.5, Regina Local Council of Women; SABR, HSSC, file 31, "Report of the Saskatchewan Reconstruction Council (Part XI) Health and Medical Services," pp. 216.

[60] SABR, HSSC, file 31, "Report of the Saskatchewan Reconstruction Council (Part XI) Health and Medical Services," pp. 212-218; SABS, SRC, file 6.6, United Farmers of Canada, p. 10; file 4, Saskatchewan Teachers Federation (North Battleford Local) March 24, 1944, 4.00PM; file 4, Connaught Home and School Association.

[61] Select Special Committee on Social Security and Health Services, *Final Report*, (Regina, 1944), p. 10.

[62] *Ibid.*

[63] *Ibid.*, p. 13.

[64] *Ibid.*, p. 14.

[65] Taylor, *supra*, p. 77.

[66] Select Special Committee on Social Security and Health Services, *Final Report*, (Regina, 1944), p. 10.

[67] URLSC, "Brief for Submission to the Government of the Province of Saskatchewan, October 15, 1943, State Hospital and Medical League," cited in The State Hospital and Medical League, *The Case For State Medicine*, (1944), p. 7.

[68] "Health Insurance Scheme Attached by S.T.F. Secretary at Conference," *Leader Post*, 2 January 1944.

[69] *Ibid.*

[70] Mr. Valleau objected to the proposed commission's lack of responsibility to the Legislative Assembly with respect to the drafting of regulations and expenditure.

[71] "Health Act criticized," *Leader Post*, 1 April 1944.

[72] Saskatchewan Reconstruction Council, *Report of the Saskatchewan Reconstruction Council*, (Regina: King's Printer, 1944), p. 172.

[73] *Ibid.*

[74] *Ibid.*, p. 176.

[75] *Ibid.*, pp. 173-174, 188-189.

[76] *Ibid.*, p. 188.

[77] The vast majority of the submissions by individual rural and urban municipalities were strictly requests for assistance in procuring the services of a physician or the construction of local hospitals.

[78] Henry E. Sigerist, *Saskatchewan Health Services Survey Commission: Report of the Commissioner*, (Regina: King's Printer, 1944), pp. 13-14.

[79] SABR, HSSC, file 2, "Recommendations To The Health Services Commission of the Saskatchewan Government by The Saskatchewan Association of Rural Municipalities," p. 2; "A Brief presented to the Health Services Commission at its hearing in Regina, Sask, September 26, by W. J. Burak, Secr-Treas. R. M. Pittville, Hazlet, Sask," p. 20; file 12, "Recommendations as submitted to the Provincial Health Services Survey Commission by M. S. Anderson, Reeve of the Rural Municipality of McKillop No. 220"; file 8, "Submission by the Regina Mutual and Medical Benefit Association," p. 5; "Supplemental Brief In Conjunction With The Melfort Medical Co-op Brief On Health Services[presented by Saskatoon Mutual and Medical Benefit Association]," p. 6; "Melfort And District Mutual Medical Benefit Association Limited (Brief presented September 16, 1944.)," p. 11; file 5, "Memorandum Respecting Health Insurance, Public Health Services, etc. Submitted to the Health Service Survey Commission of the Province of Saskatchewan, September 26, 1944, by the Local Unions of the Canadian Brother hood of Railway Employees and other Transport Workers, Regina, Saskatchewan," p. 1; file 7, "Brief Prepared, Submitted by The Canadian Daughters' League, Assembly No. 23, Regina, September 1944," p. 1; file 7, "Submission presented to the Health Services Survey Commission on behalf of Provincial Council of Women, held in Saskatoon, September 18, 1944," p. 3; file 4, "Saskatchewan Hospital Association, Brief to Survey Commission on Public Health," p. 1.

[80] SABR, HSSC, file 5, "Brief For Submission To The Commission Appointed To Make A Survey OF The Health Services In Saskatchewan: Submitted By The Moose Jaw & District Labour Council At Moose Jaw Sask. September 27, 1944," p. 2.

[81] SABR, HSSC, file 2, D. Demarias (Secretary Treasurer Rural Municipality of Big Quill No. 308) to Mindel C. Sheps & accompanying "Resolution"; file 5, "Brief on behalf of the Regina Trades and Labour Congress," file 8, "Prince Albert Mutual Medical Benefit Association, Ltd: A Brief to be presented to the Saskatchewan Health Services Survey Commission at Saskatoon, Tuesday, September 19, 1944," p. 2; file 6, United Farmers of Canada (Sask. Section) "Memorandum on "Social Health Services" to Saskatchewan Enquiry Commission, September 19th, 1944.," p. 2; file 6, "Submission To the Saskatchewan Health Survey Committee," Saskatoon, September 19th/44 (Saskatchewan Federation of Agriculture)," p. 1; file 5, "Brief submitted by P. W. Haffner for the Regina Trades and Labour Congress," pp. 2-3; file 5., Saskatoon Trades and Labour Council, September 19th, 1944; file 10, Fred Gordon (Secretary CCF Saskatoon Constituency) to Secretary Sigerist Commission, September 16, 1944; file 27, "Report of Sittings Held At Saskatoon - September 20, 1944 (Saskatchewan Old Age Pensioners Association's declaration that they endorsed the State Hospital and Medical League Eight Point Plan For State Medicine)," p. 1.

[82] SABR, HSSC, file 5, "Submission by Joint Legislative Committee of the 6th Railway Transportation Brotherhood."

[83] SABR, HSSC, file 5, brief submitted by P. W. Haffner for the Regina Trades and Labour Congress," p. 2.

[84] SABR, HSSC, file 6, "Submission To the Saskatchewan Health Survey Committee," Saskatoon, September 19th/44(Saskatchewan Federation of Agriculture)," p. 1.

[85] *Ibid.*

[86] SABR, HSSC, file 8, "Melfort and District Mutual and Medical Benefit Association Limited," p. 10.

[87] SABR, HSSC, file 3, "Addendum of Dr. JFC. Anderson., Saskatoon, Sept, 1944," p. 2.

[88] SABR, HSSC, file 8, "Supplemental Brief In Conjunction With The Melfort Medical CO-OP Brief On Health Services [presented by Saskatoon Mutual and Medical Benefit Association]," p. 4.

[89] "Local Medical Co-op To Launch Drive For Members," *Saskatoon Star Phoenix*, 4 October 1944.

[90] Ibid.

[91] SABR, HSSC, file 5, "Memorandum Respecting Health Insurance, Public Health Services, etc. Submitted to the Health Service Survey Commission of the Province of Saskatchewan, Septembers 26, 1944, by the Local Unions of the Canadian Brother Hood of Railway Employees and other Transport Workers, Regina, Saskatchewan," pp. 1-2.

[92] *SMQ*, Vol., 8, No. 4 (December, 1944), p. 8.

[93] Sigerist, *supra*, p. 6.

[94] *Ibid.*, p. 10.

[95] SABR, HSSC, file 6, "Submission To the Saskatchewan Health Survey Committee," Saskatoon, September 19th/44," p. 1.

[96] Lipset, *Agrarian Socialism, op. cit.*, p. 297.

[97] SABR, HSSC, file 8, "Brief presented at Saskatoon to Doctor Sigerist and the personnel of the HSSC from the State Hospital & Medical League of the Province of Saskatchewan," p. 1.

[98] SABS, Pamphlet Collection, "Submission by The State Hospital and Medical League, Regina, Saskatchewan, To The Hon. Brooke Claxton, Minister of Health, Ottawa, Canada, May 30, 1946," p. 1.

Chapter 4

The Co-operative Commonwealth Federation, Henry Sigerist and Physician Remuneration Policy in Saskatchewan: 1937 – December 1945

Introduction

The CCF's rise to power in Saskatchewan coincided with demands for radical reform of the ffs system. This chapter examines the party's position on salary remuneration prior to and during the 1944 provincial election; and as the government of Saskatchewan during its first eight months in office.

The CCF Health Care Policy and the 1944 Provincial Election: Salary or Fee-For-Service?

The "Handbook to the Saskatchewan CCF Platform and Policy," issued in 1937, is the earliest document cited by scholars in support of their assertion that the party originally envisaged a provincial medical services plan in which all physicians would work on a salaried basis.[1] This document seems to have been written by Dr. Hugh MacLean, a Regina-based surgeon and Vice President of the Saskatchewan CCF until his departure to California in 1938 for health reasons. It appears to be a verbatim excerpt from a text Dr. MacLean delivered as a radio address on March 17, 1937, in the capacity of Vice President of the Saskatchewan CCF, and as a speech to the annual convention of the Women's Farm Organization on June 2, 1937, in Saskatoon.[2]

Lipset presents an extensive quotation from the 1937 Handbook in *Agrarian Socialism* to substantiate his claim that the CCF was opposed to a health insurance scheme, which he defines as a ffs medical services plan in which the "doctors would continue to practice exactly as they did under private medicine."[3] The CCF, Lipset maintains, envisaged a salaried medical service in which "the emphasis would be

changed from curative to preventive measures."[4] Doctors would be "paid to keep people well rather than to treat their ailments."[5] Stan Rands provides a similar interpretation of the 1937 Handbook in *Policy and Privilege*.[6]

MacLean's text is primarily a call for greater and more equitable access to modern medical care without charge to the patient. It is in this context that MacLean spoke of the need for "preventive medicine."[7] MacLean did not imply that the medical profession was not engaged in preventative medicine because they were remunerated on a ffs basis as opposed to salary, but rather because the majority of citizens at the time could not afford medical treatment and only went to a physician when an illness was at a critical stage:

> The matter of payment or non-payment for medical services is probably not the most pernicious evil. With all the advances of medical services we cannot make them available to a very large number. In our present system of practice, preventive medicine is largely neglected because the members of the [medical] profession are almost wholly engaged in the curative end of practice, so that preventable deaths are not being prevented and correctable conditions are not being corrected because the people are not in a financial condition to have their condition discovered.[8] (This excerpt from MacLean's text is quoted in *Agrarian Socialism* with the crucial exception of the clause "because the people are not in a financial condition to have their condition discovered.")

MacLean's ideas concerning the organization of a future health care system constitute a very small portion of the text, are not fully elaborated, vague, and quite ambiguous. Statements can be easily found and interpreted to support pre-conceived ideas about CCF physician remuneration policy. For example, MacLean's references to and praise for the provincial tuberculosis and cancer treatment programmes, and the municipal doctor system (all of these health care plans employed salaried physicians) in the context of his call for state control of health care do not necessarily mean that he was advocating, let alone envisaging, a state salaried medical service. There is, however, one passage in MacLean's text concerning curative medical practice in a

future health care system that could be interpreted as supportive of a salaried general practitioner service:

> Here also the curative side of practice could be undertaken with the hospital at the centre. The doctor could then do the work that for which he is best suited and especially trained and then he could devote his energies not to the competition of securing a living, but to the striving after better results. The nurse could also be employed...(the later two sentences are quoted by Lipset in *Agrarian Socialism*)[9]

However, MacLean may have simply been referring to the fact that in a state-financed medical services plan, physicians would be relieved of the often difficult task of collecting from their patients, price-cutting, and the anxiety of securing an adequate income because payment for their services would be guaranteed by the government. The removal of this burden would also allow the physician to "devote his energies not to the competition of securing a living, but to the striving after better results."[10] Even if the latter interpretation is accepted, one may suggest that the former statement does not in itself provide sufficient evidence for a claim that the Saskatchewan CCF envisaged the establishment of state salaried medical service.

In any case, no where in Lipset's excerpt from the 1937 CCF Health Plank, MacLean's radio address and speech to the Women's Farm Organization is there a declaration that a CCF government would place physicians on salary. One can safely state that there is no commitment to salary remuneration in the 1937 health care plank in its entirety, for surly Lipset would have quoted such a pledge in *Agrarian Socialism* to support his assertions. Subsequent policy papers and statements issued by the Saskatchewan CCF leading up to and during the 1944 provincial election campaign, unlike those of the National and Ontario CCF in 1943,[11] did not suggest, let alone declare, that a CCF government would place doctors on salary; nor do the resolutions pertaining to health services policy passed at the party's annual provincial conventions.[12]

In 1943-1944, as part of the 1944 provincial election campaign, the CCF health care policy was set forth in the following documents: 1) "CCF Program for Saskatchewan," first issued in November 1943 and reprinted April 1944; 2) a pamphlet "Let There Be No Blackout of Health;" and 3) a newspaper advertisement "The CCF Plans Health."[13] In these documents, as well as resolutions passed at the party's annual conventions, the party promised to set up a complete system of "socialized medicine with a special emphasis on preventative medicine so that every resident of Saskatchewan will receive adequate medical, surgical, dental, nursing and hospital service without charge."[14]

As noted in Chapter 3, by the early 1940's there was a consensus in Saskatchewan that there were two distinct genre of medical services schemes: 1) contributory health insurance; and 2) state medicine financed from general taxation with doctors on salary. In this context, the term socialized medicine was seldom used in Saskatchewan, with the exception of the Saskatchewan CCF. As noted in Chapter 3, the few instances of this term's application suggest that socialized medicine was understood as a generic term for a medical services plan providing universal coverage, either in the form of contributory health insurance or state medicine. None of the aforementioned CCF policy papers, nor summaries of the CCF health policy in Saskatchewan newspapers,[15] suggest that the CCF or the Saskatchewan public understood the party's pledge to implement socialized medicine as a commitment to salaried physicians.

In fact, none of the above mentioned CCF policy statements indicate how the CCF believed health care should be financed (via taxation or personal contributions) and doctors paid. Health policy resolutions passed at the party's annual conventions are similarly vague, with the exception of the 1943 CCF convention "resolution on

social services." This resolution states that "provincial and federal government contributions to cover all costs should be made out of the Consolidated Revenue funds,"[16] suggesting that the CCF stood for state medicine. In terms of physician remuneration, however, the resolution merely states that:

> all payments for professional services rendered should be made on the basis of a mutually acceptable contract for services.[17]

The resolution supports McLeod and McLeod's contention in *Tommy Douglas: The Road to Jerusalem* that the Douglas-Fines Executive decided in 1943 that a provincial medical services plan should be financed with "general government revenues," but "the question of whether doctors should work on salary or receive a fee for each service provided was left open."[18]

Nevertheless, the behaviour of some party members may have led some observers at the time to believe that the party supported a state salaried medical service. First, as noted in Chapter 3, the supporters of a scheme financed entirely from general government revenues(i.e. state medicine) in Saskatchewan, as opposed to individual contributions (premiums or a personal tax), were, without exception, in favour of a salaried scheme.

Second, the party itself attacked and criticized contributory health insurance using the language of the supporters of salaried state medicine. The CCF, like the SHML and UFC, for example, claimed that health insurance "only covers those who can afford to pay the insurance premiums"; "it does not provide adequate facilities for preventive medicine," etc.[19] However, criticism of contributory health insurance did not necessarily imply support for salary remuneration as Rands and Lipset suggest.[20] It was understood in Saskatchewan that in a health insurance scheme doctors could be paid on salary, capitation or ffs.

As noted in Chapter 3, the medical co-operatives, one of the most vociferous opponents of ffs remuneration in the province, preferred a scheme of contributory health insurance, with doctors on salary or capitation, to state medicine. As such, the supporters of salaried state medicine, let alone the CCF, did not attack health insurance because it did not entail the placing of doctors on salary.

Third, prominent members of the party were active in the SHML. P. G. Makaroff, Vice President of the CCF in 1940-1941 and "a leading party member outside the Legislature,"[21] was on the SHML executive and an outspoken advocate of salary remuneration.[22] And the Saskatoon CCF constituency informed the 1944 Sigerist Commission that it endorsed the SHML "Eight Point Plan for State Medicine."[23] However, the "CCF Program for Saskatchewan" stated categorically, albeit tactfully, so as not to alienate the SHML, that it did not support the League's "Eight Point Plan":

> While the C.C.F. is not committed to the support of the League's plan, the C.C.F. commends the work the League has done and approves the careful study of its plan.[24]

Despite the ambiguity surrounding the activities of some party members and officials it is apparent that the CCF did not have a clear policy on physician remuneration, let alone a commitment to a state-salaried medical service, prior to and during the 1944 election campaign.

Health care was, however, at the centre of the 1944 Saskatchewan provincial election campaign. Next to agriculture policy, health and education received the most attention by party candidates and speakers.[25]

The CCF led an all out assault on the Liberal government's health care record, and its platform reflected this campaign issue. The party levelled a multitude of accusations to the effect that the Liberal

government had neglected the health care needs of Saskatchewan people: mortality rate for infants was "twice as high as it needs to be"; preventive medicine was "almost completely neglected"; and most importantly, "thousands of people are going without medical treatment because they cannot afford it."[26]

In addition, the CCF argued that the federal government's health insurance proposals were "not enough to meet the health care needs of the people."[27] Echoing the SHML and other proponents of state medicine, the CCF maintained that health insurance only covered those able to afford the insurance premiums and did not make provisions for preventive services. The CCF stated further that there were not enough doctors, or adequate facilities in rural Saskatchewan for treatment and diagnosis.[28]

None of the parties, however, indicated how they believed doctors should be paid in a provincial medical services scheme. Physician remuneration was not an issue in the 1944 provincial election.

Except for a proposal to set up a non-political body similar to the Board of Directors of the Saskatchewan Anti-tuberculosis League to administer health services, the CCF programme was short on details.

The "CCF Program for Saskatchewan" declared that "in working out its health plans" a CCF government would "seek,"[29] and hope to obtain, the support of doctors and nurses. But it might "have to rely mainly on the younger doctors and nurses with a more progressive view point than that of some of the older members of the professions."[30] This pledge to seek the co-operation of the medical profession was re-iterated in "Let There Be No Blackout Of Health" and the "CCF Plans For Health," minus the disparaging remark with respect to the health care views of older physicians.

The CCF declared that a complete medical and hospital service could not be implemented immediately, but in stages, as the province's resources allowed. As an immediate step towards this objective, the party promised to immediately assist municipalities in financing municipal doctors and hospitals, expand the municipal doctor system to cover the two/thirds of rural Saskatchewan without such schemes; build health centres, and establish travelling clinics.[31] The CCF plan to expand the municipal doctor system was not considered radical in Saskatchewan. This policy had been endorsed by the Saskatchewan Legislature's Select Special Committee on Social Security and Health Services(1943-44) and the Saskatchewan Reconstruction Council. The CCF plan of action, in contrast to the Liberal's questionable commitment to health insurance contingent as it was on federal finances, contributed to the party's landslide victory at the polls in June of 1944.

Following the 1944 election victory, Dr. Hugh MacLean, who would act as the Premier Douglas' external adviser on health care policy during his tenure as Minister of Public Health from 1944 to 1949, gave an address on health services to the Saskatchewan CCF convention on July 13, 1944. Jacalyn Duffin and Leslie A. Falk in "Sigerist in Saskatchewan: The Quest for Balance in Social and Technical Medicine" state that MacLean's address "appears to have been the blueprint" for Sigerist's report.[32] In the area of financing, MacLean declared:

> The matter of financing health services should come largely if not altogether from the consolidated revenues to which all people contribute according to their ability to pay.[33]

In terms of physician remuneration, MacLean's address suggested a personal preference for salary remuneration. For example, after praising the medical care plan of the Kaiser Ship Building Corporation in the United States, based on group practice clinics staffed by salaried doctors, MacLean stated that the Kaiser plan:

> demonstrates to the medical profession and to others that there can be found medical men of high calibre working for a salary adequate to the skill of the doctor rendering it. Also that those who carry out this plan are not fearful of regimentation nor the stultifying of personal initiative....[34]

However, he did not call for the establishment of a state salaried medical service. MacLean stated that either "salary or a fee-for-service" could be employed in a provincial medical services plan, such as "in the Workmen's Compensation Act" or "on a system to be agreed upon by consultation by the medical profession and the Government."[35] Moreover, whatever the choice:

> No scheme can or should be put into operation without asking for the co-operation of the medical profession.[36]

Preparation for Salaried State Medicine?

When the CCF took office in June of 1944, party leader T. C. Douglas became Premier of the province of Saskatchewan. At Dr. Hugh MacLean's suggestion, Douglas also assumed the portfolio of Health Minister, signalling the importance his administration would place on health reform.[37] Preparations began at once to enable the new government to implement its health platform.

The Premier's first act as Minister of Public Health was to appoint Dr. Mindel Cherniak Sheps of Winnipeg, a general practitioner, as his assistant. Mr. Thomas H. McLeod, an economist and then personal assistant to the Premier, was assigned to work with Dr. M. Sheps.[38] The choice of Dr. Sheps was very much a political appointment to insure that the government had personnel that were sympathetic to its health care objectives. She chaired the Manitoba CCF research committee on health and was a member of the national CCF research committee on health.[39] Mindel and her husband Dr. Cecil G. Sheps, who was serving as Director of Venereal Disease Control for the Canadian Army in Alberta before he joined her in 1945,[40] were staunch socialists with family

members among the upper echelons of the Manitoba CCF.[41] CCF activists with deep roots in the CCF movement's urban prairie stronghold, Winnipeg's North End, the Sheps oversaw the Douglas government's health reform initiatives in the formative and turbulent 1944-46 period.

Mindel Sheps' first task was to assist an ad hoc Commission to conduct a comprehensive health survey of the province. According to Malcolm G. Taylor, the government decided that the survey should first "provide a series of explicit objectives and priorities," and second, "dramatize the government's thrust in health services."[42] Premier Douglas told Dr. Hugh MacLean that the "real object" of this survey was to 1) determine "the actual needs" of the province, and 2) "set out the more immediate steps that are essential to meet these needs."[43] Dr. M. Sheps was appointed secretary to the Commission.

Dr. Henry E. Sigerist, physician and internationally renowned professor of medical history at Johns Hopkins University, Baltimore, Maryland, was contacted and agreed to lead the survey. At the time of his appointment, Dr. Sigerist was a highly respected, yet controversial commentator on the need for universal prepaid medical care services; he was an expert and advocate of the Soviet health care system.[44]

Prior to his sojourn in Saskatchewan, Sigerist had made several high-profile visits to Canada in the early 1940's at the invitation of progressive individuals and organizations, such as the Canadian Association of Medical Students and Interns, and the Health League of Canada.[45] On these occasions he gave laudatory addresses on the Soviet health care system and stressed the need for universal access to modern medical care, or, in his words, to rectify the imbalance between the "technical" and "social" aspects of medicine.[46] During his third visit, in February of 1944, he addressed the Social Security Committee of the House of Commons, where he first met T. C. Douglas.

Sigerist had already accepted an offer from the national CCF to make a cross-Canada lecture tour when the Saskatchewan CCF was swept to power on June 15, 1944. The speaking tour was cancelled in order to allow Sigerist to accept Premier Douglas' request to lead the Saskatchewan survey.[47]

Dr. Sigerist's health care ideas at the time of his appointment were set out in an article published in the July 1944 edition of the *Canadian Journal of Public Health*. It is based on his address to the Social Security Committee of the House of Commons on February 10, 1944. Regarding the remuneration of doctors he wrote:

> There are three ways of remunerating doctors under a health insurance scheme [1) fee-for-service; 2) capitation; 3) salary]...The third, and in my opinion by far the best method, is for the funds to appoint physicians on salaries graded according to experience, responsibility, and hazard. The advantages of such a system are obvious...I am well aware that the idea of being salaried employees does not appeal to the majority of doctors, because it is not the traditional form of remuneration. They also fear that a salaried system might reduce their initiative. The experience in other countries, however, has shown that if salaries are adequate ...the doctors are very soon reconciled with such a system and appreciate the security and independence it gives them.[48]

In this context, the appointment of Dr. Sigerist to conduct a health survey in the province would have been, with out a doubt, viewed with suspicion by the SCPS. In other circles, particularly the SHML and its affiliated organizations, securing Dr. Sigerist may have been interpreted as a signal that radical health care policies could be expected in post-war Saskatchewan. Indeed, during its presentation to the 1943 Select Special Committee on Social Security and Health Services, the SHML recommended that the provincial government hire Sigerist to undertake a survey of health conditions in Saskatchewan similar to those he had conducted in the Soviet Union.[49]

As Jacalyn Duffin notes in "The Guru and the Godfather: Henry Sigerist, Hugh MacLean and the Politics of Health Care Reform in the 1940s Canada":

> Tommy Douglas seems to have chosen Sigerist to head up the survey because he was a distinguished outsider, with impeccable credentials, whose endorsement of the CCF plans would be difficult to criticize. They had met in Ottawa the preceding February and, given Sigerist's previous high-profile visits to Canada, the prior contract with the CCF, and his international reputation as an authority and a scholar, the choice seems to have been a foregone conclusion. But T. H. McLeod, Douglas' former economic advisor, said that the premier would not make any big decision without consultation with his experts and for health, the expert was "Doc MacLean."[50]

In this context, it is worth mentioning that Dr. Hugh MacLean, back in California, questioned Sigerist's appointment and suggested two other professionals with expertise in medical economics:

> We discussed Dr. H. E. Sigerist....All agree that he is a very scholarly gentleman who knows a great deal of the history of Sociology and Medicine. No one could better give a lecture on the need of extending the medical services to all the people such as has been done in Russia but we are rather afraid the he may not have the background of economics necessary to put into operation a system such as Saskatchewan should have....It is my opinion that the ground is ready for sowing the seed. As I mentioned in my address, the people and the profession have already been educated on the need.[51]

Dr. MacLean's assessment of the potential contribution of Dr. Sigerist to the survey suggests that the medical historian's appointment was motivated primarily by the government's objective to attain province-wide publicity for its health reform agenda.

To the Premier's disappointment, Dr. MacLean declined an invitation to serve on the Commission, insisting that there would be too many out-of-province physicians on the survey committee.[52] Instead, MacLean proposed that Dr. Lloyd Brown of Regina represent the medical profession, as Brown was head of the SCPS medical economics committee.[53] Dr. Brown agreed to serve on the HSSC with the College's consent and an understanding that the Report submitted by Dr. Sigerist would not necessarily be of Dr. Brown's own opinion.[54] Mr. Clarence Gibson, Superintendent of the General Hospital in Regina, Mrs. Ann Heffel, School Nurse, and Dr. J. L. Connel, dentist, made up the rest of the survey team.

Dr. MacLean also recommended that the survey committee include Mr. E. R. Powell of the State Hospital and Medical League:

> It would be politic to have someone say, like E. R. Powell, who has done a great deal of research work in this problem and has written that little book recently entitled the Medical Quest. I am not sure whether or not he would be hard to handle but if you could have him tied into it you might swing that quite large body belonging to the State Hospital and Medical League.[55]

Dr. MacLean's advice, however, was disregarded. No lay persons were appointed to the Commission. Dr. M. Sheps began her duties as secretary to the Commission, August 14, 1944. Dr. Sigerist was to arrive in Regina September 6, 1944, at which time the Commission would commence its tour of the province.

While this flurry of activity occurred within the government, the SCPS was at work on a number of fronts preparing for the developments that lay ahead. The College set up a negotiating committee to deal with the new government on "matters of medical interest, especially health insurance."[56] The College negotiating committee was comprised of the following physicians: Drs. U. J. Gareau(private practitioner), J. L. Brown(paediatrician), J. F. C. Anderson(specialist) R. K. Johnston(municipal doctor) O. M. Irwin(private practitioner), R. G. Ferguson(salaried specialist), the President and Registrar, R. W. Kirby and A. W. Argue(private practitioners).[57]

The SCPS' initial fears about a CCF government appear to have subsided (at least with some SCPS officials), as the CCF unveiled its health care agenda. In a letter to Dr. T. C. Routley of the CMA dated August 1, 1944, a SCPS official wrote:

> Since that time we have had, as you know, an election in this province and the new party installed....from what I can gather, it looks as though they are just going to enlarge the present arrangements that are in force for municipal doctors, which seems to be satisfactory to most people, the doctors included in this province. They also announce that they are going to look after the hospitalization and medical care of the Old Age Pensioners....However, they are setting up a Health Commission, I understand, that is going to have doctors on it and also laymen, who have been working with Hospitals, to look after hospitalization and the medical care of all these people. As far as I can see it is not going to be so very revolutionary, but they do aim later to have something different established.[58]

Still, several actions undertaken by the SCPS, as well as comments by the leadership and rank and file private practitioners indicate a certain anxiety about the future. First, in the SCPS' on-going conflict with the State Hospital and Medical League, the College sought the assistance of the CMA. At a meeting of the SCPS Medical Council July, 20, 1944, College Registrar, A. W. Argue, and J. F. C. Anderson, chairman of the College's publicity committee, were requested to obtain the aid of the CMA in preparing a reply to a recent SHML submission to the Saskatchewan Reconstruction Council(SRC) that the College felt contained inaccurate data.[59] Second, the Chairman of the Central Health Insurance Committee, Dr. Gareau, noted at the SCPS annual general meeting September 18-20, 1944, that "there had been some criticism of the [SCPS] Negotiating Committee personnel in that it was thought too many were salaried men."[60] Third, an "appeal for unity in the medical profession was made."[61] Moreover, at the SCPS annual meeting of September 1944 Dr Gareau declared that:

> The big task that needs yet to be completed is that of organizing the profession, one step in this direction was the appointment of Keymen to obtain the signatures of all doctors...when [the] men return from overseas the profession should work as one unit in trying to unify the practice of medicine.[62]

It was in this atmosphere that Premier Douglas met with the SCPS Negotiating Committee on August 23, 1944, to discuss the establishment of a medical care plan for old age pensioners and other social assistance beneficiaries.

The Old Age Pensioners Scheme

According to Malcolm G. Taylor's account of the negotiations of August 23, 1944, based on correspondence with Dr. C. J. Houston, "differences in their ideological approaches" emerged.[63] But "despite their differences in philosophy...the basic understandings on the

operation and the costs of the social assistance medical care program were agreed upon."[64] Doctors' payments would be made on a prorated ffs basis, to be drawn from a pooled sum representing $9.50 per capita. A formal offer consisting of the above terms was sent to the College September 13, 1944,[65] and was accepted October 1, 1944. On January 1, 1945, the approximately 25, 000 old age pensioners, blind pensioners, family allowance recipients and children who were wards of the state were eligible for free hospital and medical services.

McLeod and McLeod suggest that ffs payment was at the insistence of the SCPS.[66] Even so, C. J. Houston's account of the negotiations does not suggest that Douglas tried to obtain a medical services plan with doctors on capitation or salary. According to Houston's correspondence with Malcolm G. Taylor, at the meetings of August 23, 1944, Douglas informed the College that he wished to provide medical services to old age pensioners and other wards of the state and "asked for suggestions, about methods costs etc."[67] Houston writes further:

> My recollection is that there was no pre-selected position defended by either side. Both sides agreed that this was a special group justifying special treatment – and both sides were intrigued by the fact that this could be used as a special group to provide figures on which costs of future programmes could be more realistically calculated. Douglas wanted a programme for the pensioner's now! We offered him a practical way of doing it. He agreed in principle.[68]

These negotiations and their outcome may have been an early indication that the CCF's chief aim was the provision of state-funded medical services to the people of Saskatchewan as rapidly as possible. In this context, the method of payment for medical services appears to have been negotiable and, one may even suggest, immaterial to the CCF. The negotiations also indicate that Douglas was committed to a policy of co-operation with the medical profession.

Despite Douglas' acceptance of ffs in the government's first medical care agreement with the College, the future of ffs medicine in

Saskatchewan was far from certain. As Taylor notes, the "agreement did not deal with the main issue, a universal health insurance program."[69] It was presumed by many, in both medical and lay circles, that the Douglas government's policy concerning a province-wide medical care plan would be determined to a considerable extent by the outcome of the health survey now underway.

The Health Services Survey Commission: September 6 - Oct 5, 1944

Dr. Sigerist arrived in Regina on September 6, 1944, just two days before an Order-in-Council officially established the Health Services Survey Commission(HSSC). The Order-in-Council, approved and ordered by the Lieutenant Governor, September 8, 1944, stated that the Commission was for the purpose of:

> having an exhaustive study and inquiry made into and concerning existing health services and schemes of all types in Saskatchewan as well as hospitals, nursing homes, and all equipment or buildings available for the extension of health services, and further, to make a study of existing and potential facilities for training all types of health personnel, and for these purposes to consult with all organizations, and to include in his considerations any questions which he may hold to be relevant and to recommend to the Government of the Province of Saskatchewan a program which will provide for the extension of the above services and facilities to all parts of the Province in a more integrated and efficient manner and to make any recommendations he considers advisable for further study which will help in such a plan.[70]

This extract from the HSSC mandate suggests that the government had already decided the structure and content of the health system it hoped to establish in Saskatchewan, i.e. an expansion of the province's municipal doctor scheme, hospital system, and public health infrastructure, etc. Indeed, as we shall see, Dr. Sigerist would state precisely this when questioned by SCPS officials.

Following several days of meetings at the Legislature, public hearings were held in Regina on September 11-12, 1944. On September 13, 1944, the HSSC began its tour of the province.

Initially, the medical historian's public statements confirmed both the highest expectations of salaried medicine supporters, and the worst suspicions of the College. In an interview, published in the Regina Leader Post September 7, 1944, Dr. Sigerist praised and explained the health care system of the Soviet Union, consisting of health centres staffed by physicians remunerated on a salary basis according to experience, responsibility, and hazard. Sigerist called this type of delivery system "organized medicine."[71] During the interview, he also countered private practitioner's criticisms of salary remuneration with the same logic voiced by the SHML:

> The charge that organization will destroy the doctor's initiative does not hold water, any more than it would for teachers.[72]

Hence, with Dr. Sigerist, the SHML and its affiliated supporters of salaried medicine received publicity for their health care ideas, most notably, their "clinic plan," modelled as it was on the Soviet health care system.

Dr. Sigerist's appointment and initial pronouncements may have fuelled expectations that health care policies along the lines advocated by the SHML would be implemented by the Douglas government when the war ended. However, a week after Sigerist's comments, on the first day of the HSSC tour of the province, Premier Douglas said:

> "Our goal is state medicine, organized medicine, or socialized medicine, call it what you like. But it does not imply that every medical man will be employed as a civil servant," he said. It would not be practical to establish a system in Saskatchewan under which all doctors were servants of the state. The geographical make up of the province made necessary the inauguration of a system of whereby there would be government health doctors, municipality paid doctors and private practitioners. The health service plan as envisaged by his government, said the premier, would be a combination of provincial and municipal services operating in conjunction with private practice. The program would be directed by the Saskatchewan government, with municipal and private doctors co-operating to provide medical services to all residents in the province regardless of their ability to pay.[73]

Douglas' statements, however, may not have precluded the possibility of Dr. Sigerist recommending a state salaried medical scheme in his report

to the provincial government. In his posthumously published autobiographical writings, Sigerist claims that he had sole responsibility for the Commission's report:

> I have the Status of Beveridge, that is, I alone will be responsible for the report and the other members act as technical advisers. In this way we are sure to avoid a minority report.[74]

This fact was clear to both advocates and opponents of salaried state medicine, as the proceedings of the SCPS Annual General Meeting on September 18-20, 1944, indicate.

Dr. Kirby's Presidential address to the annual gathering of the province's physicians suggests that College officials were optimistic but anxious about the future. The Premier's pledges of co-operation seem to have reassured the SCPS leadership of the government's intentions, but the doctors were clearly concerned about Sigerist's forthcoming report. Kirby stated:

> We have the assurance of Premier Douglas that the present government proposes to work with the medical profession in setting up any Health Insurance scheme. This pronouncement, while gratifying to us, clearly carries with it an important responsibility as co-partner in the formative stages as well as in its implementation...We are all to have the opportunity of hearing Dr. Sigerist, the Chairman of the Committee...Dr. Sigerist has already outlined his view in a recent publication of the[Canadian] Journal of Public Health, which no doubt many of you have read. While these views are not set down with this province specifically in mind, as it was written before this present study was undertaken, we as the recognized body to carry on the work of caring for the sick in Saskatchewan await with considerable anticipation the report of findings and suggestions they will make.[75]

The College's optimism was helped by Sigerist's response to a query by SCPS officials at a HSSC hearing in Saskatoon that coincided with the SCPS annual meeting. Sigerist was asked by a College representative if he supported salaried state medicine. He responded that:

> he was not committed to a policy of state medicine. Premier Douglas, he said, had already outlined the plan to build health services from existing facilities.[76]

The College's fears were further assuaged by the Premier's banquet address at the final evening of the SCPS convention. Douglas said that:

> The government...had no wish to make all doctors civil servants. There was no real controversy between health insurance and state medicine. The government believed that health services, preventive and therapeutic should be available to all people in the province irrespective of their ability to pay. He could not, he said, set a fixed pattern for the method by which this would be carried out and he was not particularly preoccupied with forcing any particular technique. The details would be worked out on whatever basis the government could get possible co-operation with the medical profession.[77]

Indeed, throughout the formative 1944-45 period, Premier Douglas repeatedly dismissed any suggestions that his government intended to introduce a medical care scheme with all doctors on salary.

It is worth noting here that the transcripts of the HSSC public hearings and tour of the province indicate that Sigerist was made aware of the fact that the province's salaried municipal doctors were also private practitioners:

> On the way from Stasbourg to Wadena the Members of the Commission stopped at Wynyard and there had a conversation with Dr. K.M. Polec. Dr. Polec and Dr. Brawley of Wynyard share in a municipal contract for the area and each has a private practice besides.[78]

He was also informed of the municipal doctors' preference for ffs remuneration in a provincial medical services scheme. Dr. R. K. Johnston told the commission that they "would go on a fee-for-service if Health Insurance comes in."[79]

Report of the Commissioner, H. E. Sigerist

The HSSC received its final submission on September 28, 1944, in Regina. As noted in Chapter 3, the representations revealed support in Saskatchewan for the establishment of a salaried medical service. However, this support was not reflected in the HSSC's *Report of the Commissioner*, submitted October 4, 1944.

Dr. Sigerist's report was, in the main, a health care plan for rural Saskatchewan. The province's urban centres were discussed only briefly, beginning with an introductory statement that "the problem of providing health services to the inhabitants of the cities is less difficult and less urgent than the problem of rural health services."[80]

Reference was made to the various medical services plans in the cities, including MSI, and the "great benefits" they provided to those involved. Regarding cities, the report concluded:

> at the moment the most practical policy may be the gradual extension of public services so as to include maternity care and hospitalization, supplemented by a system of compulsory health insurance, the details of which would have to be worked out.[81]

For rural Saskatchewan, Sigerist recommended that the municipal doctor system which "has stood the test of time...should be maintained and developed."[82] Municipal doctors would provide a general practitioner service in rural health centres. Cases requiring surgery and other specialized work would be treated in District Hospitals where group practise would predominate. Remarking that municipal doctors "were unquestionably overburdened with work and underpaid," the report advised the provincial government to set a minimum salary, representing net income, that would increase with years of service according to a scale to be established. Physicians should be granted paid vacations, and, every few years, leave of absence for post-graduate training.[83] These suggestions to improve the conditions of municipal practise were neither new nor unique. Indeed, the introduction of Dr. Collin's proposed model contract would enact all of these recommendations. Sigerist made no references to the ffs municipal doctor contracts.

In the sensitive area of physician remuneration in general, the report states simply that "there can be no doubt that in the future more and more medical personnel will be employed on a salary basis."[84] The report endorsed the concept of salary remuneration, but did not, as some hoped, put forth an agenda to either place private practitioners on salary or recommend the termination of the ffs municipal doctor contracts. Nor did it advise that salaried municipal doctors be denied private practice privileges.

A number of observations concerning the Dr Sigerist's report can be made.

First, David Naylor in *Private Practise & Public Payment*, states:

> As a medical observer later remarked: "It is much milder than might have been expected from one known to be such an enthusiastic advocate of the Russian System."[85]

One might add the following to Naylor's point. When one considers the statements of both Dr. Sigerist and Premier Douglas in September 1944, the rather moderate health care plan put forward by the HSSC Commissioner was probably neither unforeseen, nor unexpected by Saskatchewan residents.

Second, the health care plan outlined in the HSSC report was almost identical to that envisaged by the Saskatchewan CCF leadership since the 1930's. Dr. Sigerist's recommendations can be found almost verbatim in the 1937 CCF Handbook, the 1943-1944 CCF health care plank, Dr. Hugh MacLean's address of July 1944, and in T. C. Douglas' policy statements as Premier and Minister of Public Health in the autumn of 1944. Thus the Sigerist report should be considered as a continuation and confirmation of previous CCF health care policies.

Third, the report's findings and proposals also reflected the policy papers, briefs and petitions of SARM, UFCSS, SHML(minus their demand that doctors be placed on salary) and many more organizations and individuals. Moreover, many of these same ideas were also recommended and supported by the SCPS. As Mombourquette notes: "What was unique about the report was that this was the first time the ideas were presented in a comprehensive package to a government which had the political will to put the reforms into effect."[86]

The Establishment of the Health Services Planning Commission

Following Dr. Sigerist's departure, Dr. M. Sheps and T. H. McLeod set to work drafting legislation that the Premier declared would "fulfil the spirit of the [HSSC] report." The Health Services Act became law on November 10, 1944. This Act authorized: 1) the division of the province into health regions "for the administration of health services under the Act and the Public Health Act"; 2) public payment of health services "in any health region" and "for such persons or such class or classes of persons as may be designated by the Lieutenant-Governor in Council"; and 3) the distribution of "grants or subsidies to municipalities, hospital boards and health regions, or any of them for the provision and operation of health services."[87]

The Health Services Act of November 1944 also created the Health Services Planning Commission(HSPC). The commission's broad mandate included the following tasks to facilitate the establishment of a province-wide health services scheme as outlined in the HSSC report: 1) determine the costs of providing health services and recommend ways of financing and implementing them; 2) work out in detail a complete health care plan, including financing, for one or more health regions; 3) plan a compulsory health insurance programme for one or more urban centres; 4) and recommend remedial action for municipalities which do not have adequate health services.[88] These tasks, as was the establishment of the Commission itself, were among Sigerist's "recommendations for immediate action."[89] The legislation also authorized the appointment of an advisory committee to the HSPC.[90]

Dr. Mindel C. Sheps, Mr. T. H. McLeod and Mr. C. C. Gibson were appointed to the HSPC via an Order in Council approved and ordered on November 14, 1944.[91] This small group became the nucleus of both

planning and administration of medical and hospital services during the Douglas government's first term in office.

Following the creation of the HSPC, Dr. Mindel C. Sheps and Mr. T. H. McLeod started work on health care proposals for rural Saskatchewan. The HSPC completed its "Report on Regional Health Services: A Proposed Plan" on February 15, 1945. An Advisory Committee of the Health Services Planning Commission, representing professional and occupational groups, institutions, labour and women's groups was then established to consider the Commission's proposal. The first meeting of HSPC Advisory Committee convened on March 2, 1945.

An examination of Saskatchewan CCF health care policy from 1937 until the party became the government of Saskatchewan in July of 1944 suggests that it was never explicitly committed to the establishment of a state salaried medical service. The CCF appears to have been undecided as to how physicians would be paid in a provincial medical services plan when it assumed office. The 1943-1944 CCF health care policy stated that a CCF government would seek the co-operation of the medical profession in developing a provincial medical services plan. This pledge was reiterated with considerable emphasis in Dr. Hugh MacLean's address to the 1944 CCF provincial convention.

In power, Premier T. C. Douglas repeatedly denied that his government planned to place physicians on salary. He declared that it was the government's policy to provide medical services to all the people regardless of their ability to pay - the method by which this was to be accomplished was not important. Moreover, this objective was to be obtained with the co-operation of the medical profession. One may suggest that, in view of the SCPS' ardent opposition to alternative remuneration systems, the pursuit and maintenance of government-SCPS co-operation would inevitably result in ffs schemes. These declared

policies were followed in securing a medical care plan for old age pensioners and other social assistance beneficiaries.

The outcome and negotiations for the Old Age Pensioners(O.A.P) scheme suggests that the CCF's chief aim was the provision of publicly-funded medical services to the people of Saskatchewan. The method of payment for these medical services, whether ffs, salary, or capitation, was negotiable. Owing to the College's adamant opposition to capitation and salary remuneration, for the government to insist upon either of these payment methods, would have, without a doubt, retarded the introduction of medical services under a state-controlled plan. A hard-line position on physician remuneration would have led to protracted negotiations, or the difficult and risk-prone option of by-passing the College and attempting to directly force the profession into a salaried medical service. It would appear that neither of these scenarios was agreeable to the Douglas government. Indeed, McLeod and McLeod state that "to the distress of his socialist supporters, Douglas declined to force the doctors on to a salary system in the mid-1940's because he wanted to get his health program for the poor off to a quick start."[92]

The O.A.P agreement, with its inclusion of ffs payment, is the first tangible manifestation(beyond both public and private statements) that the Douglas government was committed to a policy of co-operation with the medical profession in developing a medical care programme for the province.

The old-age pension scheme provided the SCPS with a vehicle with which it could work toward the entrenchment of ffs in the province's fledgling state-financed medical care system. Indeed, College officials recognized the O.A.P scheme as just such an opportunity, as a memo drafted by Dr. B. C. Leech(Chairman of the College's Medical

Committee responsible for administering O.A.P medical service payments to participating physicians) makes clear:

> The organized profession has undertaken through the O.A.P. scheme to prove conclusively that a fee for service basis of payment for medical care can operate and be adequate for beneficiaries and fair and satisfactory to both government(or contracting party) and all members of the profession who take part.[93]

Preservation of the ffs remuneration system was, without a doubt, an impetus behind the SCPS' complete co-operation with the O.A.P. scheme, which became fully operational on January 1, 1945. In the O.A.P scheme's inaugural year, College officials made repeated calls for full compliance with the programme's administrative practices, such as the following that appeared in the May 1945 issue of the *Saskatchewan Medical Quarterly*:

> There are still a few doctors who are refusing to co-operate with the old-age pension scheme and offer as an excuse "irksome forms"...The proponents of state medicine have always used as an argument, that the salaried doctor would not be bothered with bookkeeping and form filling so that those who would have Health Insurance, voluntary or compulsory, must be prepared for a certain amount of form filing. The committee would again ask for your co-operation.[94]

The significance of Douglas' acceptance of ffs payment and the O.A.P. scheme per se has not always been fully recognized.

The appointment of Henry Sigerist clearly was not part of a CCF strategy to implement a state salaried medical service in Saskatchewan. Sigerist did not advocate the establishment of a salaried service during his health survey of Saskatchewan in the autumn of 1944. Nor did he recommend or set forth a plan for such a medical care system in his report to the provincial government. However, following Sigerist's departure, the HSPC would devise and present to the government and representatives of the public and the SCPS proposals for the development of a province-wide salaried general practitioner service in rural Saskatchewan - despite the fact that Premier Douglas appears to have already dismissed such a policy.

Endnotes:

[1] Lipset, *Agrarian Socialism, op. cit.*, p. 289; Rands, *Privilege and Policy, op. cit.*, p. 98.

[2] Saskatchewan Archives Board, Saskatoon (hereafter SABS), Papers of Dr. Hugh MacLean (hereafter MacLean Papers), file 2, "Radio Address by Dr. Hugh MacLean, Vice President, C.C.F. SASK. Section, Wednesday, March 17, 1937," pp. 2, 4; "Health Services., Women's Farm Organization. By Dr. Hugh MacLean., Wednesday June 2, 1937," pp. 5, 10.

[3] Lipset, *supra*, p. 289

[4] *Ibid.*, p. 288.

[5] *Ibid.*

[6] Rands, *supra*, p. 98.

[7] SABS, MacLean Papers, file 2, "Radio Address by Dr. Hugh MacLean," p. 3.

[8] *Ibid*; Lipset, *supra*, p. 289.

[9] *Ibid.*

[10] *Ibid.*

[11] Naylor, *Private Practice, Public Payment, op. cit.*, p.123; Rands, *supra*, pp. 98-99.

[12] See for example, "Minutes of Sixth Annual Convention of C.C. F. Saskatchewan Section held in The Bessborough Hotel, Saskatoon, July 17-18, 1941, Resolutions: Health." SABS, Papers of the Co-operative Commonwealth Federation, Saskatchewan Section (hereafter CCF Papers), Minute Book #2, p. 7 (#629).

[13] Saskatchewan Archives Board, Regina (hereafter SABR), Political Pamphlets, file 19, #41, "The CCF Program for Saskatchewan," first printing, November, 1943, reprinted, April 1944, pp. 7-8; file 19, "Let There Be No Blackout Of Health," circa 1943-1944; "The CCF Plans For Health," *Regina Leader*, 12 June 1944.

[14] *Ibid.*

[15] See for example, "Political Parties Outline Stance," *Leader Post*, 20 May 1944.

[16] SABS, CCF Papers, Minute Book #3., "Resolution on Health Services," pp. 13 – 14 (#749-750).

[17] *Ibid.*

[18] McLeod and McLeod, *Tommy Douglas, op. cit.*, p. 148.

[19] See for example, "The CCF Plans For Health," *Leader Post*, 12 June 1944.

[20] Lipset, *supra*, p. 289; Rands, "The CCF in Saskatchewan" in Donald C. Kerr ed. *Western Canadian Politics, op. cit.*, p. 61.

[21] McLeod and McLeod, *supra*, p. 127.

[22] See for example, P. G. Makaroff, "The Municipal Doctor, Health Insurance, Co-operative Insurance And Other Alternatives," radio address delivered over CJRM and CFQC, February 21, 1943, cited in State Hospital And Medical League, *The Case For State Medicine* (1944), pp. 23-26.

[23] SABR, Records of the Health Services Survey Commission (hereafter HSSC), file 10, Fred Gordon (Secretary CCF Saskatoon Constituency) to the Secretary (Mindel C. Sheps) Dr. Sigerist Health Commission, 16 September 1944.

[24] SABR, Political Pamphlets, "The CCF Program for Saskatchewan," p. 7.

[25] Raymond Merle Sherdahl, "The Saskatchewan General Election of 1944," (Unpublished Master's Thesis, University of Saskatchewan, 1966), pp. 72, 82.

[26] "The CCF Plans For Health," *Leader Post*, 12 June 1944.

[27] *Ibid.*

[28] *Ibid.*

[29] SABR, Political Pamphlets, "The CCF Program for Saskatchewan," pp. 7-8.

[30] *Ibid.*

[31] "The CCF Plans For Health," *Leader Post*, 12 June 1944; "Political Parties Outline Stance," *Leader Post*, 20 May 1944.

[32] Duffin and Falk, "Sigerist in Saskatchewan," *op. cit.*, p. 672; See also Duffin, "The Guru and the Godfather," *op. cit.*, pp. 203-208.

[33] SABS, MacLean Papers, file 2, "An Address on Medical Health Services by Dr. Hugh MacLean At the C.C.F. Convention, Regina, Saskatchewan July 13, 1944," p. 4.

[34] *Ibid.*, p. 3.

[35] *Ibid.*, p. 4.

[36] *Ibid.*

[37] SABS, MacLean Papers, file 3, "Premier Douglas Becomes Minister of Health," n. d.

[38] Malcolm G. Taylor, *Health Insurance and Canadian Public Policy*, *op. cit.*, p. 87.

[39] Allan Mason Chesney Medical Archives of the Johns Hopkins Medical Institutions, Henry Sigerist Papers, Box 25, Mindel C. Sheps to Henry E. Sigerist, 12 August 1944.

[40] Duffin, "The Guru and the Godfather," *supra*, pp. 195-196.

[41] McLeod and McLeod, *supra*, p. 147.

[42] Taylor, *supra*, p. 88.

[43] SABS, MacLean Papers, file 29, T. C. Douglas to Dr. Hugh MacLean, 7 August 1941.

[44] Sigerist made his first field survey of the Soviet health care system in 1935, returning in 1936 for further study. His findings were published in 1937 under the title *Socialized Medicine in the Soviet Union*. In

order to keep up with developments, Dr. Sigerist made a third trip to the Soviet Union in 1938. In 1943 he founded the American Review of Soviet Medicine. Henry Sigerist, *Medicine and Health in the Soviet Union* (New York: The Citadel Press, 1947), pp. xii-xiii; Duffin, "The Guru and the Godfather," *supra*, p. 212 (n. #6).

[45] For an account of Henry Sigerist's three trips to Canada in 1941, 1943, and 1944 prior to his Saskatchewan survey see Duffin and Falk, "Sigerist in Saskatchewan," *supra*, pp. 660-667; Duffin, "The Guru and the Godfather," *supra*, pp. 194 -195.

[46] Ibid.

[47] Duffin and Falk, "Sigerist in Saskatchewan," supra, p. 670. Duffin, "The Guru and the Godfather," *supra*, p. 195.

[48] Henry E. Sigerist, "Medical Care for All the People," *Canadian Journal of Public Health*, Vol. 35, No. 7 (July, 1944), pp. 259-260.

[49] SABR, HSSC, file 30, "Relevant Material in Proceedings of Select Special Committee on Social Security and Health Services,"(unpaginated).

[50] Jacalyn Duffin, "The Guru and the Godfather," *supra*, p. 196.

[51] SABS, MacLean Papers, file 12, Dr. Hugh MacLean to T. C. Douglas, 2 August 1944.

[52] SABS, MacLean Papers, file 29, MacLean to Dr. Sigerist co. Premier Douglas, 3 October 1944.

[53] SABS, MacLean Papers, file 29, MacLean to Dr. Harold Graham, 6 December 1948.

[54] Dr. J.F.C. Anderson, "Summary of Plan For Socialized Health Services," *Saskatchewan Medical Quarterly* (*SMQ*), Vol. 9, No. 1 (May, 1945), p. 6.

[55] SABS, MacLean Papers, file 12, MacLean to Douglas, 11 August 1944.

[56] *SMQ* ,Vol. 8, No. 3 (September, 1944), p. 12.

[57] *Ibid.*

[58] SMA/SCPS, file "Health Insurance Miscellaneous," Chairman Divisional Advisory Committee to Dr. T. C. Routley, 1 August 1944.

[59] *SMQ*, Vol. 8, No. 3 (September, 1944), p. 12.

[60] *SMQ*, Vol. 8, No. 4 (December, 1944), p. 9.

[61] *Ibid.*, p. 8.

[62] *Ibid.*, p. 9.

[63] It would appear that the "differences in their ideological approaches," noted by Taylor, concerned the following heated exchange recalled by Dr. C. J. Houston, rather than opposing ideas on physician remuneration: "I suppose we had criticized him for being doctrinaire and unaware of the true health needs of the people as we doctors were. In reply he was pretty cutting about the ignorance of doctors on health insurance matters. We replied that we thought we were informed. He said he had seen no evidence of it. We replied by inviting him to come and be informed! He was furious. But I think it a measure of the man that he replied 'All right, I have another meeting now but I'll come back tonight at 7 O'clock.' And he

did...the framework of the mechanics of the old age pensioners plan was agreed upon that evening in a few short hours...." SABS, Papers of Dr. C. J. Houston (hereafter Houston Papers), file 23, C. J. Houston to Malcolm G. Taylor, 25 February 1945.

[64] Taylor, *supra*, p. 244.

[65] *SMQ*, Vol. 8, No. 2 (June, 1944), pp. 19-20

[66] McLeod and McLeod, *supra*, p. 149.

[67] SABS, Houston Papers, file 23, C. J. Houston to Malcolm G. Taylor, 25 February 1945.

[68] *Ibid.*

[69] Taylor, *supra*, p.244.

[70] O.C. 1013/44. *The Saskatchewan Gazette*, No. 17, p. 3.

[71] "Organized Medicine: Army plan should be applied to Civilians," *Leader Post*, 7 September 1944.

[72] *Ibid.*

[73] "Doctors will not be civil servants," *Leader Post*, 14 September 1944.

[74] Nora Sigerist Beeson, *Henry E. Sigerist Autobiographical Writings* (Montreal: McGill University Press, 1966), p. 189.

[75] *SMQ*,, Vol. 8, No. 4 (December, 1944), p. 6.

[76] "Wide Range of Proposals Heard By Sask. Health Service Survey," *Western Producer*, 28 September 1944.

[77] "Adequate Health Service For All The People is C.C.F. Aim," *Western Producer*, 28 September 1944.

[78] SABR, HSSC, file 27, "Report of Sitting held at Strasbourg, Sask. Sept. 13, 1944 at 10.30 a.m. in the Town Hall."

[79] SABR, HSSC, file 27, "Report of Hearing in Eston, September 21, 1944.," p. 3.

[80] Henry E. Sigerist, *Saskatchewan Health Services Survey Commission: Report of the Commissioner*, (Regina: Kings Printer, 1944), p. 6.

[81] *Ibid.*

[82] *Ibid.*, p. 5.

[83] *Ibid.*

[84] *Ibid.* p. 10.

[85] Naylor, *supra*, p. 138.

[86] Duane John Mombourquette, "A Government and Health Care: The Co-operative Commonwealth Federation in Saskatchewan," (Unpublished Master's Thesis, University of Regina, 1990), p. 55.

[87] Bill 58 - An Act respecting the Provision of Health Services; Health Services Act, 1944.

[88] *Ibid.*

[89] Sigerist, *Report of the Commissioner, supra,* p. 12.

[90] Bill 58 - An act respecting the Provision of Health Services; Health Services Act. 1944.

[91] O.C. 1316/44.

[92] McLeod and McLeod, *supra*, p. 198.

[93] SMA/SCPS, file "O.A.P Administration, 1944," Dr. B. C. Leech, "O. A. P. etc. Scheme," n. d.

[94] *SMQ*, Vol. 9, No. 1 (May, 1945), pp. 31-32.

Chapter 5

The Rejection of the 1945 HSPC Salaried Medical Service Proposals

Introduction

In early 1945 the HSPC completed its health care proposals for rural Saskatchewan. Central to these proposals was a recommendation for the establishment of a salaried general practitioner service. This chapter begins with a brief description of these health care plans, paying close attention to their proposed implementation. Public and organized medicine's receptivity to the HSPC proposals is then detailed. Each departure from the HSPC plans for a salaried medical service is in turn analyzed, including the establishment of the Swift Current medical care plan. Public reaction to ffs remuneration in this experimental health insurance programme is detailed as a further test of Lipset's contention that the Saskatchewan electorate did not support the establishment of salaried medical service. The development and extension of the municipal doctor system under the Douglas government is explored to determine if this initiative was the first step of a strategy to implement a salaried service at a later date.

1945 Health Services Planning Commission Rural Health Care Proposals

The HSPC rural health care proposals were set out in a series of policy memoranda prepared for the Minister of Public Health titled "Regional Health Services," and in an abridged version of these documents submitted February 15, 1945, as a "Report on Regional Health Services: A Proposed Plan."[1] These papers recommended four main policies: regional organization, local control and autonomy, group practice and diagnostic centres, and, most importantly, a salaried general practitioner service.[2]

The HSPC recommended that the "general practitioner service should be a salaried service,"[3] built upon the existing municipal doctor system. General practitioners would be stationed in local health centres serving the population of one or more rural municipalities and the towns and villages therein. The HSPC proposed model contract for the employment of general practitioners by the proposed health boards stipulated that physicians carry out all medical and obstetrical work, act as a public health officer, and submit regular reports to the lay health boards. In keeping with salaried service, the physician would "not conduct any private practice except in an emergency or until another physician is called."[4] In addition to his salary, graded according to experience, qualifications, responsibility and working conditions, physicians would be provided with a pension plan, paid holidays, and paid leave for post-graduate study, as well as a well-equipped, rent-free office. They would also have the right to appeal dismissal by the local health board and request transfer.[5]

The immediate provision of a medical and hospital service without charge to the patient in rural Saskatchewan as envisaged by the HSPC was impeded by two factors. First, such an ambitious project would "necessitate substantial contributions by the Federal Government."[6] Second, in 1945 Saskatchewan severely lacked the required facilities (hospitals, nursing homes, etc.),[7] modern diagnostic and treatment equipment, and all types of health care personnel (technicians, nurses, specialists and in particular general practitioners)[8] to deliver the high standard of service the HSPC envisaged in every area of the province. In 1946 Premier Douglas noted that:

> even if Saskatchewan had $20,000,000 available to spend on a health scheme, we could not have instituted a complete health program because of insufficient equipment and trained personnel.[9]

The HSPC believed that alleviating the shortages of facilities and trained personnel, as opposed to removing the direct cost of hospital and medical care to the citizen of Saskatchewan, should be the province's first priority "since the economic status of the people has improved to a degree, while qualified personnel has become less adequate in numbers."[10] The provincial government would follow the advice of its health planners and direct most of its health care budget towards hospital construction, the expansion and modernization of existing health care facilities, the procurement of equipment, the training of nurses, mid-wives, laboratory and X-Ray technicians, and the construction and staffing of a medical school,[11] as opposed to assuming, or substantially subsidizing, the costs of providing hospital and medical services to the people of Saskatchewan.

The HSPC hoped that at least one region would be set up in 1945 with a complete hospital and medical service as an experiment. Other regions would be encouraged to organize in order to co-ordinate and plan existing and projected health care facilities and services. Until there were adequate personnel and facilities for all the regions to provide a complete health service, the HSPC recommended that every resident of rural Saskatchewan be provided with a family physician, and that the cost of the doctor's services be shared by the community served by the physician.[12]

In order to provide general medical care to all the residents of rural Saskatchewan, the HSPC proposed the creation of a financial assistance programme to enable and encourage municipal councils to employ general practitioners on a salary basis, i.e. hire municipal doctors - as the CCF promised during the 1944 provincial election campaign. Equalization grants would be made available to the poorer and less populous municipalities. A flat grant was also recommended in

order to "induce the more prosperous rural municipalities to enter the scheme."[13] It was through these grant-in-aids that the HSPC hoped to develop and extend the existing municipal doctor plans into a "province-wide, salaried general practitioner service...outside the eight cities, as a minimum and a foundation," and "lay the groundwork for a complete regional service."[14]

If the entire rural and small urban population of the province took advantage of these grants, an expenditure of $475,000 would be required. The HSPC estimated that no more than $150,000 to $200,000 would be necessary in the first year as it would be "some time before the whole population would take advantage" of the grants.[15]

Meeting of the Advisory Committee to the Health Service Planning Commission, March, 2-3, 1945

Once the HSPC proposals for rural health care were completed, the provincial government hurriedly appointed an advisory committee to the commission, as authorized by the 1944 Health Services Act. The advisory committee's functions were to: a) convey the opinions of their groups with respect to the plans presented to them; b) interpret the government's plans to their organizations; c) form sub-committees on matters of particular interest to certain groups; and d) "suggest plans and subjects for investigation."[16] Ultimately comprised of 31 members, the HSPC Advisory Committee consisted of representatives of the province's medical and para-medical associations, trade unions, agriculture organizations, the Saskatchewan Association of Rural Municipalities(SARM), and a number of private citizens and lay bodies interested in health care reform, such as Matt Anderson and the State Hospital and Medical League(SHML).

The Advisory Committee held its first meeting on March 2-3, 1945.

The minutes suggest that the HSPC proposals were well received by the Committee's lay representatives. M. S. Anderson, for example, was particularly supportive of the plan:

> Mr. M. S. Anderson thought the plan very good, and suggested that the quickest way to sell the plan would be for the Government to give small financial assistance to areas already organized. He was pleased by the stress place on local responsibility. He was sure that with the feeling among the people and the Government we have now, it will not be long before we have the plan in operation....[17]

Moreover, the Advisory Committee passed a motion put forward by Mr. J. A. Thain of Saskatoon, representative of the Provincial Council of Trades and Labour Congress, that the HSPC "advise the Government to proceed with the necessary organization to set up at least one region in the very near future."[18]

According to the minutes, the lay members' sole objection to the proposals concerned the decentralization of medical personnel and facilities, and in particular the concept of having specialists travelling to outlying hospitals to attend patients. Lay delegates concurred with the Committee's medical and dental representatives that it would be far more practical and efficient if specialists were stationary, working all the time; patients should be brought to the specialists at the regional centres. There is no evidence in the minutes of lay opposition to the establishment of a salaried general practitioner service.[19]

The SCPS representatives on the Advisory Committee, Dr. J. F. C. Anderson and Dr. C. J. Houston, did not share their lay counterparts' enthusiasm for the proposals. Dr. Anderson had reservations concerning the proposed administration of the medical service, stating that "too much local interference is not good, if the local Board has too much control over the doctor."[20] The physicians also disagreed with the decentralization proposal. Regarding the proposed salaried general practitioner service, however, the college representatives were more

guarded in their criticism.[21] Dr. Houston merely stated that "conditions under which services are to be rendered should be discussed with those rendering services."[22] Directly following Dr. Houston's statement, Mr. Ansell, representative of the Local Unions of the Canadian Brotherhood of Railway Employees, "suggested that eventually the whole medical service would be a salaried service."[23]

Subsequently, Drs. Anderson and Houston "vigorously protested a vote being taken on the acceptability of the plan."[24] However, J. A. Thain of the Trades and Labour Council "urged with success that the committee should endorse the plan before it adjourned in order that progress in implementing it would be possible."[25] It is important to note here, however, that according to Dr. C. J. Houston's report to SCPS on the Advisory Committee meeting of March 2-3, 1945, "Douglas had been present at various times and had stated once that the "Commission's plan was not necessarily the policy of the government."[26] Dr. Anderson stated that "he had not the authority to endorse any plan now, but would take the plan back to the College and they would be prepared to comment in detail."[27] Accordingly, a meeting with Premier Douglas and the Deputy Minister of Health, Dr. Hames, was requested by the College and scheduled for March 21, 1945.[28]

By that time, the provincial government had announced its plans to introduce the HSPC proposed grants scheme, including a flat per-capita grant. In an address to a SARM meeting on March 7, 1945, Premier Douglas stated that grants would be given to rural communities employing municipal doctors provided that their contracts met certain conditions.[29] The SCPS objected to making the grants dependent upon the municipal doctors being restricted from engaging in private practice, as recommended by the HSPC. College officials predicted "dissension" by the province's municipal doctors if they were denied their private

practice privileges and confined to a straight salary.[30] Indeed, in his report to the College's Central Health Insurance Committee on the HSPC Advisory Committee meeting of March 2, 1945, Dr. C. J. Houston suggested that the province's municipal doctors might leave rural Saskatchewan "if they are to be restricted entirely to contract practice."[31] Consequently, the government's medical care grant scheme and the proposed salary municipal doctor contract would be at the forefront of the grievances put forward by SCPS Health Insurance Committee at its meeting with Premier Douglas on March 21, 1945.

Meeting of the Central Health Insurance Committee and T. C. Douglas, March 21, 1945.

At the outset of the Premier's meeting with the SCPS Central Health Services Committee in the afternoon of March 21, 1945, Douglas was presented with a lengthy resolution that stated the College's opposition to "an exclusively salaried service," and reiterated its support for "state-aided health insurance on a fee-for-service basis."[32] According to the *Saskatchewan Medical Quarterly*, the ensuing discussion hinged around the following points in particular:

> (a) Whether Mr. Douglas and his Government intended a salaried service medical service only?... (b) The necessity for flat grants and their possible abuse. (c) The administrative set-up.[33]

In terms of the latter issue, the College was opposed to the Department of Health administering medical services. The SCPS wanted the administration to be vested in an independent, non-political Commission with "adequate" representation of the medical profession.[34] In addition, the SCPS noted that there were no provisions for medical representation on the proposed local, district and regional health boards. The doctors were opposed to the "teacher-schoolboard relationship" that would result from such an arrangement.[35] Moreover, as Taylor observed, "if regional boards negotiated contracts with regional medical

societies, the political control by the College of the system as a whole would have been seriously fragmented."[36]

In response to these concerns, Douglas first stated "that the profession was unduly alarmed and reading intentions into the draft that were not there."[37] His "concern was to provide medical care to everyone as rapidly as possible."[38] He then reiterated his position from the outset of the Sigerist Commission that the method by which medical services were to be provided did not matter, just as long as this objective was attained. The government's policy was to provide state-aided health insurance in the cities and municipal doctor scheme in the rural areas, "and it was his opinion that such would still leave a very large place for private practice."[39] Finally, Premier Douglas stated categorically that the government was not committed to the establishment of a salaried medical service:

> Dr. Hazen asked whether or not his government was definitely and irrevocably committed to salaried state medicine, to which the Premier replied definitely that it was not.[40]

Next, regarding the proposed administration, Douglas stated that an independent commission was not possible because the disbursement of tax dollars must be under a government department directly responsible to the people; the local health units were for the purpose of getting people interested in health problems not to "embarrass the doctor by making him responsible to a Local Health Board."[41]

In terms of the grant-in-aid scheme for the financing of municipal doctor plans, Douglas made a significant concession to the doctors' insistence on ffs remuneration that would severely compromise the HSPC proposals for the establishment of salaried medical service:

> He[Douglas] led the meeting to believe that he was willing to subsidize rural municipalities on a fee-for-service basis as well as those rural municipalities employing municipal doctors on the salary system.[42]

The College accepted salary remuneration and the provision of equalization grants in the remote, less prosperous regions of rural Saskatchewan, but insisted on ffs outside of these areas.[43] Accordingly, Dr. Houston protested the provision of flat grants, maintaining that they would force municipalities to establish a municipal scheme "regardless as to whether it was in the patients' best interests or applicable to the community's greatest need...."[44] The doctors were opposed to grants "which could or might be used as a means of coercion to force a salaried system of medicine in rural areas."[45] The Premier was warned that the HSPC proposals would deter physicians from setting up practice in the province and cause others to leave because the "profession are definitely opposed to converting the medical profession into a salaried branch of local or central government service."[46]

Regarding the HSPC recommendation to prohibit municipal doctors from private practice, Dr. R. K. Johnston told Douglas that, based on his 1944 survey, the province's municipal doctors wanted a practice of "contract work[salary]" and "outside practice[private fee-for-service practice for surgical but mainly general medical care rendered to private patients both within(towns and villages)and outside the contracting municipality]" (as noted in the SMQ, "not municipal practice alone"[47]), and that "they favoured the municipal work as it was now operated."[48]

As the meeting came to a close, Douglas "assured" the doctors that a "new[medical care] plan could be worked out based, except in two or three matters, on the general [health insurance]principles adopted at the annual meeting of the College in September 1944."[49] To this end, the Premier proposed that the College's representatives on the Advisory committee, Drs. Anderson, Houston, and Johnston, form a sub-committee of the HSPC to "obtain the necessary revisions."[50] This suggestion was

enthusiastically received and approved by the SCPS health insurance committee. Hence, it is clear that the Premier rejected the HSPC recommendations for salaried state medicine.

Negotiations between the government and the SCPS resumed on April 14, 1945. Drs. Anderson, Houston and Johnston, as the HSPC Advisory Committee's newly-appointed medical subcommittee, met with the HSPC and Dr. Hames, deputy minister of Public Health, to discuss revisions to the HSPC proposals in accordance with SCPS health insurance principles, as recommended by Premier Douglas. The doctors reiterated their opposition to medical care grants that would "tend to coerce municipalities into adopting a certain kind of scheme."[51] They wanted to be certain that such grants would be made available to municipalities whether physicians were paid by salary or ffs. According to the minutes, "since they had already been assured of this by the premier, they were assured of it once more."[52] Aside from these comments, physician remuneration was not discussed.

The SCPS committee conceded, with respect to their objections to administration by the Department of Health, that the government must "exercise a certain amount of control" when it "supplies the funds and therefore assumes the responsibility."[53] They believed that "it might be possible to work out an agreement satisfactory to the profession" if "matters relating to technical questions" were referred to a medical advisory committee (comprised of physicians recommended by the SCPS).[54] As set forth in the SCPS' health insurance principles adopted at the College's 1944 annual convention, one of the "technical questions" that the SCPS wished to have referred to a medical advisory committee concerned physician remuneration:

> (f)Subject to regulations approved by the College of Physicians and Surgeons to secure the rights and conditions of practice of and for physicians under the scheme;[55]

If the Douglas government or the SCPS' coveted independent commission accepted and adhered to the advice of the proposed medical advisory committee on this matter regarding physician remuneration, ffs payment would be safeguarded. Fee-for-service remuneration would be further protected if the Douglas government agreed to principle no. 3 of the 1944 SCPS health insurance proposals:

> (3) The method and amount of remuneration shall be decided upon by negotiation between the Commission and the College of Surgeons.[56]

The College delegation requested that the HSPC provide comment on the 1944 SCPS health insurance principles. In due course the SCPS received a memorandum from Dr. M. Sheps consenting to the establishment of a Medical Advisory Committee whose "advice would be considered and normally accepted" on the various professional, technical and scientific matters specified by the SCPS in their 1944 health insurance principles, including clause (f) as noted above.[57] The SCPS then sought to have the Sheps memorandum officially endorsed by the Premier.

A SCPS negotiating committee, comprised of four specialists based in Saskatoon and Regina: Drs. J. L. Brown, J. F. C. Anderson, E. A. MsCusker and U. J. Gareau,[58] met with Premier Douglas August 15, 1945. The College delegation re-iterated SCPS opposition to the administration of medical services by the HSPC and demanded that administrative authority, with the exception of finance, be vested in an independent, non-political commission. At the conclusion of the August meeting Douglas requested a memorandum outlining the SCPS position; College officials were to receive a memorandum in return.[59]

Accordingly, the College sent a memo similar to the list of the health insurance principles adopted at the 1944 SCPS annual meeting and the resolution of July 29, 1945, with the exception of health

insurance principle #3 regarding the method and amount of remuneration to be paid physicians. In this document an additional clause was added under the items to be referred to the proposed Independent Commission's Medical Advisory Committee that, if accepted, would further safeguard ffs remuneration. Fee for-service would thus be protected by two clauses that the Commission would "refer to the Medical Advisory Committee...and take such action thereon as the Medical Advisory Committee recommends":

> (b) The agreement or arrangement whereunder the profession will provide medical services.
>
> (g) Subject to regulations approved by the College of Physicians and Surgeons to secure the rights and conditions of practice of and for physicians under the scheme.[60]

Correspondence with the SCPS suggests that the Premier's sole caveat with respect to the powers sought by the College for the Medical Advisory Committee and through this body, the College itself, concerned its demand to determine what physicians were eligible to practice under a provincial health care scheme.[61] After another apparently amicable meeting September 18, 1945,[62] Premier Douglas sent his famous letter of September 19, 1945, confirming his acceptance of an independent commission, a medical advisory committee, and the aforementioned remuneration clauses that, if adhered to, would preserve ffs payment in a provincial medical services plan.[63] But whether, with this letter, Premier Douglas had, in fact, both compromised the HSPC proposals, and precluded the establishment of a state salaried medical service in Saskatchewan, is unclear. As Malcolm G. Taylor notes in his Ph.D. dissertation with respect to Douglas' letter of September 19, 1945:

> the letter is somewhat ambiguous and refers to the need for "continuing discussion" and to principles which "it would seem...have been agreed upon." Whether the Government will construe these as a commitment when the time comes to introduce a province-wide plan is unclear.[64]

However, by this juncture several compromises had been made to the 1945 HSPC proposals for a province wide salaried medical service in rural Saskatchewan. It is to these compromises that we now turn.

Municipal Contract Practice: April 22, 1945 – November 3, 1945

The first deviation from the 1945 HSPC proposals for the implementation of a salaried general practitioner service in rural Saskatchewan was the introduction of a new model salary municipal doctor contract that continued to allow physicians to engage in private practice on a ffs basis. The HSPC recommended straight salary municipal doctor contract was rejected at the first meeting of the HSPC and its Advisory Committee's newly-appointed subcommittee on Local Health Services (consisting of Drs. C. J. Houston and R. K. Johnston of the SCPS and lay members Mr. M. S. Anderson of Bulyea and the President of SARM, Mr. W. S. Woods) on April 22, 1945. The existing Health Services Board(HSB) model contract was examined clause by clause. Both the Committee and the government's health planners unanimously agreed to remove Section B of the HSB model contract that stipulated that the municipal doctor was not to engage in private practice outside the confines of his municipality, except in emergency situations.[65] Clause 3b that set forth the municipal doctor's right to private practice, providing that it did not interfere with his duties to the municipality, was left intact.[66]

At a glance, the decision in early 1945 to continue to allow the province's municipal doctor's to engage in private practice appears as both a major concession to the medical profession and a significant impediment to the establishment of a salaried medical service in rural Saskatchewan. However, if the government's medical care grants scheme engendered a significant expansion of the municipal doctor system as

the HSPC anticipated, simultaneously eliminating the rural private medical practice market, the municipal doctors' private practice privileges would be of little consequence. As such, a straight salary municipal doctor contract, as recommended by the HSPC, was not essential to the development of a salaried medical service in rural Saskatchewan.

A copy of the new-model contract and questionnaire were forwarded to all municipal physicians on August 9, 1945. According to a report compiled by R. K. Johnston and Dr. C. J. Houston, the replies as of September 12, 1945, indicated that municipal doctors "do favour Municipal Contract Practice and that they are satisfied with the proposed minimum salary of $5000.00 for a 9 township municipality with a population of 2000."[67] It is important to emphasize here that this endorsement of municipal contract practice did not indicate a predilection towards salary remuneration among the municipal doctors. At the 1945 SCPS Annual Meeting on September 20-22, 1945, Dr. Johnston "pointed out that the [municipal physicians] prefer fee-for-service contracts."[68] Johnston and Houston also reported that the municipal doctors were not generally in favour of surgical contracts, but if necessary preferred ffs agreements.[69]

One may suggest, in view of the municipal doctors' preference for ffs payment, that the municipal physicians' continued support for municipal medicine stemmed, in part, from the fact acknowledged by the HSPC that a "considerable portion of the work of these physicians would be private practice."[70]

Fee-for-service contracts were also discussed at the Subcommittee meeting of April 22, 1945. Dr. M. Sheps viewed a model ffs contract as problematic:

> Dr. Sheps reported that she had not prepared a model since there were very few such contracts available in the department, and since it was difficult to see how any control could be exercised over such contracts without setting up a number of regional medical committees to pass on all work done and on all accounts. It was doubtful whether the government could do this in the case of schemes financed and controlled by local municipal councils. She suggested that all the Commission could do was to lay down certain minimum services that was to be provided and leave the rest up to the local people.[71]

Dr. Houston insisted that there be a minimum schedule of fees for ffs contracts. Dr. Johnston and the committee's lay representatives felt that 75% of the SCPS 1942 schedule, suggested by Dr. Houston, was too high. The meeting ended with this matter undecided and with the understanding that Dr. Sheps would send the committee members copies of existing ffs contracts.[72] As we shall see, the absence of a model ffs contract became a major source of tension and discord between the SCPS and the HSPC.

Having devised a new model salary municipal doctor contract, the HSPC proceeded to prepare regulations for the provision of medical care grants, namely that agreements between municipal councils and physicians conform to the new model contract. As the HSPC set to work on this task it soon became apparent that organized medicine would attempt to deter the creation of a health care system in rural Saskatchewan based on municipal contract practice.

In a confidential memo to O. W. Valleau, acting Minister of Health, May 7, 1945, Dr. Sheps reported that Medical Services Incorporated(MSI) was pressuring the council of the rural municipality(RM) of Lajord to cancel its municipal doctor contract(salary) with Dr. Kraminsky of Regina, and enter into an agreement with MSI for all its medical services.[73] Should the municipal council refuse, MSI threatened to cancel its contract with the RM for surgical services and force Dr. Kraminsky to do likewise. MSI had adopted a resolution to the effect that none of its members (all members of the Regina District Medical Society were members of this

physician-controlled medical insurance body) would enter into a municipal doctor contract. Sheps viewed this incident as the start of an MSI campaign to eliminate municipal contract practice in Saskatchewan:

> There is no doubt that, while the excitant(sic) cause for this move on the part of Medical Services, Inc., may have been cupidity, tinged with an even worse motive, the main reason is to attack the municipal doctor system. Attacking it in a wealthy municipality close to Regina is, they probably feel a good beginning.[74]

The Lajord incident emphasized the vulnerability of the government's rural medical care policy to MSI. In order to both preserve and facilitate the expansion of the municipal doctor system and other lay-controlled medical care schemes, in 1946 the government would remove the authority for rural municipalities to enter into agreements with MSI.[75]

In another initiative to avert the development of a province-wide municipal doctor system outside of the cities, the SCPS sought changes to the government's forthcoming grants for municipal medical care schemes. In a letter to Dr Mindel Sheps of May 10, 1945, Dr. C. J. Houston maintained that many of the rural municipalities eligible for equalization grants were receiving an excellent medical service from several private practitioners that was superior to one whereby residents would be tied to one municipal doctor. The sums involved in the proposed grants, which Houston referred to as excessive "bribes" that would "coerce any municipality into providing municipal doctors regardless of whether it is in the best interests of the patients concerned,"[76] could thus be better utilized obtaining other health services urgently required in these areas, e.g. hospitals, nursing homes, etc. He therefore recommended that the grants be made applicable towards the costs of a variety health services, as opposed to the exclusive use of employing municipal doctors.[77] Dr. M. Sheps

replied that the "general purpose and types of grants available...." were not HSPC recommendations, but "a result of the decision of the government;" and as such, the commission was not in the position to discuss any alteration to the grants.[78] The Deputy Minister of Health, Dr. Hames, wrote to Dr. Houston stating his concurrence with Dr Sheps' reply and that "a change in policy will not be made."[79]

Subsequently, on June 12, 1945, an order in council was passed that authorized the provision of flat grants and equalization grants to assist municipal councils in financing medical services plans.[80] As such, the provincial government introduced its medical care grants scheme for the employment of municipal physicians despite SCPS opposition. It is worth noting here that there was little that the College could do to stop this initiative. The municipal doctor system was a popular institution in rural Saskatchewan. As Premier Douglas reminded the medical profession in an essay published in the May 1945 edition of the *Saskatchewan Medical Quarterly*: "no municipality, once having adopted the system has given it up of its own accord."[81] To openly oppose the government's financial assistance programme for the extension of the salaried municipal doctors system would only further damage, by the SCPS' own admission, organized medicine's poor public image.[82] In addition, R. K. Johnston, the municipal doctors' representative on the SCPS Health Insurance Committee, was in accord with flat grants because, one may suggest, they would encourage the inclusion of a minimum salary, holidays, etc., in the municipal contracts of the municipalities not eligible for equalization grants.[83]

Having failed in its efforts to alter the government's medical care grants scheme, the SCPS took consolation in the fact that the grants would be available to rural municipalities "whether payment is made by flat salary, fee-for-service, capitation fees or any

combination of the preceding."[84] Thus Douglas honoured his verbal promise to the SCPS Health Insurance Committee on March 2, 1945, that municipal councils operating ffs medical care schemes would also be eligible for state assistance - the second and, in hindsight, most significant compromise to the 1945 HSPC proposals.

Since 194I rural municipalities had the authority to pay their municipal doctors on a ffs basis. The vast majority of municipal councils, however, continued to renew their annual contracts on a salary basis. As noted in Chapter 2, of the approximately 179 municipal medical care plans in operation in 1944, only 10 schemes recompensed physicians on a ffs basis. Municipal councils appear to have preferred salary to ffs plans because they allowed for accurate budgeting. As long as physicians were willing to work on contract, one could safely estimate that the vast majority of existing and future municipal doctor plans would operate on a salary basis. As such, the possibility of developing a de facto salaried service as envisaged by the HSPC still existed despite this concession.

Moreover, ironically, making the grants available for ffs municipal medical care plans would aid the implementation of the government's medical grants scheme - and, in turn, a policy that could potentially lead to the establishment of a province-wide salaried medical service. Because the grant-in-aids were available for ffs as well as salary medical plans the provincial government could dismiss accusations that it was imposing salaried employment of physicians in rural Saskatchewan. For example, in reply to Dr. Houston's contention that the medical care grants would force the employment of municipal doctors, Dr. Mindel Sheps informed Houston that the rural municipalities in his area could devise a scheme whereby they agreed to

pay any of the physicians in Yorkton and the surrounding towns on a ffs basis.[85]

As the spectre of the development of a salaried general practitioner service via the expansion of the municipal doctor system still existed, the SCPS mistrusted the HSPC and wanted to have municipalities establish ffs plans, particularly those that allowed patients to consult doctors anywhere in the province. As Dr. C. J. Houston and R. K. Johnston noted in a SCPS report of August 1945 regarding municipal medical care plans, the ffs plans with free choice of physician "more nearly resembles our ideal of Health Insurance and should be more easily fitted into a state scheme when it comes."[86] In this context, College officials were concerned by the HSPC's lack of initiative and apparent reluctance to formulate a model ffs contract.[87]

The implications of the absence of a model ffs contract in connection with the medical care grants scheme were forcefully stated by C. J. Houston in a letter to Dr. Lindsay September 26, 1945:

> The grants to which I have so often referred and which no other medical men seem to have studied as to their implications - are the only tangible remainder of Madame Sheps' plan for state medicine. But the regulation and order-in-councils are all in existence to apply them as from January 1, 1945 - and the various municipal councils are studying how to get in on them. As it stands, any municipality that wants to get the grant would find only one contract officially approved - that is the model municipal physician agreement on a salary basis - and that in spite of the fact that Mr. Douglas has repeatedly stated that grants would be available whether the contract were on salary or fee-for-service basis. We want this made more definite and specific and that the municipalities should be made aware of their entitlement to a choice of contract.[88]

Drs. C. J. Houston and R. K. Johnston, whom the SCPS appointed as a committee to formulate a model ffs contracts for both general practitioner and surgical services on July 25, 1945,[89] believed that the apparent lack of initiative on the part of the HSPC to introduce an approved ffs model contract indicated a HSPC policy to encourage the establishment of salary as opposed to ffs municipal medical care plans:

> It appears that the government is committed to a scheme of prepaid medical care and that they wish to finance and service it on a municipal basis. It would also appear that certain

> elements within the government service are anxious to coerce us into one type of salaried medical practice.[90]

This conviction stemmed from and contributed to the SCPS' growing distrust of the HSPC and, in particular, Mindel Sheps, the architect of the 1945 HSPC proposals for a salaried medical service, which College officials referred to as the "Sheps Plan."[91] Dr. Houston would later confide to Dr. Lindsay, following Mindel's resignation from the HSPC in January of 1946, that he:

> always felt that Sheps' chief objective was to canalize the government's health efforts into channels that would facilitate a scheme of State Medicine and make the introduction of health insurance more difficult.[92]

As the SCPS predicted, the HSPC did not devise a model ffs contract during the summer or early autumn of 1945. However, the Commission did issue grants to municipalities with ffs plans during this period. Of the 33 municipal medical care schemes to receive grants between July 1, 1945, and Oct 31, 1945, 5 were on a ffs basis. However, to the consternation of the College 3 of these approved contracts were at 50% the SCPS fee schedule as opposed to the 75% demanded by the doctors.

Convinced that the absence of an approved model ffs contract would facilitate the establishment of salaried plans the SCPS once again sent a letter to the HSPC and Premier Douglas demanding that the HSPC devise a model ffs contract - this time with a demand that the fees referred to be at 75% the SCPS fee schedule.[93] On November 3, 1945, at a meeting requested by the SCPS to discuss "municipal contract practice" Premier Douglas agreed that the HSPC should draft a model ffs contract.[94]

Henceforth this issue ceased from being a major source of conflict between the SCPS and the provincial government, although it was not until 1947 that a model ffs contract was introduced. With Mindel

Sheps' resignation from HSPC in early 1946,[95] the SCPS' suspicions that the commission was using the absence of an approved ffs model contract to encourage the establishment of salary as opposed to ffs municipal medical care plans seem to have died. The doctors' concerns with respect to the expansion of the salary municipal doctor system were mitigated further by the inclusion of ffs payment, as opposed to salary, in the Swift Current medical care plan, the province's first experimental medical insurance plan, launched July 1, 1946. This development, moreover, entailed the discontinuation of several salary municipal doctor schemes.

The Swift Current Medical Care Programme and Physician Remuneration in Saskatchewan: 1946 - 1949

The incorporation of ffs remuneration in the province's first regional medical care plan - the fourth and final departure from the 1945 HSPC recommendations for a salaried general practitioner service - was the result of local decision making, as opposed to a direct concession to the SCPS by the Douglas government. The particular organization, form and content of medical services in the health regions, including physician remuneration, resided with local government authorities through their elected health board.[96]

As Dickinson notes, the principles of local control and initiative were institutionalized in the procedures and regulations governing the establishment and powers of health regions and their lay boards, in part, because the provincial government, "firmly rooted at the time in a tradition of agrarian democratic populism, was concerned not to usurp traditional local prerogatives and control over the provision of health care services."[97] These policies, however, led to the most visible departure from the 1945 HSPC salaried medical service

proposals because the first area in the province to secure the necessary support to set up a health region and, in turn, decide to introduce a medical services plan, Health Region #1, Swift Current,[98] was the least conducive to the establishment of a salary medical service.

Of the 30 rural municipalities, 34 villages, 6 towns and one city that constituted the Swift Current Health Region, only 4-7 rural municipalities and several villages within them had municipal doctor schemes.[99] And of these municipal medical care plans 3-4 of the schemes were on a ffs basis,[100] almost ½ of the approximately 10 ffs plans in operation in 1944-1946.[101] Moreover, the senior executive positions of the Swift Current Health Board(Carl Kjorven board chairman and Stewart Robertson, Secretary Treasurer)were drawn from these municipalities with ffs plans.[102] As was W. J. Burak, Secretary Treasurer and former reeve of the Rural Municipality of Pittville, who was instrumental in securing support for both regional organization and the establishment of a medical services plan.[103] The area's experience with ffs plans, and its acceptance of ffs remuneration is candidly recorded in the *Saskatchewan Medical Quarterly*:

> For some time several municipalities within the region had operated, quite successfully, schemes of municipal practice on the basis of freedom of choice of doctor on a fee-for-service rendered basis. The medical men of the region expressed confidence in the members of the regional executive and also believed they had the confidence of the executive.[104]

As such, the board of the Swift Current Health Health Region(SCHR) did not object when the Swift Current District Medical Society declared that it was willing to participate in a medical care plan provided that physicians were paid on a ffs basis and patients had free choice of doctor.[105] Indeed, the Board's initial overtures to the region's local physicians seem to have included a proposal to pay doctors on a ffs

basis.[106] The doctors successfully bargained for ffs payment at 75% the SCPS fee schedule.[107]

Although the inclusion of ffs remuneration in the Swift Current Medical Care plan was not a direct CCF concession to the SCPS as some scholars suggest,[108] this departure from the 1945 HSPC recommendations for salaried medicine was facilitated by the Douglas government's policy to subsidize both ffs and salary municipal plans facilitated this development.[109] Moreover, it is important to note that even if the Douglas government had retained control over physician remuneration policy in the health regions, it would appear that a similar deviation from the 1945 HSPC proposals would have occurred. At a meeting with local physicians of the proposed Moose Jaw health region on January 7, 1946, Douglas stated that if the regional board decided to implement a medical services plan, it was probable that doctors would be paid on a ffs basis:

> Following the talk there was a lengthy discussion period in which the doctors asked specific questions. Chiefly they seemed to be worried about whether or not they would be placed definitely on salary and the Premier assured them that any arrangements made by the regional board would be on the advice of their own medical advisory committee and with the approval of the Health Services Planning Commission. He suggested that it seemed probably[sic] that should the regional board undertake in the not too distant future to provide free medical services that each person in the region would then be given a card that entitled that person to go to the doctors of his choice for services and the doctor would then submit his fee to the board.[110]

In the context of organized medicine's objective, pursued since the early 1930's, to entrench ffs practice in a provincial medical services plan, the incorporation of ffs payment in the Swift Current medical care programme was an important victory. However, in 1946 the preservation of ffs medicine in Saskatchewan was far from certain.

First, just as the spectre of the establishment of a salaried service in rural Saskatchewan was receding, a new threat to ffs medicine in the province had emerged from the Saskatoon Medical and Hospital Benefit Association. By early 1946, the medical services co-

operative had grown to 13, 000 members
borrow funds and expand its operations
amendments to its charter by the provi
persons, including dependants, were el
benefits.[112] The co-operative anticipat
of 1946,[113] about 1/3 of the city's app
residents.

At the co-operative's annual mee
Angus MacPherson, Mayor of Saskatoon,
directors had been authorized to borro
the construction a group practice clin
physicians.[114] Satellite operations wo
North Battleford and 10 additional lar
towns of Rosetown, Unity, Biggar, Mild
Sutherland.[115] The director of the asso
the co-operative was "planning, with G
Saskatoon area on a voluntary basis wh
originally set out to do."[116]

The manager of the medical co-op
maintained that the provincial governm
"wished the association to avail itsel
university medical centre and hospital
association extend its services to mor
SCPS registrar, Dr. Lindsay, requested
provincial government's understanding
Douglas replied:

> As you know, the government feels that the
> necessary step in the development of adequate
> gratified whenever group practice clinics are set u
> whenever a group practice clinic is set up in this
> this is a healthy development and we have no do

first year of operation of its ffs medical care plan and the health region's projected deficits for 1947/1948.[125]

In reporting SARM's negative response to the 1947 fee-schedule at a SCPS meeting September 6, 1947, College officials announced that SARM believed that the cost-overruns of the Swift Current ffs medical services plan proved that salary contract offered greater control over expenditure.[126] They also reported that the rural municipalities were reluctant to accept ffs contracts for fear of being "dragged into a health region."[127] Based on a meeting with the SARM executive October 23, 1947, to discuss the SCPS 1947 fee-schedule and related issues HSPC Chairman Dr. F. D. Mott reported that:

> There is a very strong sentiment among members of the Executive for straight state medicine, with physicians on salary. However, they realize that this kind of development is not to be anticipated in the immediate future and they are reasonably open-minded about using the fee-for-service system as a basis for payments to physicians.[128]

On November 1, 1947, SARM informed the College Registrar, Dr R. G. Fergusson, that the 1947 SCPS fee-schedule was acceptable (albeit not at 100%, the precise percentage would have to be worked out), provided that a "cost ceiling be established" for both municipal and regional medical care plans.[129]

SARM was also in agreement with the HSPC that the salaried municipal doctor schemes should be strengthened, via adequate salaries and security measures, so that they would not be "eliminated and replaced by more expensive fee-for-service plans."[130]

Fee-for-service medicine in Saskatchewan was also threatened by the fact that the establishment of the Swift Current ffs medical care plan did not rule out the implementation of a salaried medical service in the other health regions, or the Swift Current Health Region at a later date. In areas of the province where salaried municipal doctor plans were well-entrenched, residents might be less willing to accept a

ffs scheme,[131] and insist upon alternative remuneration methods - especially in the context of the Swift Current medical care plan's previous and projected operating deficit(s). Indeed, at a meeting held December 10, 1947, to discuss expenditure ceilings for regional, municipal, and provincial ffs medical care plans, with Premier Douglas, the HSPC, and the SARM medical care committee in attendance, Mr. Kjorven and Mr. Robertson, Chairman and Secretary-Treasurer of the Swift Current Health Region Board, announced that:

> if the doctors would not agree to a reasonable limitation on the expenditure of funds, the Region was prepared to institute a system of medical care with doctors on salary and with clinics owned and operated by the Region.[132]

In this context, despite the objections of the SCPS, participating physicians in the Swift Current medical care programme agreed to a budget ceiling for 1948.[133]

Furthermore, the Douglas government could return to the principles of the original 1945 HSPC proposals - as the supporters of a salaried scheme demanded - and insist on salary remuneration in regional medical care schemes. However, it would appear that the provincial government had no intention of utilizing the municipal doctor system as a foundation for the establishment of a salaried medical service.

At a HSPC advisory committee meeting on May 9-10, 1947, Commission Chairman Dr. Mott stated that the establishment of regional medical care schemes would "mean wiping out" municipal doctor plans.[134] He observed that it might be necessary to provide a special subsidy to retain doctors in the outlying areas of health regions. Dr. Anderson remarked that the SCPS "recognized the need for salary retainers for doctors in remote areas but in addition doctors should be allowed to collect fees in order to attract them to outlying areas."[135] In this context, Dr. Mott appears to have ignored a suggestion(immediately

attacked by SCPS officials) put forward by T. H. Thain, representative of the Saskatchewan Provincial Executive, The Trades and Labour Congress of Canada, that all doctors be placed on salary.[136] As such, it would appear that the Swift Current medical care plan had established a precedent with respect to physician remuneration in regional medical care schemes.

Prior to the meeting of May 1947, T. H. Thain, who had argued with success against the objections of the SCPS that the advisory committee endorse the 1945 HSPC proposals at their unveiling on March 2, 1945, stated at a Trades and Labour Congress meeting that the Douglas government "'didn't have the guts' to implement a real scheme of socialized medicine."[137] Dr. Mott's comments with respect to regional medical services at the HSPC advisory committee meeting in May of 1947, no doubt, reaffirmed Mr Thain's convictions.

Shortly after the May meeting, Mr Thain resigned from the Advisory Committee to the HSPC. The compromises to the 1945 HSPC proposals for the establishment of a salaried medical service appear to have been the primary motivation for his action:

> After two years of continuous erosion of the plan and seeing no hope of having it established under the present system I resigned from the Commission in protest of the lack of action to place the main sections of the plan in operation, that of all administrators of services under the health services plan to be on a salary basis. I was very critical of the government for its lack of fortitude.[138]

Other advocates of a salaried service, both within and outside the CCF expressed their opposition to the ffs medical care plan introduced in the Swift Current health region,[139] and urged the provincial government and the regional health boards to hire doctors on salary.

The SHML was particularly critical of the Swift Current Health Region's ffs plan, as exemplified by the following excerpt from the editorial in the October 1947 edition of the League's *Health Services Review*:

> The Swift Current health region No. 1. has demonstrated that the financial returns to medical personnel on a fee-for-service basis when paid for by the Region so that people do not refrain from seeking medical attention is ridiculously high and out of all reason...We deplore the pussy-footing attitude which bows to the demands of organized medicine for maintaining the less efficient method of private practice.[140]

The SHML continued to pass resolutions at its annual conventions calling for doctors to be paid on a straight salaried basis.[141] The SHML believed that if the government were to employ on a salaried basis all physicians willing to practise on salary and made their services available to the public "there would soon be such inroads into private practice that sufficient medical personnel would be available on a salary basis."[142] Younger doctors and, in particular, recent and forthcoming medical graduates, who were perceived as being more agreeable to salary remuneration, were viewed by the SHML as the potential nucleus of a nascent state salaried medical service.[143]

Although the provincial government clearly did not intend to force private practitioners into a salaried medical service, it did actively recruit recent top graduates from Canadian medical schools to work in health regions and medical centres in Saskatchewan on a salary basis. Selected graduates were offered minimum salaries of $5000 per annum, two weeks annual holiday with pay, and an additional three months every second year for post-graduate work.[144] In addition, the HSPC sought to strengthen the salaried municipal doctor plans. The HSPC also pressed the Board of the Swift Current Health Region to establish a group practice clinic with a staff of full-time salaried specialists.[145]

These initiatives, coupled with the rural municipalities' preference for salary as opposed to ffs municipal doctor plans, may have prompted SHML President Dr. Setka to declare at a SARM meeting February 24, 1948, that he was "convinced that the Province was heading rapidly into a salaried medical service."[146] But this was not to be.

First, in spite of the initiatives to secure doctors on salary, the provincial government appears to have been agreeable to the continued development of a province-wide health care system on a ffs basis, provided that there was a ceiling on expenditure. In a letter to Dr. G. Gordon Ferguson, College Registrar, February 26, 1949, clarifying the government's position on physician remuneration in the ffs medical care plans operated by individual municipalities and health regions, Premier Douglas referred to these ffs schemes as the "forerunners of an over-all provincial program to be developed as soon as it is feasible."[147] He stated that he was in accord with a policy of paying physicians "adequately and generously for their services," but that such programmes must "be financially sound" and not "overtax the paying ability of the people concerned."[148]

The fact that the Douglas government was neither developing nor planning to implement a salaried medical service in the province, and in contrast, the apparent public support for such a policy was candidly stated in passing by HSPC Chairman F. D. Mott, in a letter to Dr Hugh MacLean dated March 21, 1949:

> ...the medical profession here simply don't know when they are well off. Sometimes I feel like pulling out leaving them to their fate with a population that wants to see real state medicine developed rather than the conservative form of health insurance which we are slowly developing.[149]

Second, the anticipated expansion of the predominantly salaried municipal doctors system via the government's medical care grant scheme did not occur, as Dr. C. J. Houston observed in a letter to the Dr. G. Gordon Ferguson in the late 1940's:

> These grants were in sums out of all reason & could never be justified except as a whip to encourage the RM Doctor idea. It has not worked but if times get tough it might. We should strive to have these grants made on a different[basis]....[150]

The municipal doctor system grew incrementally until 1947, its peak year with over 210,000 persons covered(about 25% of the population),[151]

when, in the words of a Department of Health official, the "better [rural] practices [had] been taken."[152] Thereafter the municipal doctor system returned to its average coverage, since 1944, of approximately 200,000 persons, where it remained until the early 1950's.[153]

In early 1945 the HSPC unveiled its proposals for the establishment of a salaried general practitioner service in rural Saskatchewan. A salaried service would be developed through a gradual extension of the province's existing municipal doctor system via the provision of financial grants and the introduction of a salary municipal doctor contract that prohibited physicians from engaging in private practice.

On March 21, 1945, SCPS officials informed Premier Douglas that the HSPC proposals were unacceptable. The College re-iterated its position that it was opposed to salary-contract arrangements with the exception of areas where the ffs method could not support and retain the services of a general practitioner. The leader of the province's municipal doctors, R. K. Johnston, protested the imposition of a straight salary municipal doctor contract, pointing out that those physicians presently engaged in municipal medicine desired a practice of municipal contract and private practice. As such, the medical profession was united in opposition to the HSPC plans for the development of the municipal doctor system into a salaried general practitioner service.

At this first demonstration of SCPS opposition Premier Douglas clearly rejected the HSPC recommendations for the establishment of a salaried medical service in rural Saskatchewan. The various departures from the 1945 HSPC proposals for salaried general practitioner service followed without any apparent resistance by the HSPC and the Minister of Health, Premier Douglas. First, the HSPC recommended straight

salary municipal doctor contract was not implemented (a new model contract was introduced that continued to allow municipal physicians to engage in private practice). Second, the government's medical care grants were available for both salary and ffs schemes. Third, Premier Douglas sent a letter dated September 25, 1945, regarding the administration of a provincial medical care scheme, that if adhered to would effectively safeguard ffs medicine. Fourth, ffs rather than salary remuneration was incorporated in the Swift Current Health Region's medical care plan.

The latter deviation from the 1945 HSPC proposals was the result of local decision making, rather than a direct concession to ffs medicine by the Douglas government. In this area of the province where ffs municipal medical plans were well entrenched and popular with the people, the regional board's initial overtures to local physicians appear to have included an offer to pay physicians on a ffs basis. However, the government's policy to subsidize both ffs and salary municipal plans facilitated this development. Moreover, it is important to note that Douglas' Moose Jaw statement of January 7, 1946, suggests that even if the government had retained control over physician remuneration policy in the health regions, a similar departure from the 1945 HSPC salaried medical service proposals would have occurred.

The provincial government sought to hire doctors on salary, as well as strengthen the salaried municipal doctor plans so that they would not be replaced by ffs schemes. However, it did not attempt nor plan (once the province was in a position to assume the cost of medical service) to force doctors into a salaried medical service. The Douglas government was agreeable to the continued development of the province's nascent medical services plan on a ffs basis, provided there were

ceilings on expenditure. Indeed, it was willing and appears to have supported the replacement of salaried municipal doctor schemes with ffs regional medical care plans. The development and extension of the municipal doctor system under the Douglas government clearly was not part of a strategy to implement a salaried medical service in the future.

Although the leadership of the SCPS was opposed to the expansion of the municipal doctor system, it does not appear that it put "pressure on its members, made it impossible for them to pursue careers as municipal doctors on salary."[154] The efforts of the Regina District Medical Society to pressure a Regina-based general practitioner to discontinue his salary municipal doctor contract with the rural municipality of Lajord in the Spring of 1945 may have been the basis for this assertion by McLeod and McLeod. However, the expansion of doctor-controlled prepayment medical care plans in rural Saskatchewan, beginning in the late 1940's, both reduced the number, and prevented the extension, of the municipal doctor schemes.[155] In this context, one may suggest that if the CCF had followed the 1945 HSPC recommendations and provided financial assistance exclusively for salary municipal medical care plans - the municipal medical system would not have been extended into a province-wide salaried medical service in rural Saskatchewan.

Public support for the implementation of the 1945 HSPC proposals was not lacking. Indeed, this programme was enthusiastically endorsed by the HSPC advisory committee, which was comprised predominantly of laypersons. The supporters of a salaried service criticized ffs payment in the Swift Current Health Region (SCHR) and urged the government to place doctors on salary. The SCHR budget deficit in its first year of operation, projected further deficits, and the SCPS

payment demands strengthened a conviction in Saskatchewan that doctors should be remunerated on salary basis in a province-wide medical service, as HSPC chairman Dr. Fred Mott observed among the executive of SARM. They also engendered a perception among the rural municipalities that the ffs method was both too expensive and financially unsound, strengthening the rural municipalities' preference for salary medical care plans. By 1947, in an area of the province distinguished by its support for ffs remuneration, the Board of the SCHR was prepared to terminate its ffs medical care plan and implement a scheme with salaried doctors and group practice clinics if the doctors would not accept an expenditure ceiling. Public opinion was clearly conducive to the development of a salaried medical service throughout the 1940's.

Endnotes:

[1] Saskatchewan Archives Board, Regina (hereafter SABR), Papers of T. H. McLeod[hereafter McLeod Papers], file 46, "Regional Health Services," December 1944.

[2] Saskatchewan Medical Association/College of Physicians and Surgeons of Saskatchewan Archives (hereafter SMA/SCPS), "Report on Regional Health Services: A Proposed Plan."

[3] *Ibid.*, Part 3. Local Health Services, p. 7.

[4] *Ibid.*, p. 9.

[5] *Ibid.*, pp. 7-9.

[6] An estimated minimum $10,000,000 per annum, in addition to capital expenditure was required for the health care system envisaged by the HSPC; *Ibid.*, Part 2. Principles of Health Services Planning, p. 1.

[7] The HSPC maintained that the province required an additional 1500 hospital beds to boost its present bed capacity of 2,484 (3.4 per 1000 residents) to 3984 (5 to 5000); *Ibid.*, Part 1. Existing Health Services, p. 10.

[8] In March of 1943, there were 311 general practitioners (1 for every 2, 882 persons) of which an estimated 1/3 were over 60 years of age. Outside of the province's eight cities there were 213 physicians (1:3471). To obtain the HSPC suggested "minimum adequate standard" of 1:2000, the province required an additional 140 general practitioners, plus 75 to replace those near retirement, a significant number of which were in municipal contract practice. *Ibid.*, Part 1. Existing Health Services, pp. 9-10.

[9] "Province sets pace declares Douglas," *Leader Post*, 16 March 1946.

[10] SMA/SCPS, "Report on Regional Health Services," p. 1(forward).

[11] Duane Mombourquette, "A Government and Health Care: The Co-operative Commonwealth Federation in Saskatchewan, 1944 –1964." (Unpublished Master's Thesis, University of Regina, 1990), pp. 79-80; *SMQ*, Vol. 9, No. 1 (May, 1945), p. 8.

[12] SMA/SCPS, "Report on Regional Health Services," Part 3. Local Health Services. p. 2; Part 5. Implementation of Plans, p. 6.

[13] *Ibid.*, Part 5. Implementation of Plans, p. 2.

[14] *Ibid.*, Part 3. Local Health Services, p. 2; SABR, McLeod Papers, file 46, "Regional Health Services: Memorandum IV, Local Health Services," p. 21.

[15] SMA/SCPS, "Report on Regional Health Services," Part 5. Implementation of Plans, pp. 2-3.

[16] *Ibid.*, p. 1.

[17] SABR, McLeod Papers, file 1, "Minutes of Meeting of the Advisory Committee, March 2 & 3, 1945," p. 2.

[18] *Ibid.*, pp. 6-8.

[19] *Ibid.*, p. 7.

[20] *Ibid.*, p. 5.

[21] A letter from Dr. Mindel Sheps to Dr. Henry Sigerist describing both public and SCPS reaction to the HSPC proposals at the HSPC advisory committee meeting in March of 1945 also contains no mention of physician opposition to the HSPC recommendation for a salaried medical service. Alan Mason Chesney Medical Archives of the Johns Hopkins Medical Institutions, Henry Sigerist Papers, Box 25, Mindel Sheps to Henry Sigerist, 8 March 1945.

[22] SABR, McLeod Papers, file 1, "Minutes of Meeting of the Advisory Committee, March 2 & 3, 1945," p. 8.

[23] *Ibid.*, pp. 4-8.

[24] *Saskatchewan Medical Quarterly* (hereafter *SMQ*), Vol. 9, No. 3 (December, 1945), p. 25.

[25] "New plans for health services," *Leader Post*, 22 May 1947.

[26] *SMQ*, Vol. 9, No. 1 (May, 1945), p. 15.

[27] SABR, McLeod Papers, file 1, "Minutes of Meeting of the Advisory Committee, March 2 & 3, 1945," p. 7.

[28] SMA/SCPS, file "Negotiations: Douglas," Dr. John A. Valens to T. C. Douglas, 7 March 1945; Douglas to Dr. Valens, 8 March 1945.

[29] SMA/SCPS, file 6-14-0 ("Municipal Medicine"), 12 March 1945.

[30] *Ibid.*

[31] *SMQ*, Vol. 9, No. 1(May, 1945), p. 15.

[32] *Ibid.*, pp. 15-16.

[33] *SMQ*, Vol. 9, No. 3 (December, 1945), p. 27.

[34] *Ibid.*

[35] *SMQ*, Vol. 9, No. 1 (May, 1945), p. 21

[36] Taylor, *Health Insurance and Canadian Public Policy, op. cit.*, p. 248.

[37] *SMQ*, Vol. 9, No. 1 (May, 1945), 17.

[38] *Ibid.*

[39] *Ibid.*

[40] *Ibid.*, p. 18.

[41] *Ibid.*

[42] *Ibid.*

[43] *Ibid.*, pp. 19-20.

[44] *SMQ*, Vol. 9, No. 3 (December, 1945), p. 27.

[45] *SMQ*, Vol. 9, No. 1 (May, 1945), p. 20.

[46] *Ibid.*, p. 21.

[47] *SMQ*, Vol. 9, No. 3 (December, 1945), p. 26.

[48] *Ibid*; *SMQ*, Vol. 9, No. 1 (May, 1945), p. 21.

[49] *SMQ*, Vol. 9, No. 3 (December, 1945), p. 28.

[50] *Ibid.*

[51] SABR, Records of the Health Services Planning Commission (hereafter HSPC), file 12, "Memorandum Re. Meeting of Health Services Planning Commission with Medical Committee: April 14, 1945," p. 2.

[52] *Ibid.*

[53] *Ibid.*, p. 1.

[54] *Ibid.*

[55] *SMQ*, Vol. 8, No. 3 (September, 1944), p. 13.

[56] *Ibid.*, p. 14.

[57] *SMQ*, Vol. 9, No. 3 (December, 1945), p. 28; SABR, Thomas Clement Douglas Papers (hereafter Douglas Papers), file 111 133 (14-24) Memorandum for Douglas from Sheps, "Notes re Meeting with Health Insurance Committee of Sask. College of Physicians & Surgeons," n. d. (circa December 1945), pp. 2, 4.

[58] Taylor, *supra*, p. 248.

[59] *SMQ*, Vol. 9, No. 3 (December, 1945), p. 30.

[60] SABR, Douglas Papers, file 111, 133 (14-24) "THE SUGGESTION OF THE HEALTH INSURANCE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS IN THE MATTER OF THE ADMINSITRATIVE BODY FOR ANY HEALTH SERVICE PLAN IN SASKATCHEWAN," 23 August 1945, p. 3.

[61] Premier Douglas' reservations regarding this demand concerned the SCPS' dual role as both licensing/ regulatory agency of the medical profession on behalf of the public and the political arm of organized medicine in Saskatchewan charged with safeguarding the profession's socio-economic interests. As Douglas observed in a reply to the SCPS memorandum on administration of August 23, 1945, under this arrangement "differences of opinion" with respect to the policies of organized medicine, as opposed to professional qualifications alone, might affect a doctor's eligibility to practice medicine in a provincial medical care scheme. Douglas stated that he would be hesitant to make this suggestion if physicians in the province had not "expressed their fear that their professional qualifications might not be the sole consideration if classification were determined by a licensing body, which at one and the same time is the profession's bargaining agent;" and were he not aware that the SCPS requested that applications and licenses to practise medicine in Saskatchewan "be accompanied by an undertaking that the applicant will not enter into municipal or other contracts without the approval of the College." This latter reference to municipal contract practice may suggest that the provincial government feared that the inclusion of this clause might deter future initiatives to introduce non-traditional medical practice (e.g. salaried group

practice) in a provincial medical service plan. SABR, Douglas Papers, file 111, 133 (14-24), reply to memorandum of August 23, 1945, p. 4.

[62] SMA/SCPS, file 2-10-1A ("Medical Advisory Committee"), "Meeting of the Negotiating Committee of the Central Health Services Committee with Premier T. C. Douglas," 18 September 1945.

[63] It is important to note that there is no evidence in the SMQ and such correspondence and minutes that exist concerning these negotiations of any resistance by the HSPC and, more importantly, Premier Douglas to the inclusion of the aforementioned clauses that if adhered to by the government would effectively preclude the establishment of a salaried medical service in Saskatchewan. Indeed, these sources suggest that physician remuneration was not even an issue at the bargaining sessions. SMA/SCPS, file 2-10-1A(Medical Advisory Committee), "Meeting of the Negotiating Committee of the Central Health Services Committee with Premier T. C. Douglas," 18 September 45.

[64] Malcolm G. Taylor, "The Saskatchewan Hospital Services Plan: A Study in Compulsory Health Insurance," (Unpublished Ph. D. Thesis, University of California, 1949), pp. 121-122.

[65] It will be recalled in Chapter 2 that this clause was neither adhered to by municipal doctors, nor enforced by municipal councils. Until more doctors entered rural practice, to restrict the municipal doctors to their contract arrangements would deny many residents access to a physician. As demonstrated in Chapter 2, a significant portion of the rural population received medical care on a private ffs basis from salaried municipal doctors. Significantly, M. S. Anderson was not opposed to such a restriction in principle, once all the residents of Saskatchewan had medical coverage. It would appear that it was these considerations, coupled with SCPS opposition, that saw the HSPC and the Committee's lay representatives assent to the removal of this clause. SMA/SCPS, file 7-4-8 (Advisory Committee Health Services Planning Commission), "Minutes of the Meeting of the Advisory SubCommittee on Local Health Services Held April 22, 1945," p. 1.

[66] *Ibid.*, p. 5.

[67] SMA/SCPS, file "Dr. Houston's Municipal Doctor Contract File," R. K. Johnston & C. J. Houston to the College of Physicians and Surgeons, 12 September 1945.

[68] *SMQ*, Vol. 9, No. 3 (December, 1945), p. 12.

[69] *Ibid.*

[70] SABR, Douglas Papers, 111, 133(14-24), Mindel C. Sheps to all physicians in Saskatchewan, 27 June 1945.

[71] SMA/SCPS, file 7-4-8 (Advisory Committee Health Services Planning Commission), "Minutes of the Meeting of the Advisory Subcommittee on Local Health Services Held April 22, 1945," p. 7.

[72] *Ibid.*

[73] SABR, McLeod Papers, file 27, "Memo Re. Rural Municipality of Lajord. No. 128 Health Services Scheme," 7 May 1945.

[74] *Ibid.*, p. 5.

[75] Since 1941 legislation permitted rural municipalities to enter agreements with MSI for the provision of medical services on a fee-for-service basis with the approval of the Minister of Health. In 1946 the government consolidated all the statutory provisions authorizing municipal medical care plans under a section of the Health Services Act. This act set forth the means by which a municipality could provide medical care services to its residents. The provisions of the Act permitted contracts with mutual medical

societies but no other body. As such, the authority for a municipality to enter into contracts with MSI was eliminated. SABR, Records of the Department of Health, Policy Research and Management Services Branch, file 8, "Summary of Material on Medical Care Program for Saskatchewan" no date (circa 1959-61) p. 25.

[76] SABR, HSPC, file 12, C. J. Houston to Dr. Mindel Sheps, 10 May 1946.

[77] *Ibid.*

[78] *Ibid.*, Dr. Mindel Sheps to C. J. Houston, 14 May 1946.

[79] *Ibid.*, C. F. W. Hammes, Deputy Minister of Health to C. J. Houston, 15 May 1945.

[80] Order in Council 867/45. Regina, Tuesday 12, 1945. *Saskatchewan Gazzette*, 30 June 1945.

[81] T. C. Douglas, "The Doctor in Saskatchewan's Health Plans," *SMQ*, Vol. 9, No. 1 (May, 1945), p. 28.

[82] For example, a SCPS Bulletin issued in March of 1943 noted that: "We all know that, individually, the Doctor is everyone's friend, but as a group we are regarded as anything but that." Quoted in Taylor, *Health Insurance and Canadian Public Policy*, *supra*, p. 242.

[83] SABR, HSPC, file 12, "Memorandum Re. Meeting of Health Services Planning Commission with Medical Committee: April 14, 1945," p. 2.

[84] Order in Council 867/45. Regina, Tuesday, June 12, 1945, Regulations Respects Grants and Loans with Respect to Medical Services under the Health Services Act. *Saskatchewan Gazzette*, 30 June 1945.

[85] SABR, HSPC, file 12, C. J. Houston to Dr. Mindel Sheps, 10 May 1946; Mindel C. Sheps to C. J. Houston, 14 May 1945.

[86] *Ibid.*, p. 2.

[87] See for example Dr. L. Brown's review of the Central Health Insurance Committee's work and negotiations with the Douglas government at the SCPS annual meeting of September 20-21, 1945. *SMQ*, Vol. 9, No. 3 (December, 1945), p. 11.

[88] SMA/SCPS, file 6-14-3, C. J. Houston to Dr. J. G. K. Lindsay, 26 September 1945.

[89] *SMQ*, Vol. 9, No. 2 (September, 1945), p. 15.

[90] SMA/SCPS, file "Dr. Houston's Municipal Doctor Contract File," R. K. Johnson & C. J. Houston's report to Central Health Insurance Committee on municipal doctor contracts, 15 September 1945.

[91] SMA/SCPS, file 6-13-0, C. J. Houston to Dr. J. G. K. Lindsay, 26 September 1945.

[92] SMA/SCPS, file 6-13-0, C. J. Houston to Lindsay, 7 February 1946.

[93] SCPS/SMA, file "Dr. Houston's Municipal Contract file," "Minutes of Meeting of Central Health Services Committee," 21 October 1945, p. 5.

[94] SMA/SCPS, file 2-10-1(Medical Advisory Committee), "Meeting of the Negotiating Committee of the Central Health Services Committee with Premier T. C. Douglas," 3 November 1945, p. 2; SABR, Douglas Papers, file 111 133(14-24) Lindsay to Douglas, 20 November 1945; Lindsay to Douglas, 25 October 1945.

[95] On December 30, 1945, the SCPS requested the removal of "Mindel and Cecil Sheps from the formation or implementation of health services in the province" - a demand Douglas flatly rejected. However, Douglas told the SCPS that Mindel had found it necessary to resign as secretary from the HSPC for family reasons. She was temporarily replaced by her husband Dr. C.G. Sheps, who became acting chairman of the HSPC (a position that had been unofficially held by Mindel) and Dr. O. K. Hjertas who became secretary. The Drs. Sheps would leave the province during the summer of 1946. Under Cecil Sheps' replacement, Dr. Frederick D. Mott, a former senior officer in the United States Public Health Service and a graduate of the McGill Medical School, relations between the provincial government and the SCPS would improve considerably.

[96] Once an area was declared a health region, a regional health board would be set up comprised of representatives from the municipalities of the region. The health boards would be empowered to plan, provide, finance, as well as administer health care services in the region, with the advice of various technical committees composed of doctors, nurses etc; subject to the approval of the Department of Health through arrangements with local hospitals, physicians etc. Regulations Governing the Establishment of Health Regions Under The Health Services Act. Chapter 51 of the Statutes of Saskatchewan, 1944. (Second Section); SABS, Houston Papers, file 41, Health Services Planning Commission, "Pertinent Facts About Health Regions," n.d., p. 1; SMA/SCPS, file 6-13-6 (Health Region #6, Moose Jaw), material on regional organization and health services forwarded to municipal councils in the proposed health region #6, Moose Jaw, 25 May 1945., p. 5.

[97] Harry Dickinson, "The Struggle for State Health Insurance: Reconsidering the Role of Saskatchewan Farmers," *Studies in Political Economy*, Vol. 41(Summer 1943), p. 148.

[98] For an account of the establishment of the Swift Current Health Region see Feather, "Formation of the Swift Current Health Region," *op. cit.*

[99] Several accounts of the formation of the Swift Current Health Region indicate that at least four rural municipalities provided their residents with general medical care. A document prepared in the early 1960-1961 on municipal medical care plans in Saskatchewan states that seven rural municipalities, and several towns and villages discontinued their municipal medical care plans when they joined the Swift Current Medical Care plan. Feather, supra, p. 70; *SMQ*, (April, 1947) p. 21; SMA/SCPS, Advisory Planning Committee on Medical Care, "Memorandum on Municipal Medical Care Plans in Saskatchewan," circa 1960-1961, p. 1(note 1.).

[100] The Rural Municipalities of Riverside No 168, Webb No. 138, Pittville No. 169 and, possibly, Carbri 229 had fee-for-service plans. SCPS/SMA, ("Dr. Houston's Municipal Contract File"), Mindel C. Sheps to Dr. C. J. Houston, 7 May 1945; Feather, *supra*, p. 71; *SMQ*, Vol. 10, No. 2 (July, 1946), p. 8.

[101] SABR, McLeod Papers, file 38, "Fee For Service Schemes," circa 1944 -1945.

[102] Carl Kjorven was reeve of the RM of Riverside No. 168. Stewart Robinson was the former secretary – treasurer of the RM of Webb, 138. Feather, *supra*, p. 71.

[103] It is worth noting here that Burak was an outspoken advocate and promoter of a fee-for-service medical care plan first established in his RM of Pittville in 1937. The "Pittville Plan" served as the model for many of the province's ffs plans, including those in the Swift Current area. From the beginning of his one man crusade to establish a health region in the Swift Current area, Burak maintained that a complete medical service could be provide by the region for $9-10 per person, based on the operational experience of the Pittville fee-for-service medical care plan. SABR, McLeod Papers, file 19, "Health Plans: An address delivered to the Convention of Saskatchewan Hospital Association, At Moose Jaw, Sask., October 31st, 1944 by W. J. Burak, Hazlet, Sask.," p. 2; Feather, *supra*, pp. 71-72.

[104] *SMQ*, Vol. 10, No. 2 (July, 1946), p. 8.

[105] *Ibid.*

[106] At the second executive meeting of the Swift Current Health Board February 14, 1946, it was moved, without any apparent objections, that the Secretary write to the health region's medical advisory committee asking for their co-operation in the establishment of a ffs medical care scheme and that a tentative offer of 50% to 65% of the SCPS fee-schedule be made. SABS. Records of the Swift Current Health Board And Committee Minutes (hereafter SCHB), file 11, Minutes of Regional Board Meeting, 17 January 1945; 14 February 1946.

[107] SABR, HSPC, file XII, Memo from Dr. O. K. Hjertas to Dr. Sheps Re. Meeting held in Swift Current of the Regional Executive and the medical men of the District, 6 May 1946.

[108] Lipset, for example, states that it was the Douglas government (as opposed the Swift Current Health Board) that "agreed to pay the physicians[in Swift Current] on a fee-for-service basis...." Lipset, *supra,* p. 293; See also Jacalyn Duffin and Leslie A. Falk, "Sigerist in Saskatchewan," *op. cit.*, p. 676.

[109] The scheme was financed by a combined property and personal tax and a grant from the provincial government. This state subsidy, approximately 10% of the health regions medical services budget, was comprised of the 25 cents per capita and equalization grants the various municipalities that constituted the health region were entitled for purpose of financing municipal medical care plans. Records of the Department of Health, Policy Research and Management Services Branch, file 14(a)"History of Public Health in Saskatchewan (with a special reference to the History of the Swift current Health Region)," circa 1958., p. 8; "History of the Swift Current Health Region Medical Care Plan: 1946-1966, June, 1969," p. 11; *SMQ*, Vol. 10, No. 2 (July ,1946), p. 8; Taylor, *Health Insurance and Canadian Public Policy, supra,* p. 251.

[110] SABR, McLeod Papers, file 37, "Report on Dr. Hjertas' Trip to Moose Jaw with the Premier on Jan 7, 1946."

[111] "Ask Voice On Board," Saskatoon Star Phoenix, 30 April 1946.

[112] Ibid.

[113] "Medical Co-op widens scope," *Leader Post*, 1 May 1945.

[114] "Medical Co-op Directors Authorized to Borrow Million for Development," *Saskatoon Star Phoenix*, 30 April 1946.

[115] "Medical Centres Planned At Various Rural Points," *Saskatoon Star Phoenix*, 30 April 1946.

[116] "Trial Period for State Medicine," *Saskatoon Star Phoenix*, 8 May 1946

[117] "Medical Co-op Directors Authorized to Borrow Million for Development," *Saskatoon Star Phoenix*, 30 April 1946.

[118] SMA/SCPS, file "Minister of Public Health: Douglas; Negotiations," Dr. J.G.K. Lindsay to T. C. Douglas, 25 June 1946.

[119] SMA/SCPS, file "Minister of Public Health: Douglas; Negotiations," T. C. Douglas to Dr. J.G.K. Lindsay, 25 June 1946.

[120] Taylor, *Health Insurance and Canadian Public Policy, supra*, p. 260.

[121] SABR, HSPC, file 121b, E.J. Loer to Dr. F. D. Mott, 12 October 1946.

[122] *Ibid*; The medical co-operative subsequently petitioned the provincial government to establish a "first rate clinic" in connection with the University Hospital and Medical School and that it be made "fully available" to all its members and the public at large. SABR, HSPC, file 121b, E.J. Loer to Dr. F. D. Mott, 7 November 1946.

[123] SABR, HSPC, file 121b, E.J. Loer to Dr. F. D. Mott, 12 October 1946.

[124] A survey of the municipal doctor system undertaken by the HSPC in 1947 revealed that there were only 12-13 ffs schemes, indicating that the vast majority of municipalities preferred salary as opposed to ffs contacts. SMA/SCPS, Health Service Planning Commission, Research and Statistics Division, 1948, "Survey of Municipal Doctor Plans Operating in 1947."

[125] "Another Deficit," *Saskatoon Star Phoenix*, 20 October 1947.

[126] *SMQ*, Vol. 2., No. 4 (December, 1947), p. 44.

[127] *Ibid.*

[128] SABR, HSPC, file 143, F. D. Mott, "Memorandum For File: HSPC 6-2-2: re. Meeting with Executive of S.A.R.M.," 25 October 1947.

[129] The SCPS agreed to accept payment at 85% the 1947 fee schedule for 1948, which SARM considered a significant gain. SABR, HSPC, file 143, C. G. Brydan, Secretary of SARM to Dr. F. D. Mott, 23 March 1948.

[130] SABR, HSPC, file 143, F. D. Mott, Memo For File: HSPC 6-2-2: re. meeting with Executive of Saskatchewan Association of Rural Municipalities, 15 January 1948; F. D. Mott to T. C. Douglas, "Address at Convention of Saskatchewan Association of Rural Municipalities," 25 February 1948.

[131] In 1955 proposals for the establishment of regional fee-for-service medical service plans based on the Swift Current model in the Rural Regina and Assiniboia-Gravelbourg health regions were defeated in two plebiscites. In an analysis of the voting patems, Milton R. I. Roemer concluded that people enjoying the benefits of low-cost salaried municipal doctor schemes were inclined to oppose the fee-for-service regional plans, fearing loss of autonomy, and higher costs as a result of fee-for-service remuneration. Joan Feather, "Impact of the Swift Current Health Region: Experiment or Model?" *Prairie Forum*, Vol. 16, No. 2 (Fall, 1991), p. 230.

[132] SABR, HSPC, file 130, F. D. Mott, "Memorandum for the File: re. meeting of December 10, 1947 with S.A.R.M. Regina Health Services Union etc. concerning 1947 Contract Schedule of Fees and Related Problems," n.d.

[133] E. A. Tollefson, *Bitter Medicine: The Saskatchewan Medicare Feud*, (Saskatoon, Saskatchewan: Modern Press, 1963), p. 41.

[134] SMA/SCPS, file 7-4-8, "Advisory Committee to the Health Services Planning Commission, Minutes and Proceedings, May 9 and 10, 1947," p. 33.

[135] *Ibid.*

[136] *Ibid.*

[137] "New plans for health services," *Leader Post*, 22 May 47.

[138] SABR, Records of the State Hospital and Medical League, file 8, "My Memories of the State Hospital and Medical League by Joseph A. Thain," p. 6.

[139] Maintaining that the ffs method was "the antithesis of preventive medicine," and the Swift Current Health Region's ffs medical care plan was "'unsatisfactory'" as it is impossible to budget satisfactorily in advance and that it has proven to be too costly," the Saskatoon CCF constituency at its annual convention June 13, 1947, resolved: "That in the establishment of future Health Regions, the Government bring strong pressure to bear to ensure adoption of a salary basis of payment of medical practitioners so that that the principle of 'paying the doctors well to keep the people well' may have an opportunity to be realized." This resolution was in turn submitted to the Resolution's committee, chaired by Premier Douglas, at the Provincial CCF Convention July 29, 30, 31, 1947, in Saskatoon. The following resolution was passed: "We urge that wherever possible the Provincial Government and the Regional Health Board should encourage the hiring of doctors on a salary basis." SABS, CCF Papers, file 11 55(1), "Resolutions passed at the Saskatoon Constituency Convention on June 13, 1947," pp. 5176 – 5177; file 1 11, Minute Book, 1944 - 1948(#4) "Minutes of Twelfth Annual Provincial CCF Convention July 29, 30, 31, 1947 - Bessborough Hotel Saskatoon - Sask," # 1053.

[140] SABS, Pamphlet Collection, "Editorial: Well Ordered Medical Services," *Health Services Review*, (October 1947), p. 4.

[141] SABS, Pamphlet Collection, "Brief To The Government of The Province of Saskatchewan: Submitted by The State Hospital and Medical League 1946," *Health Services Review*, Vol. 2., No. 1 (May 1946), pp. 6-7; "Brief To The Government of The Province of Saskatchewan: Submitted by The State Hospital and Medical League February 8, 1947," *Health Services Review*, Vol. 3., No. 1(April, 1947), pp. 6-7.

[142] SABS, Pamphlet Collection, "editorial: Well Ordered Medical Services," *Health Services Review* (October 1947), p. 4.

[143] *Ibid.*

[144] "Physicians Shy From Sask. Posts," *Saskatoon Star Phoenix*, 21 February 1947.

[145] SABR, HSPC, file 2e, "Memorandum For The File: re. Employment of Specialists by Health Region No. 1., 30 November 1948."

[146] SABS, Pamphlet file, "League Officials Address Sask. Assn. Of Rural Municipalities," *Health Services Review*, Vol. 3., No. 5 (April, 1948), p. 19.

[147] SABR, HSPC, file 1O5c (1of 2), T.C. Douglas to Dr. G. Ferguson, 26 February 1949.

[148] *Ibid.*

[149] SABS, MacLean Papers, file 29, Dr. Fred Mott to Dr Hugh MacLean, 21 March 1949.

[150] SMA/SCPS, file "Dr. Houston's Municipal Contract file," C. J. Houston to Dr. G. Gordon Ferguson, n. d., circa late 1940s. SMA/SCPS, Advisory Planning Committee on Medical Care, "Memorandum on Municipal Medical Care Plans in Saskatchewan," circa 1960-1961, p. 2.

[151] SMA/SCPS, Advisory Planning Committee on Medical Care, "Memorandum on Municipal Medical Care Plans in Saskatchewan," circa 1960-1961, p. 2.

[152] SMA/SCPS, file 7-4-8, "Advisory Committee to the Health Services Planning Commission, Minutes and Proceedings, May 9 and 10, 1947," p. 33.

[153] In 1950 there were 173 plans providing coverage to 200, 000 persons, approximately 24% of the province's 833, 000 residents; National Archives of Canada, Papers of Frederick D. Mott, Milton I. Roemer, "Prepaid Medical Care and Changing Needs in Saskatchewan," Paper presented at the American Public Health Association, Kansas City, Missouri, November 14, 1955; p. 4.

[154] McLeod and McLeod, *Tommy Douglas, op. cit.*, p. 150.

[155] Naylor, *Private Practice, Public Payment, op. cit.*, p. 178.

Chapter 6

CONCLUSION

An examination of Saskatchewan CCF party health policy reveals that the CCF was never committed to, or an advocate of, the establishment of a state salaried medical service. After the CCF came to power in Saskatchewan Premier Douglas repeatedly denied that his government would place the medical profession on salary. Douglas' health policy statements in the Autumn of 1944, coupled with his immediate consent in August of 1944 to ffs payment for a medical services plan for old age pensioners and other social assistance beneficiaries, suggest that his government's objective was to provide medical care to the citizens of Saskatchewan as rapidly and amicably as possible with the co-operation of the medical profession. Thus it would seem that Premier Douglas and the Saskatchewan CCF had rejected a state salaried medical service long before the HSPC presented such a proposal to its advisory committee on March 2, 1945. Indeed, Premier Douglas immediately rejected the HSPC recommendations for a salaried service when the SCPS expressed its opposition to them on March 21, 1945.

In this context there is no documentary evidence to suggest that after Douglas' meeting with the SCPS on March 21, 1945, the Premier and the Cabinet "weighed the situation and assessed the opposition of the College,"[1] and then rejected the HSPC recommendations for a salaried medical service as Malcolm G. Taylor maintains. Nor does it appear that the CCF government considered implementing the 1945 HSPC physician remuneration recommendations in the face of SCPS opposition after Douglas' meeting with the SCPS as existing scholarship suggests.[2] After

March 21, 1945, the various departures from the 1945 HSPC proposals for a salaried medical service in rural Saskatchewan occurred without any apparent resistance from the Douglas government or the HSPC.

Accordingly, a careful examination of the events, negotiations, and documentation concerning the development of medical services in Saskatchewan during the CCF's first term in office reveals that there was no confrontation between the Douglas government and the SCPS with regards to salary remuneration - apart from the fact that the HSPC devised and presented to its advisory committee proposals for a salaried general practitioner service in rural Saskatchewan. It would appear that Taylor both overstated and over-emphasized the importance and intensity of the friction concerning the 1945 HSPC proposals in his account of the development of Saskatchewan medicare; a fact that Dr. C. J. Houston of the SCPS, who was present and a key participant at the negotiations in the formative 1944 - 1946 period, took great exception with in reviewing a draft of Taylor's *Health Insurance and Canadian Public Policy*.

With respect to the 1945 HSPC proposals and their architect Mindel Sheps, Houston writes emphatically:

> Certainly it [in Houston's words "the so-called Sheps report of 1945"] was not pursued by the Department nor ever became any semblance of public policy re. government policy. And now I see it is resurrected from the Dead! - and presented as a source of Rift and Confrontation(sic)! Actually I had thought no one even in government had ever taken Mindel seriously - so I was most surprised to see her little fling given any prominence in the influence of events.[3]

These aforementioned inaccuracies in the established historical accounts of the development of Saskatchewan medicare must be taken into account in determining why the CCF did not establish a salaried medical service in rural Saskatchewan as recommended by the HSPC in 1945.

Historians offer three interpretations about why the CCF government of Tommy Douglas rejected the 1945 HSPC proposals for the

establishment of a salaried general practitioner service in rural Saskatchewan. First, Taylor states that the HSPC proposals were not implemented because of SCPS opposition and its threat that such a plan would both induce many physicians to leave the province and deter others from settling in Saskatchewan. Second, David C. Naylor maintains that Premier Douglas' "concern was to implement programs of health services as amicably and rapidly as possible."[4] Naylor suggests that this fact, coupled with SCPS opposition and the threat that the HSPC plan would both cause doctors to leave and discourage immigration, exacerbating the province's existing doctor shortage, led to Premier Douglas' concessions to the medical profession in 1945-1946. Third, Lipset intimates that the compromises to the original HSPC proposals occurred because the CCF was not backed by a public that supported the establishment of a salaried medical service. Lipset argued that the Douglas government did not follow the 1945 HSPC recommendations because a) the electorate did not understand or demand qualitative changes in medical care, and b) there was a lack of organized pressure groups that supported qualitative changes.

The Douglas government faced a medical profession united in its opposition to the development of the municipal doctor system into a state salaried medical service. The SCPS submission to the 1943-1944 Special Select Committee on Social Security and Health Services included the 1934 CMA principle on health insurance that "contract salary service be limited to areas with a population insufficient to maintain a general practitioner in the area, without additional support form the Insurance Fund."[5] This clause was inserted directly after the following the statement highlighted by Malcolm G. Taylor: "We think that the scheme can be combined with something equivalent to the Municipal Doctor Plan, with payment on a combined salary and fee

basis."[6] In this context, the SCPS clearly was not stating that it was agreeable to the establishment of a substantial, let alone a province-wide, salaried general practitioner service in rural Saskatchewan with ffs payment for major surgery as Taylor intimates. Rather, the SCPS was indicating its acceptance of combined salary/ffs payment in areas where ffs alone was not feasible. It is unlikely that Premier Douglas and the HSPC were "unprepared" for the SCPS negative response to the 1945 HSPC proposals, as Taylor maintains.[7] It is difficult to conceive that the CCF was unaware of the SCPS' ardent opposition to salary remuneration.

Although the municipal doctors were more accepting of salary remuneration both in and outside the context of a provincial medical service scheme than their colleagues in private practice, they were equally opposed to straight salary remuneration for the provision of general medical services. The municipal doctors attached great importance to their lucrative private practice privileges and their substantial private income, which they referred to as "outside practice." This private practice did not consist exclusively of ffs payment for major surgery, as Taylor and other scholars intimate, but primarily of general medical services to private patients both within(towns and villages) and outside the boundaries of the contracting municipality. Hence when R. K. Johnston informed Premier Douglas on March 21, 1945, that the municipal doctors wanted a practice "consisting of municipal contract work and outside practice and that on the whole they favoured the municipal work as it was now operated,"[8] he was not stating that the municipal doctors were in favour of straight salary remuneration with the exception of major surgery on a ffs basis as Taylor infers. Rather, he was protesting the HSPC straight salary municipal doctor contract. Dr. C. Stuart Houston's assessment that the

HSPC proposals "at once alienated the salaried municipal doctors, for it would deny them any right to private practice or to attend any one from beyond a right area boundary,"[9] is a more accurate interpretation of the municipal doctors' response to the HSPC proposals. R. K. Johnston clearly was not, to quote Taylor, a "dissenting voice" in the College delegation on March 21, 1945.[10]

Although the CCF does not appear to have considered implementing the 1945 HSPC programme for a salaried medical service in the face of this fervent opposition as existing scholarship maintains, one may suggest that the Douglas government would have followed the HSPC physician remuneration recommendations if the medical profession had not been opposed. On the basis of this probability alone, SCPS opposition clearly was a factor in the rejection of the 1945 HSPC proposals.

Premier Douglas' declaration to the SCPS negotiating committee on March 21, 1945, that the government was not committed to salaried state medicine and the forthcoming departures from the HSPC proposals for a salaried medical service were not a capitulation to the demands of the medical profession as such. Rather, they were a reiteration and confirmation of a policy decision first enunciated publicly in the Autumn of 1944 that the government was not going to force the medical profession into a salaried medical service. One may suggest, however, that the SCPS' fervent opposition to salaried employment contributed to this earlier decision that led to the Premier Douglas' immediate rejection of the HSPC proposals on March 21, 1945.

Although SCPS opposition was clearly a factor in the rejection of the HSPC proposals, the role of the province's doctor shortage and SCPS threats that the development of a salaried medical service would compel doctors to leave the province and deter others from coming in

this decision is less discernible. The Douglas government appears to have rejected the concept of a state salaried medical service such as that envisaged by the HSPC long before the SCPS made such threats to Douglas on March 21, 1945.

If the CCF had contemplated implementing a salaried medical service, it would have had to consider that such an initiative would probably cause doctors to leave the province and discourage immigration, thereby exacerbating the province's existing doctor shortage. The vast majority of the highly mobile medical profession in Saskatchewan and Canada was opposed to salary remuneration or preferred ffs. And the province was surrounded by jurisdictions with ffs payment.

Nonetheless, the establishment of a state salaried medical service was seen as a viable policy option in Saskatchewan as evidenced by the large number of lay organizations both interested in and engaged in the provision of health services that advocated such a scheme for the province; the recommendations and proposals for the development of a salaried service by the CCF health planners; and the endorsement of the 1945 HSPC proposals on March 2, 1945, by its advisory committee. In the accounts of the various meetings and forums where support for the establishment of a state salaried medical service was expressed, such as Premier Douglas' meeting with the executive of SARM and the Swift Current Regional Health Board (SCHB) in 1947, there is no record of government officials or lay persons stating that a salaried service was not feasible. The numerous organizations that advocated or supported the establishment of salaried medical service, such as the SHML, the SARM executive, etc., were fully cognizant of the aforementioned disadvantages and difficulties of implementing such a service. The HSPC and the supporters of salaried medicine appear to

have believed that the prospect of assured and generous remuneration, pensions, as well as modern and well-equipped facilities would attract a sufficient number of physicians for the development of a salaried medical service.

The establishment of a salaried medical service in Saskatchewan without the co-operation of the medical profession (and even outright SCPS opposition and obstruction) and with the province's doctor shortage was viewed as a viable course for the province by the HSPC and a large number of organizations representative of Saskatchewan society. In this context, one may suggest that the 1945 HSPC proposals were not rejected by the CCF solely on the basis of SCPS opposition and the threat of loss of doctors. Other factors must have been involved.

Although the establishment of a salaried medical service was considered to be feasible in Saskatchewan, because of SCPS opposition and the probable loss and deterred immigration of doctors, the provision of accessible medical services to all the people, as promised by the CCF, would take longer to realize. Perhaps this was unacceptable to Premier Douglas. As Douglas told the SCPS on March 21, 1945, his "concern was to provide medical care to everyone as rapidly as possible."[11] This stated objective would be attained far more quickly with the co-operation of the medical profession and the development of medical care services on a ffs basis. Hence Douglas' statements to the SCPS in the autumn of 1944 that medical services would be provided "on whatever basis the government could get possible co-operation with the medical profession."[12]

Douglas' statements to the SCPS and the general public, beginning in the autumn of 1944, and his negotiations with the College for the provision of medical services to pensioners and other social assistance beneficiaries, support Naylor's interpretation that the HSPC

recommendations for the establishment of a salaried medical service were not implemented because Premier Douglas' "concern was to implement programs of health services as amicably and rapidly as possible (Douglas' very words to the SCPS on March 21, 1945)."[13]

Public support for the HSPC proposals and a state salaried medical service was not lacking as Lipset contends. Indeed, T. C. Douglas appears to have rejected this policy option for Saskatchewan in 1944 and in turn the 1945 HSPC proposals within an environment of considerable support for such an initiative. There was a broadly-based, well-organized and determined popular movement for the establishment of state salaried medical service in the 1940s led by the State Hospital and Medical League. So strong was this movement that the SCPS launched a comprehensive and sophisticated public relations campaign in 1943 to counter this perceived threat to its interests. The solid, province-wide support for a salaried medical service was revealed in the submissions to the Health Services Survey Commission(HSSC) chaired by H. E. Sigerist, the last and most consultative(in terms of representations)of three government inquiries into health services in Saskatchewan in 1943-1944. In addition to the SHML, the two agriculture organizations that appeared before the commission, and a diverse number of trade unions, rural municipalities, and citizen organizations indicated their support for salaried state medicine to the HSSC.

Additional support for the establishment of a salaried medical service in Saskatchewan resided with the three medical service co-operatives in Regina, Saskatoon, and Melfort. In their briefs to the HSSC the co-operatives endorsed contributory health insurance with doctors paid by salary or capitation. Like the SHML, the medical co-operatives claimed that the ffs method was not conducive to preventive

medicine, and vocally so, to the extent that the SCPS was compelled to address these assertions in its brief to the Sigerist Commission. This segment of the movement for a salaried medical service in Saskatchewan clearly desired what Lipset considers "qualitative changes in medical care."[14]

SARM does not appear to have officially endorsed the establishment of a state salaried medical service as Naylor suggests. Throughout the 1940's this organization indicated that it was agreeable to ffs payment. However, according to HSPC Commissioner F. D. Mott's observations at a 1947 meeting, there was strong support for salaried state medicine among many members of the SARM executive.

Thus, contrary to Lipset's assertion, there appears to have been a considerable number of organized pressure groups that supported the establishment of a state salaried medical service. One may suggest that these organizations would have, in Lipset's words, acted to "counterbalance" the SCPS if the CCF had followed the 1945 HSPC recommendations for the establishment of a salaried general practitioner service in rural Saskatchewan.[15] Some of these groups and their representatives, in a variety forums, publicly criticized ffs payment in the Swift Current Health Region and lobbied the provincial government to both place doctors on salary and encourage the development of salaried medical care schemes in the other health regions. The CCF clearly would not have been wanting for allies among the public if it had attempted to inaugurate a state-salaried medical service in the 1940's - either through an immediate placement of all doctors on salary, or as the HSPC proposed, via an expansion of the province's existing salaried municipal doctor system. Indeed, the SHML and its broad and active membership was, as stated in its brief to the Sigerist Commission advocating salaried state medicine, "prepared to go

to the limits side by side with any government having courage and conviction that these ideals can be attained."[16]

Several other factors made 1940's Saskatchewan favourable to the implementation of the 1945 HSPC proposals. First, by the SCPS' own admission, organized medicine was not held in high esteem by the general public. Whether just or not, there was a perception in Saskatchewan that SCPS fee-schedules and payment demands were excessive.

Second, there was a perception in Saskatchewan that the ffs method was too expensive and unsuitable for medical care plans because it did not allow for accurate budgeting. This belief was strengthened in 1947 as a result of actual and projected deficits of the Swift Current Health Region ffs medical care plan. As the SCPS observed in 1947, the rural municipalities were loath to accept ffs payments for municipal doctor plans for fear of being drawn into a ffs regional plan modelled after the Swift Current plan. In rural Saskatchewan, salary was the preferred method of physician remuneration for lay-controlled medical care plans, as evidenced by the fact that the vast majority of municipal doctor plans continued to operate on a salary basis.

Third, the establishment of a state salaried medical service was not viewed as a radical policy in Saskatchewan, owing, in part, to the presence and popularity of the province's extensive salaried municipal doctor system. As a result, in Taylor's words, "the introduction of a system as radical as that proposed by the Commission [HSPC],"[17] i.e. the expansion and development of the province's existing municipal doctor system into a salaried medical service, was not perceived to be radical by the people of Saskatchewan, let alone a departure from the development of health services in rural Saskatchewan since the 1930's. Indeed, the 1945 HSPC proposals seem to have been enthusiastically

endorsed by its advisory committee representing a cross-section of the public. Public opinion clearly would not have been a great obstacle to the implementation of the 1945 HSPC recommendations for a salaried service.

In this context, because the 1945 HSPC proposals were seen as a viable course for the development of a provincial medical services plan without the co-operation of organized medicine, and many of the party's principal and active constituencies of support, such as the organized farming movement, labour, and the teaching profession favoured the introduction of a salaried medical service, one may suggest that if the CCF had been committed as a party, and more importantly as a government, to salary remuneration as some historians have claimed, the Douglas government would have implemented the 1945 HSPC recommendations for a salaried service in spite of SCPS opposition.

In the final analysis, it would appear that the CCF government of T. C. Douglas did not follow the 1945 HSPC proposals for a state salaried medical service because; neither the party or government was committed to salary remuneration; the policy of the Douglas government was to provide medical services to the people of Saskatchewan as rapidly as possible with the co-operation of organized medicine; and the medical profession, including the province's salaried municipal doctors, was fervently opposed to being placed on salary.

Endnotes:

[1] Taylor, *Health Insurance and Canadian Public Policy, op. cit.*, p. 248.

[2] It is worth noting here that Dr. Mindel C. Sheps was referring to the Douglas government's medical care programme for old age pensioners and other social assistance beneficiaries, introduced in January of 1945, when she wrote to Henry Sigerist on March 8, 1945, that after "delay and temporizing, that [issue] was settled just the way the doctors wanted it...in the direction we didn't want them to go." Alan Mason Chesney Medical Archives, Johns Hopkins Medical Institutions, Sigerist Papers, Box 25, Mindel Sheps to Henry E. Sigerist, 8 March 1945. She was not referring to the 1945 HSPC proposals for a salaried general practitioner service in rural Saskatchewan as Duffin and Falk suggest. Duffin and Falk, "*Sigerist in Saskatchewan*," *op. cit.*, p. 676.

[3] Saskatchewan Archives Board, Saskatoon, The Papers of Dr. C. J. Houston, file 23, Houston to Malcolm G. Taylor, 25 February 1975, p. 8.

[4] Naylor, *Private Practice, Public Payment, op. cit.*, p. 140.

[5] SMA/SCPS, The Council of the College of Physicians and Surgeons of Saskatchewan, "Submissions To The Select Committee of the Legislative Assembly of Saskatchewan, March 1943," p. 5.

[6] *Ibid.*, p. 4.

[7] Taylor, *supra*, p. 245.

[8] *Ibid.*, p. 246.

[9] C. Stuart Houston, "The early years of the Saskatchewan Medical Quarterly," *op. cit.*, pp. 1127-1128.

[10] Taylor, *supra*, p. 246.

[11] *Saskatchewan Medical Quarterly,* Vol. 9, No. 1 (May, 1945), p. 17.

[12] "Adequate Health Service For All The People is C.C.F. Aim," *Western Producer*, 28 September 1944.

[13] Naylor, *supra*, p. 140.

[14] Lipset, *Agrarian Socialism*, *op. cit.*, p. 297.

[15] *Ibid.*

[16] Saskatchewan Archives Board, Regina, Records of the Health Services Survey Commission, file 8, "Brief presented at Saskatoon to Doctor Sigerist and the personnel of the HSSC from the State Hospital & Medical League of the Province of Saskatchewan," p. 15.

[17] Taylor, *supra*, p. 248.

BIBLIOGRAPHY

ABBREVIATIONS

AMCMA	Alan Mason Chesney Medical Archives, Johns Hopkins Medical Institutions
NAC	National Archives of Canada
SABR	Saskatchewan Archives Board, Regina
SABS	Saskatchewan Archives Board, Saskatoon
SMA/SCPS	Archives of the Saskatchewan Medical Association and the College of Physicians and Surgeons of Saskatchewan
URLSC	University of Regina Library, Special Collections

PRIMARY SOURCES

Government Documents: Unpublished

Saskatchewan. Records of the Department of Health, Policy Research and Management Services Branch. 1945-1949. (SABR).

Saskatchewan. Records of the Health Services Board. 1934-1944. (SABS).

Saskatchewan. Records of the Health Services Planning Commission. 1944-1949. (SABR).

Saskatchewan. Records of the Health Services Survey Commission. 1944. (SABR).

Saskatchewan. Records of the Legislative Assembly Office Unpublished Sessional Papers. 1943-1944. (SABR).

Saskatchewan. Intersessional Committee on Social Security and Health Services: *Report to Select Special Committee on Social Security and Health Services Session 1944*. (SABR).

Saskatchewan. Health Services Planning Commission. *Report on Regional Health Services: A Proposed Plan*. 1945.

Saskatchewan. Records of the Saskatchewan Reconstruction Council. 1944. (SABS).

Government Documents: Published

Saskatchewan. *Report of the Saskatchewan Reconstruction Council. Regina:* King's Printer, 1944.

Saskatchewan. First Report of the Select Special Committee re Social Welfare, etc. *Saskatchewan Legislative Journal*. 1943.

Saskatchewan. Select Special Committee on Social Security and Health Services: *Final Report*. Regina: King's Printer, 1944.

Saskatchewan. Department of Public Health. *History of the Swift Current Health Region Medical Care Plan*, 1946-1966. Regina: The Department of Public Health, Research and Planning Branch, 1959.

Saskatchewan. Health Services Planning Commission. Survey of Municipal Doctor Plans Operating in 1947. Health Services Planning Commission, Research and Statistics Division, 1948.

Unpublished Documents

Records of the State Hospital and Medical League. (SABR).

State Hospital and Medical League, *The Case For State Medicine*. 1944. (URLSC).

Records of the Co-operative Commonwealth Federation, Saskatchewan Section. 1937-1947. (SABS).

Records of the Swift Current Health Board and Committee Minutes. 1946. (SABS).

Political Pamphlets. (SABR).

Pamphlet Collection. (SABS).

Private Papers

Papers of the Honourable Thomas Clement Douglas. (SABR).

Papers of Dr. Chester J. Houston. (SABS).

Papers of Dr. Hugh MacLean. (SABS).

Papers of Thomas H. McLeod. (SABR).

Papers of Dr. Frederick D. Mott. (NAC).

Papers of Dr. Henry Sigerist. (AMCMA).

Papers of the Honourable Dr. John Michael Uhrich. (SABR).

Newspapers, Annual Reports, Minutes, and Contemporary Journals

Annual Reports of the College of Physicians and Surgeons. 1930-1936. SMA/SCPS.

Annual Reports of the Saskatchewan Medical Association. 1930-1936. SMA/SCPS.

Minutes of the Annual Meetings of the College of Physicians and Surgeons of Saskatchewan. 1930-1936. SMA/SCPS.

Minutes of the Annual Meetings of the Saskatchewan Medical Association. 1930-1936. SMA/SCPS.

The Health Services Review (Regina). 1945-1948. (various issues).

Prince Albert Daily Herald. 1944-1945. (various issues).

Regina Daily Star. 1937. (various issues).

Leader Post (Regina). 1934-1947. (various issues).

Saskatchewan Medical Quarterly. 1937-1947. (various issues).

Saskatoon Star Phoenix. 1944-1947. (various issues).

Western Producer (Regina). 1936-1944. (various issues).

Published Diaries, Memoirs and Contemporary Accounts

Coppock, Frank H., "The Menace of Contract Practice," *Canadian Doctor*, (March, 1938), pp. 27-28.

Johnston, R. K., "We Like Municipal Contract Practice!" *Canadian Doctor*, (May, 1938), pp. 17-19.

Roemer, Milton I., "Prepaid Medical Care and Changing Needs in Saskatchewan," Paper presented at the American Public Health Association, Kansas City, Missouri, November 14, 1955.

Rorem, Clarence Rufus. *The Municipal Doctor System in Rural Saskatchewan*. Chicago: University of Chicago Press, 1931.

Sigerist, Henry E. "Medical Care for All the People," *Canadian Journal of Public Health*, Vol. 35, No. 7 (July, 1944), pp. 253-267.

Sigerist, Henry E. Autobiographical Writings. Selected and Translated by Nora Sigerist Beeson. Montreal-Kingston: McGill-Queens University Press, 1966.

Sigerist, Henry E. *Medicine and Health in the Soviet Union*. Citadel Press. 1947.

SECONDARY SOURCES

ARTICLES

Dickinson, Harley D., "The Struggle for State Health Insurance: Reconsidering the Role of Saskatchewan Farmers," *Studies In Political Economy*, 41, (Summer, 1943), pp. 133-156.

Duffin, Jacalyn and Falk, Leslie A, "Sigerist in Saskatchewan: The Quest for Balance in Social and Technical Medicine," *Bulletin of the History of Medicine*, 70, (1996), pp. 658-683.

Duffin, Jacalyn, "The Guru and the Godfather: Henry Sigerist, Hugh MacLean and the Politics of Health Care Reform in 1940s Canada," *Canadian Bulletin of Medical History*, Vol. 9, (1992), pp. 191-218.

Feather, Joan and Mathews, Vincent L, "Early Medical Care in Saskatchewan," *Saskatchewan History*, Vol. XXXVII, No. 2 (Spring, 1984), pp. 41-54.

Feather, Joan, "From Concept to Reality: Formation of the Swift Current Health Region," *Prairie Forum*, Vol. 16, No. 1 (Spring, 1991), pp. 59-80.

Feather, Joan, "Impact of the Swift Current Health Region: Experiment or Model?," *Prairie Forum*, Vol. 16, No. 2, (Fall, 1991), pp. 225-248.

Fierlbeck, Katherine, "Canadian Health Care Reform and the Politics of Decentralization," in Christa Altenstetter and James Warner Bjorkman ed. *Health Policy Reform, National Variations and Globalization* (London: Macmillan Press Ltd, 1997), pp. 17-38.

Houston, C. Stuart, "The early years of the Saskatchewan Medical Quarterly," *Canadian Medical Association Journal*, Vol. 118 (May, 1978), pp. 1122-1128.

Houston, C. Stuart, "Saskatchewan's municipal doctors: a forerunner of the medicare system that developed 50 years later," *Canadian Medical Association Journal*, Vol. 151, No. 11 (December, 1994), pp. 1642-1644.

Mombourquette, Duane, "An Inalienable Right: The CCF and Rapid Health Care Reform,1944-1948," *Saskatchewan History*, Vol. 43, No. 3(1991), pp. 101-116.

Ostry, Aleck, "Prelude to Medicare: Institutional Change And Continuity in Saskatchewan, 1944-1962," *Prairie Forum*, Vol. 30, No. 1 (Spring, 1995), pp. 87-105.

Rands, Stan, "The CCF in Saskatchewan" in Donald C. Kerr ed. *Western Canadian Politics: The Radical Tradition* (Edmonton: NeWest Press, 1981), pp. 58-64.

Swartz, Donald, "The Politics of Reform: Public Health Insurance In Canada," *International Journal of Health Services*, Vol. 23, No. 2(1993), pp. 219-238.

Books

Badgley, Robin F. and Wolfe, Samuel. *Doctors' Strike: Medical Care and Conflict in Saskatchewan*. Toronto: Macmillan of Canada, 1967.

Gray, G. *Federalism and Health Policy*. Toronto: University of Toronto Press, 1991.

Houston, C. Stuart. *R. G. Ferguson: Crusader against Tuberculosis*. Toronto: Hannah Institute for the History of Medicine & Dundurn Press, 1991.

Lipset, S. M. *Agrarian Socialism: The Co-operative Commonwealth in Saskatchewan*. Berkley: University of California, 1950.

McLeod, Thomas H. and McLeod Ian. *Tommy Douglas: The Road to Jerusalem*. Edmonton: Hurtig Publishers, 1987.

Naylor, C. David. *Private Practise, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966*. Kingston and Montreal: McGill-Queens University Press, 1986.

Rands, Stan. *Privilege and Policy: A History of Community Clinics in Saskatchewan*. Saskatoon: Community Health Co-operative Federation, 1995.

Taylor, M.G. *Health Insurance and Canadian Public Policy: The Seven Decisions that Created The Canadian Health Insurance System*. Montreal: McGill-Queen's University Press, 1978.

Tollefson, E. A. *Bitter Medicine: The Saskatchewan Medicare Feud*, Saskatoon: Modern Press, 1963.

Unpublished Theses

Mombourquette, Duane John. "A Government and Health Care: The Co-operative Commonwealth Federation in Saskatchewan." Unpublished M. A. Thesis, University of Regina, 1990.

Sherdahl, Raymond M. "The Saskatchewan General Election of 1944." Unpublished M. A. Thesis, University of Saskatchewan, 1963.

Taylor, Malcolm G. "The Saskatchewan Hospital Services Plan: A Study in Compulsory Health Insurance." Unpublished Ph.D. Thesis, University of California, 1949.

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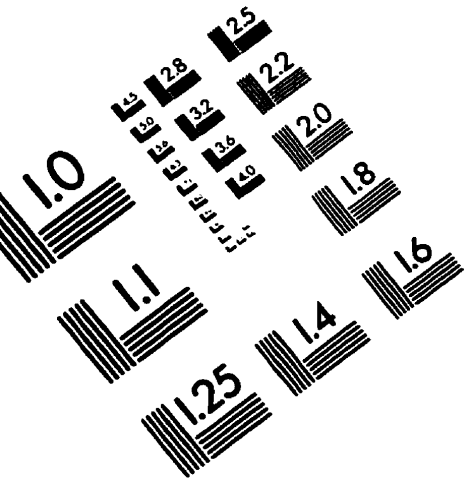

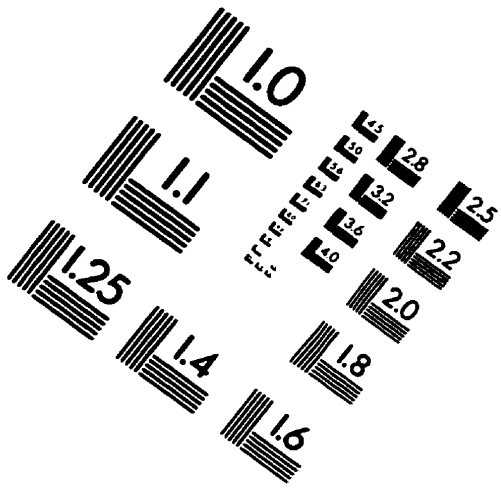

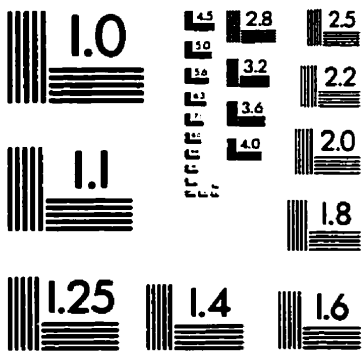

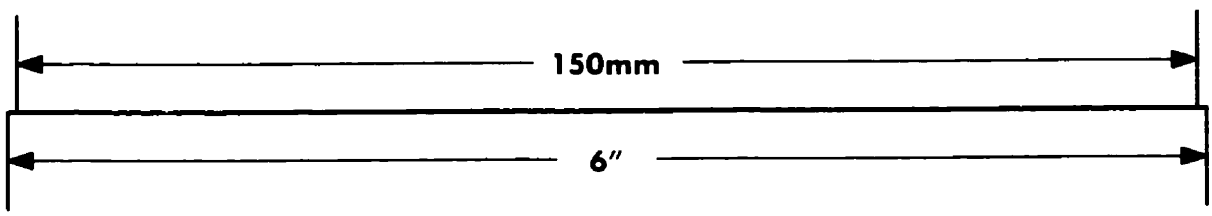

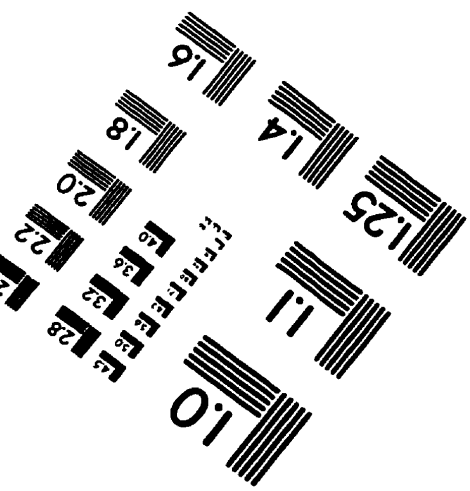

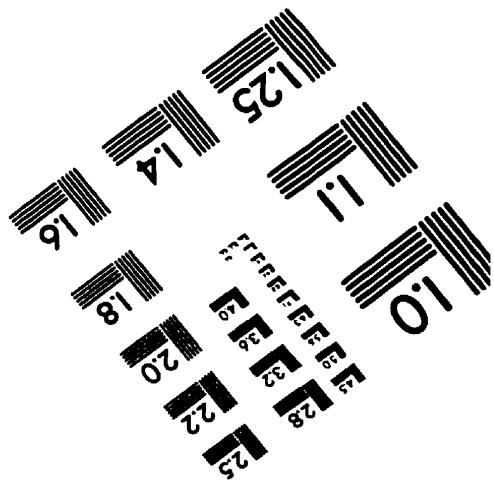

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