Passion and Persistence, Cooperation and Commitment: The Roots of Public Health Care in Canada

Lois L. Ross

CHAPTER
ONE

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What are the factors that encourage development within a community or society? What are the institutions, attitudes, and social framework that nudge development forward? What does it take to achieve development?

While these questions are not new, some consider they are pertinent only for developing nations of the South. But, it wasn't long ago that these very same questions underscored major challenges here in Canada. Are those of us living in the "North" — the so-called developed world — really that distant from, or immune to, the social and economic conditions we identify as belonging to countries or regions in the "South" — the so-called "developing" nations?

Some regions or areas in most countries, including Canada, may still be considered to be "developing". Conditions, for example, in Canada's Indigenous communities are often comparable to those found in developing countries. Concomitantly, Médecins Sans Frontières, best known for its work in the poorest nations and in the battle zones of this world, is now providing medical care at clinics in Paris and Marseilles for patients who are denied insurance coverage under France's latest health care reforms.[1]

This essay argues that Canada should not tread on roads already traveled, as we once again enter the fray of the public versus private health care debate. It also argues that, just as in Canada, the right to health care in developing nations will not be granted by governments so much as it will be demanded by a collective or a community prepared to organize around the issue. The right to public health care in Canada did not occur quietly or easily. While the Canadian experience may not be transplanted as is, there are lessons and parallels which the South may find useful.

This chapter recounts the roots of Canada's public health care system, relating them to the current domestic and international debates, and argues that Canadians learned through trial and error that a voluntary, private system of health care did not provide nearly the efficiencies or quality as one that was publicly-administered. There is little evidence that

much has changed, in terms of costs and quality of health care, to favour privatization. Canadians, and their governments, should be reinforcing and protecting Canada's public health care system and supporting the principle of public, universal health care, as part of sound development policy — both here at home and beyond. Physician-anthropologist Paul Farmer notes that increasing inequity in health is a form of "structural violence" — and that we need to begin "thinking globally, acting locally" to ensure it is considered a basic social right.[2] It could also be argued that because Canada has led in creating and implementing a publicly-funded and administered health structure, we have a special responsibility to support the efforts of those in greatest need elsewhere in the world — as good neighbours do.

In Canada, Tommy Clement Douglas is known as the Father of Medicare[3] because of his foresight and his courage in implementing North America's first universal and public-administered health care system. And all of this in a province that had the highest per capita debt and the second lowest per capita income in the country.[4] T.C. Douglas was indeed instrumental to the fight for Medicare, but he would also be the first to note that he did not achieve that victory on his own. Nor would he claim to be the first to have seen merit in the idea of a publicly-operated and administered health plan.

The roots of Canada's public health care system are anchored by the names of countless individuals and groups who committed time, energy, and the little cash many of them had to try and solve conditions that either created or maintained poverty in their communities. Those same conditions were causing needless pain and misery — and were not allowing for the human or community development that people saw as fundamental to a productive and caring society.

Here, then, is the story of how Canada's publicly-funded and administered health care system was created through a series of experiments, innovations, and courage. It is a story that took more than 50 years to unfold and one worth re-telling time and again, for a number of reasons. Canada's health care system is held up as an example of what is possible by many organizations in the South.

The debate over public health care in Canada continues, and without knowing what roads we have traveled, it is impossible to determine a future direction. Many Canadians do not know about the "roots" or struggles of health care and the costs and sacrifices made to achieve it. On the international stage, civil society is calling for the global right to health (see Chapter Two) — essentially a call to recognize the importance of effective and equitable health care systems, but also a call for recognition of the impact of the social determinants of health.[5]

Canadians have a story to share with the rest of the world about how people, working together, organized communities to push for the right to public health care, and how access to health care has stemmed poverty and enabled development in this part of the world. Within the development of Canada's public health care system, there have also been solid examples of emphasis on improving public health, social conditions, and preventive health care. In fact, the view that both medical care and improved social conditions are part of overall health was identified early on in Saskatchewan, the birthplace of Canada's public health care system.

Life before Medicare

As a child, I grew up on Saskatchewan stories, often told around the kitchen table…stories of hard winters, of inequality, and of the "haves and the have-nots". Stories of cooperation, of lending a hand, of human greed, and of incidents — all too common I would come to learn — that can only be regarded as cruel and unusual.

Prior to public health care, far too many families in Saskatchewan could relate heart-breaking episodes that, today, might seem more fiction than fact. There are still old-timers who mark the passage of time and events with "before Medicare" and "after Medicare" stories. In the early 1990s, while doing community work in the Saskatchewan city of Swift Current, I had a brief conversation with an elderly woman. As she tried to recall the date of a particular event, she noted that "it must have been in 1948, since my son was born by then, and he is the first baby I had that I did not have to pay for." That year — 1948 — was the year the hospitalization program was introduced in Saskatchewan, allowing for anyone who was ill enough to be hospitalized to receive free medical treatment. Not having to "pay for a baby" as she put it, was a definite milestone, since costs of giving birth in pre-Medicare Saskatchewan had driven some families into near bankruptcy, or worse (see Chapter Three for details of a similar situation in developing countries today).

There are other stories even more vivid. In my mind's eye, I see the horse-drawn cutter[6] taking a young boy and his older brother into a small southwestern Saskatchewan town in the middle of a prairie snowstorm. The town is more than six miles away from the farmstead, and the boy is suffering from acute appendicitis. The local hospital in this largely Catholic community of 1,500 is operated by the Grey Nuns. The timeframe is the mid-1930s. And though the boy arrives at the hospital before his appendix bursts, he is shown to a waiting room, while his older brother again braves the blizzard to retrace the six miles to the family farm to get their father. The 12-year-old boy is refused care until his father finally arrives at the Grey Nuns hospital. Why the delay? The father has to sign legal papers to secure the debt against the family farm for the pending medical care. Should the crops fail and the medical bill not be paid, the land will cover the debt. The boy is eventually operated on — and lives.[7] Others, in similar circumstances, were not so lucky.[8]

Only a few years ago, a friend of mine who farms in southern Saskatchewan related a very personal story. During a conversation about family and farming, I asked if his father had homesteaded[9] the land. Hesitating, he noted that the land was a "homestead". When I asked if his father was still alive, he explained that his father had died years ago. My friend's mother had had a complicated pregnancy for one of his siblings and the birth created large medical bills. From one year to the next, the crops failed, making it impossible to pay off the debt. Payment had been guaranteed against the land. One day my friend's father headed down to the dugout.[10] Hours later he was found — a victim of suicide. In the 1930s in Saskatchewan, when a person died, their debts died with them. This man had only his farm with which to try and ensure the livelihood of his family, and he likely had hopes that some of his children would take over the land when he eventually retired. The only way to keep that dream alive, in light of the medical debt, was to ensure that the debt died with him. And it did. My friend still farms the land that his father homesteaded.

The agrarian roots of public health

Saskatchewan, built on the "wheat economy," is often referred to by residents as "next year country" — meaning if this year is rough, next year will be better. And if not "next year," then the "next year" after that. Agrarian economies everywhere are built around a culture of resilience, stamina, hardship, and hope.

How did Saskatchewan, and in particular southwestern Saskatchewan, become the birthplace of public health care?

The reasons are many, but if you take a drive down the secondary roads of southern Saskatchewan, the geography and sparsely-populated landscape allows you to imagine just how tough it must have been to carve a living out of the prairie sod. When Palliser[11] surveyed this area in 1857, he called it semi-arid and unsuitable for agriculture. Searing in the summer sun, given to bone-chilling winds and snow blizzards in the winter, with an average annual rainfall of 240mm or 9.5 inches, the climate was harsh. But climate and geography are only some of the factors. These were also shared with sister provinces of Manitoba and Alberta, yet it is here in Saskatchewan that ideas of a public health care system took root.[12]

What is not so easy to understand is how, in this expanse of the Palliser triangle, people were able to organize what must certainly be considered one of the greatest innovations in social development in North America — an experiment in "social medicine" that, in time, would rival all others in the field, either on this continent or beyond. Even today, Canada's health care system is "unique in the world in that it bans coverage of core services (physician and hospital) by private insurance companies, allowing supplemental insurance only for perquisites such as private hospital

rooms. This ban constrains the emergence of a parallel private medical or hospital sector and puts pressure on the provinces to meet the expectations of middle-class Canadians."[13]

The first steps toward public health care in Saskatchewan were small, but set an example of future possibilities. Prairie pioneers, people who settled the west, came from eastern Canada and Europe in search of a better life. The federal government had promised free homesteads to those willing to occupy lands and farm them within three years of their arrival. The pioneers arrived, taking the train as far as the tracks would go, and walking the rest of the distance. They came to a land that had absolutely no infrastructure. Those early settlers had to create communities literally from scratch. There was no local government, no town, no church, no community centre, schools, doctors, hospitals or town offices. Many huddled together in makeshift structures, doing their best to endure the first few winters. Houses were erected with neighbours lending each other a hand. People learned to co-operate and "pool" their efforts — it was a matter of survival. It was in everyone's interest to lend a hand — and to ensure that as many families made a "go of it" as possible. Successful establishment — development — of a community depended on it.

Necessity honed problem-solving abilities, as individuals and communities worked to establish structures based on collective or communal efforts, and not simply based on the need for profit. The prairie wheat pools were established by farmers so that they could "pool" their grain at harvest time, all the better to fend off the *laissez-faire* market forces that many farmers felt had used their power abusively in previous years. With storage facilities and a marketing structure based on "pooling" of crops from members, farmers no longer had to negotiate individually with the "merchants of grain". Credit cooperatives were also formed, so that people had a say in how money was loaned, at what interest rate, and what terms of repayment. Access to credit was key to maintaining the family farm in "next year country". Saskatchewan still has one of the strongest Credit Union banking systems in the country. There were also attempts at cooperative farming, both production co-ops and machinery co-ops.[14]

When Saskatchewan became a province in 1905, there were six hospitals serving 250,000 people. Death rates in rural areas were higher than in urban areas, where there were often full-time public health officials. In addition, rural areas often had trouble keeping doctors because there was no guarantee from one year to the next that individuals in the community would have a good crop and be able to pay for their medical services.

One of the first steps[15] towards public administration and financing of health care in Saskatchewan was the creation of the municipal doctor system. In 1915, in an effort to keep the services of its newly-arrived physician from Illinois, Dr H.J. Schmitt, the rural municipality of Sarnia #221

agreed to pay the doctor a retainer or salary of $1,500. Dr Schmitt, who during the course of his practice covered nine townships[16] by horse and buggy, was having difficulty collecting from impoverished farmers and was considering relocating to a larger, more prosperous community. This experimental move by local government led to the passage of the Municipal Hospitals Act in 1916, allowing for rural municipalities to make a grant to physicians to supplement their incomes. Then in 1919, legislation was passed to allow for municipalities to pay the salary of a doctor, if that salary did not exceed $5,000 per year, so that the doctor could provide free medical care to the residents of the municipality.

In the years that would follow, provincial legislation would be amended several times to include the sharing of physician services between municipalities as well as to allow for a per capita tax assessment to pay for the physician. This system of financing health care — essentially the "pooling" of monies — created a footing for public health care in Saskatchewan. By 1927, there were 13 municipal doctors practising — most being paid between $3,500 and $5,000. The per capita tax ensured that no individual patient was burdened as the municipal tax system "recognized ability to pay, since the more land one held, the more one paid."[17] As the 1930s proceeded, things got only worse for those rural municipalities that had not adopted the municipal doctor plan. The Saskatchewan section of the United Farmers of Canada encouraged the municipal doctor system and its members organized to push municipal councils to adopt the plan. An information pamphlet noted the reasoning succinctly:

> *"At present we are committed to pooling our wheat and other farm products. The municipal doctor scheme is in reality a pooling of our doctor bills…and insurance against unduly high doctor bills in any one year — an equalization scheme. Are you willing to invest $4.50 per quarter section in the health of our section of the nation? A nation's first wealth is health, and levies to protect our first wealth should have priority over all others."*[18]

The municipal doctor plan was the first step in integrating the idea of "pooling" finances for health care. But it was not perfect. And it was not portable — meaning that a patient could visit only doctors contracted by the municipality and within its borders. In addition, the plan did not cover hospitalization. It could be improved upon, and early on there were ideas of how to do that.

One of these, in particular, illustrates how individuals can make a difference through organization and persistence. And how good ideas in one part of the world can be carried forward to others.

Known as the "Matt Anderson Plan," it was built on the experiences of a Scandinavian immigrant of the same name. Having lived in Norway as a boy, Matt Anderson knew about public health care systems in that country, and was troubled that Canada had nothing to compare. In addition,

"As chairman of the board, you had to collect dues...

...to make ends meet. If you had problems, and couldn't pay the nurses…then they would go somewhere else. You never knew what was going to happen if you had a bad crop. You couldn't guarantee the wages. People would only be able to make small payments (health bills)… and that would be over years…and if you saw the conditions they lived in and their children — you wondered if it was right to try and collect from these people…still you would be surprised how much they did scrape up…you would see the toddlers running around with hardly no clothes on…it makes you think…the hospital board dealt with the hospital debt, but the doctors had to collect their own bills…a person who had a bit of property was likelier to get care than those who had nothing…I wouldn't say that people were ignored…but the doctors would pick'em over and try to pick those who had some money…all of that created a lot of interest in having everybody pay a bit…but once the doctors got the drift of it and realized that they were going to get paid every month and they didn't have to go into the countryside to try and collect, they liked it…there was a lot of educational work — we had to build up the region…people were a bit against socialism…but a lot of people realized it didn't matter if it was a socialist idea or whatever, everybody ended up sick or in the hospital eventually..."

Sam Gill, *the Mayor of the town of Leader and chairman of the Hospital Board, as told to Lois L. Ross during an interview, May 6, 1991, Leader, Saskatchewan.*

like most farmers of the time, he had suffered crop losses and had heavy medical expenses to pay for his family. He was also familiar with the municipal doctor plan that some rural municipalities were adopting. Anderson proposed a medical program that included doctor visits and hospitalization — a public health insurance plan that would be based on a personal tax. Under the plan, any patient could visit a doctor anywhere. Anderson discussed the plan with doctors and neighbours in his municipality and eventually, in 1927, a resolution was put before the Rural Municipalities convention. The plan wasn't supported because municipal reeves[19] felt that raising taxes would be unpopular. Instead, the organization appealed to the provincial government to implement a plan that would allow people to look after their health, even calling for "state" hospital, medical, and health services.

Year after year, for the next 10 years, and throughout the 1930s, Matt Anderson would present the resolution at the annual Rural Municipalities convention. In 1938, he brought forward a resolution calling on the provincial and federal governments to work together to implement a public health care program based on taxes. The delegates discussed the resolution but brushed it aside, saying it wasn't possible.

"On the way home from the convention, I felt both discouraged and disappointed. As I was thinking of the problem, it came to me all at once — why not do it myself instead of asking the government to do it?"[20]

Anderson decided to see if he could start a Medicare program within his own municipality. As reeve, he approached the provincial government and requested passage of a law to allow the Rural Municipality of McKillop to levy a personal tax for the purpose. He went back to his municipality and put forward a motion, noting the Order-in-Council that made the personal levy by the municipality legal. While many had been skeptical, the rural municipality supported Anderson's Medicare plan. The plan went into effect January 1, 1939. The initial tax was $5 per person, with a maximum of $50 per family. The plan covered 2,350 people. Soon after, the provincial government expanded the legislation to allow other municipalities to levy personal taxes. As word spread, other rural municipalities became interested in passing the plan. In essence, the "Matt Anderson Plan" was the precursor to both provincial and later federal Medicare plans.

Due to changes in legislation similar to that which allowed local governments to levy taxes for health care, voluntary insurance programs were started through various associations. These plans grew slowly because most people lived in the rural areas and could either not afford membership in these associations or were lucky enough to be covered by a municipal doctor plan. But even in 1939, a cooperative medical insurance plan set up by an association of consumers faced stiff opposition by doctors in Regina. The health cooperative had hired a group of doctors to be on salary and staff a clinic supported early on by more than 1,500 members. The doctors were pressured not to join the co-op, and the group of doctors in opposition quickly moved to set up their own private medical insurance scheme. This was a sign of what was to come and the deep divisions between the entrepreneurial view of health as a "commodity" and health as a "social right". Should health care be sold through private business practices owned by doctors, and paid for on a fee-for-service basis? Or should health care be publicly-funded with physicians on salary as part of a government-sponsored system? This public/private dynamic is the same struggle that permeates national and international arenas today. By 1939, in areas of the province where the municipal doctor system had not taken hold, private insurance companies — often operated by doctors themselves — were offering coverage. The debate between public and private health care insurance was beginning to take shape.

In the first 40 years of the last century, the people of Saskatchewan had already taken large steps and made inroads toward having health recognized as a right. And while both federal and provincial governments of various stripes had noted the need for health care in their platforms, and even promised to implement an adequate system, very many people were

left out in the cold if they could not afford to pay for their own health care costs. Municipalities that had adopted the municipal doctor systems were under severe financial pressure to maintain basic health care in the face of years of poor crops. As well, in many cases, the municipalities became collection agents. While the concept of "pooling" was working, the size of the "pool", given the agrarian economic realities, was not large enough to sustain the need. The burden of financing adequate health care had fallen largely to municipal councils.

Free hospitalization comes to Saskatchewan

So when the young T.C. Douglas, with a decade of political and electoral experience under his belt, campaigned on a provincial platform providing public health and dental care, the people of Saskatchewan took note and opted for the chance. In 1944, the Cooperative Commonwealth Federation (CCF), led by Douglas, came to power — the first socialist government in North America. The new government took office on July 10 and wasted no time in planning to carry out its mandate.

Within a few months a report, written by Dr Henry E. Sigerist,[21] was filed recommending regional health districts based on preventive medicine, hospitals, rural health centres, and maintaining and developing the system of municipal doctors. Sigerist also proposed free hospitalization.

Within three months of taking office, the Saskatchewan CCF had introduced complete health treatment for those with cancer (diagnostic and curative plans), and free care for the mentally ill and those suffering from sexually transmitted diseases. Then a few months later, in January 1945, the province issued a blue card entitling old age pensioners, the disabled, and those on mother's allowance[22] to complete health care including medical, surgical, glasses, hearing aids, and prescription drugs.

In 1946, the Saskatchewan government passed legislation allowing for the first universal hospitalization program in North America. Doctors in Saskatchewan almost universally supported the creation of the program, since they could now admit patients without concern for cost.

That year the CCF government created 14 health regions, selecting one of those regions to embark on a pilot project to help build the provincial plan. In that region, known as Swift Current Health Region #1, medical and hospital care, as well as dental care for those 16 and under, would be covered. The structure, data and experience of the Swift Current Region would provide the province with a model on which to build a provincial plan, just as Saskatchewan would later become the model for Canada's Medicare system.

But as the CCF government was speedily moving toward these new programs, it was also facing tremendous financial pressures. The province was saddled with the highest per capita debt in the country. In addition,

though the federal government had indicated it would pay 50 per cent of health programs initiated by the provinces, that promise would turn out to be a hollow one for years to come. As Douglas noted: "We were confident…I was young and naïve…and of course the federal government didn't come with anything…and for 11 years the people of Saskatchewan paid the entire costs of comprehensive hospital insurance."[23]

Southwestern Saskatchewan was the poorest area of the province, and had suffered drought throughout the 1930s. In the previous generation, only one year in every seven had provided a return to farmers. For that reason, many of the municipalities and residents were burdened with debt due to unpaid health care bills — and were seeking solutions.

A full public program, which would "pool" funds from several municipalities drawing on a combination of land and personal taxes and provincial support, seemed feasible. It took several meetings among at least 10 municipalities, combined with leadership at the local level, to engender co-operation and overcome the competition that could exist between towns and municipalities. There were heated debates and votes throughout the region at municipal meetings, with some residents fearing that taxes would rise exorbitantly. But on January 17, at the organizational meeting for the newly-formed Swift Current Health Region #1, 60 delegates from the municipalities instructed the regional health board to provide comprehensive hospital and medical care as well as limited dental care "as soon as possible". The doctors in the region, many having lived through difficult times, saw the benefits of public and preventive health programs, and worked in co-operation with residents to build the pilot project.

By July 1946, universal hospital and medical care came into force throughout Swift Current Health Region #1, a full two years ahead of Great Britain's National Health Plan. It became the first region in Canada to combine public health with preventive care, and its board was made up of "staunch Liberals and Conservatives and CCFers, but they all left their politics at the doorstep."[24] The region would soon have a medical officer, seven public health nurses, a health educator, and three sanitary inspectors. By 1948, the number of doctors in the region would have jumped from 19 to 36. Over the course of the next 15 years the infant mortality rate within Health Region #1 would drop from the highest in the province to the lowest, achieving a rate of 14.4 per thousand live births by 1965. The region's infant mortality rate was far lower than that for Canada as a whole, which in the early 1960s was almost double at 27 per 1,000 live births.[25]

While the CCF government kept its promise, once the initial programs were begun it was forced to pace the rate of change to the financial reality of the province. Nonetheless, the public health programs available — in particular universal hospitalization — were superior to all others in the country and lifted the burden of health care from the shoulders of indi-

viduals and families. Communities continued their development, and the 1950s are recalled by many as the first decade in which a relatively solid bridge between prosperity and equity was created in one of the poorest regions in the province.

While the early public health care programs[26] did not meet with much opposition from the medical profession, by the mid-1950s there were signs that some doctors saw health insurance more as a product to be sold than as a public right. The Saskatchewan government, led by T.C. Douglas, implemented crucial public health care programs through the late 1940s and '50s, but it was waiting on the federal government's promise of cost-sharing to implement a universal and comprehensive province-wide Medicare program. By the late 1950s, while those areas which had municipal doctor plans maintained their programs, the system of municipal doctors was not being expanded. Meanwhile, for-profit insurance plans operated by doctors were expanding quickly. By 1959, more than 40 per cent of the Saskatchewan population was covered, in varying degrees, by these private insurance schemes.

While the Saskatchewan Medical Association had good relations with the provincial government in the early years of Douglas's mandate, and had publicly noted its appreciation of the Premier and his role as Minister of Health, there were also early signs of the diverging interests to come. For one, the culture among prairie doctors was beginning to shift: those doctors who had weathered the poverty and drought years of the 1930s were retiring and younger doctors with less experience of hardship were replacing them. Many more doctors were also moving to the cities, rather than dedicate themselves to the seemingly more difficult life of a rural physician. By 1961, 54 per cent of doctors would live in urban areas, though only 22 per cent of the province's population lived in cities. As well, with private insurance plans operated by doctors, physicians' ability to essentially set and control their own fee structure was becoming increasingly attractive.

Meanwhile, Canada's southern neighbours in the United States had for several decades been trying to engage various levels of government to adopt a publicly-funded system. In 1939, what is known as the 'Wagner Bill' was introduced nationally. One purpose of the bill was to allow the US to put a National Health Program into practice. And while consumer groups supported the move, among those who attacked the bill was the American Medical Association (AMA).[27] In fact, during much of the last century, the US citizenry has pressured at various times for public health care, most recently during the Kennedy administration of the 1960s and during the Clinton administration in the 1990s.

In 1957, the Conservative Party, led by Saskatchewan-born Prime Minister John Diefenbaker, was elected to federal office in Canada.

"When I was a boy in Scotland before World War I...

...I fell and hurt my knee. A bone disease called osteomyelitis set in and for three or more years I was in and out of hospital. We had no money for doctors, let alone specialists. After we immigrated to Canada, the pain in my knee came back. Mother took me to the outdoor clinic of a Winnipeg hospital. They put me in the public ward as a charity patient and I still remember the young house doctor saying that my leg must be cut off. But I was lucky. A brilliant orthopeodic surgeon, whose name was Smith, came through the wards looking for patients he could use in teaching demonstrations. He examined my swollen knee and then went to see my parents… Chance intervened and a specialist cured me without thought of a fee. I shall always be grateful to the medical profession for the skill that kept me from becoming a cripple, but the experience of being a charity patient remains with me. All my adult life I have dreamed of the day when an experience like mine would be impossible and we would have in Canada a program of complete medical care without a price tag."

Premier T.C. Douglas, as told to the Star Weekly, June 4, 1960

Within a year, Diefenbaker decided to make good on the idea of 50 per cent cost sharing for those provinces wanting to set up and administer a public health care program. While the idea of private insurance plans was already well underway in many parts of Canada, more than 30 per cent of Canadians had no health insurance at all.

Public medical care becomes a reality

In April of 1959, Saskatchewan Premier Tommy Douglas announced plans to implement Medicare across the province of Saskatchewan — a program based on principles that would guarantee equity by being universal, comprehensive, affordable, portable, and publicly-administered. The CCF provincial government decided to seek a fifth electoral mandate in 1960. A major component of its election program was public medical care. The Saskatchewan Medical Association (SMA) and the Chamber of Commerce campaigned — along with the CCF's main opposition, the Liberal Party led by Ross Thatcher — against Medicare.

The SMA was armed with tactics and resources from the American Medical Association, which since the 1920s had been successful in stymieing any moves toward public health care in the US. The SMA set up a system of cells, with one doctor or "key man" whom they ensured would distribute public relations material quickly and who could keep in regular contact with doctors in his area. The SMA also assessed a special $100 fee on each of the 900 doctors in the province and, with additional funds directed from the coffers of the Association, managed to dedicate more

than $95,000 toward its campaign against Medicare. The Association was not beyond pressuring, and purging, maverick doctors who did not see public health care as a threat and challenged the SMA position. The Association, borrowing a page from the AMA, worked hard to evoke the US witch hunts of the McCarthy era by "red-baiting" in their publicity kits. One piece of SMA propaganda emphasized: "The concept of universal medical coverage is not new and the approach by government to seek support is just the same as it was when first enunciated by Karl Marx in his Communistic theories of the last century literature…"[28] Essentially, the campaign was a dry run for things to come.

Nonetheless, the CCF was successfully re-elected on June 8, 1960, and moved ahead to implement its main campaign platform, Medicare, and the five key principles — universality, comprehensiveness, public administration, portability, and accessibility.

Following the recommendations of the Thompson Committee[29] — an advisory planning committee whose 12 members included six physicians — the Government of Saskatchewan moved to pass the Saskatchewan Medical Care Insurance Act in November 1961. By this time, Woodrow Lloyd was CCF Premier of Saskatchewan.[30] The Thompson Committee had accepted more than 50 briefs and had held fact-finding visits and taken opinions from experts in more than seven countries including Australia, Great Britain, Norway, and Denmark. Its main recommendation was the universal coverage of the entire population — rather than universally available coverage on a voluntary basis. The committee rejected what is now popularly known as a two-tier system, noting that it would be difficult and costly to administer, and that a voluntary system would lead to uneven coverage of the population; it would eventually cost the government more because subsidies would have to be given to those with inadequate health coverage.

Naturally those doctors who were accustomed to their own private insurance schemes and who had campaigned hard against re-election of the CCF were not happy. What is known as the "Doctors' Strike" of 1962 took place during 23 days in June and July, after repeated impasses between the doctors associations and the commission charged with implementing health care.

Essentially the College of Physicians and Surgeons and the Saskatchewan Medical Association's final position was that patients should be reimbursed by the government for health care services and charges administered by commercial companies or by doctors' plans. The public would buy insurance policies, if they chose to do so, and poor people would have their premiums paid by the government at fee rates determined by doctors. In a nutshell, the doctors' associations were pushing to ensconce private insurance schemes, with rates determined by doctors

and the government subsidizing those who could not afford the costs. By May, the doctors had decided that if their proposal was not adopted, they would begin to withdraw their services by going on strike — in effect, refusing to provide service in hospitals and doctors' offices. Some doctors would be left to deal with emergencies, but only a skeletal service would remain and some facilities would have to be closed.

The CCF government wasn't prepared to accept a plan that would endorse the "commodification" of health care — not when it had pledged since the 1930s to bring in a public and comprehensive health care system, and had just been re-elected with an increased majority on a platform mandating that it implement a public system of Medicare across Saskatchewan.

The Doctors' Strike in the summer of 1962 was hard fought. A system of organizational "cells" was up and running. "Keep our Doctors" (KOD) committees were set up by women who said that their group had been formed spontaneously over a "cup of coffee" one morning. Interestingly, the KOD committees were strikingly similar to Operation Coffee Cup, the American Medical Association's campaign of the late 1950s and early 1960s that opposed the Kennedy Democrats' plan to extend Social Security to include health insurance for the elderly, known as Medicaid.[31] It is well-documented that in 1962, just as in ensuing years, the AMA financed and encouraged, often surreptitiously, its Canadian counterparts to actively campaign against public, universal, health care.[32]

When the Doctors' Strike began on July 1, the sides were deeply polarized. The doctors were largely supported by the business community and the Chamber of Commerce, as well as the pharmacists who stopped filling prescriptions during the strike. Meanwhile, organizations representing farmers and labour supported Medicare. Still, the withdrawal of services worried many, and the province moved to accept the services of British doctors who offered to come to Canada to provide medical services in the interim. In some communities, medical practitioners who supported public health care banded together to form clinics.

For 23 days the strike continued, often pitting family members and neighbours against each other — but the provincial government led by Premier Lloyd largely followed a strategy based on calm and silence. It was a delicate, volatile situation — one that some feared could become violent. In the end, the strike lost momentum as it became clear that the doctors could not garner the public support they had hoped for. On July 23, 1962, a negotiated settlement was signed in Saskatoon — one that preserved the five principles of Medicare (universal, comprehensive, publicly-administered, portable and affordable), but which did not challenge doctors' privileges to determine fees nor close the door to public consultations on quality of care.

By August, the amendments to the legislation as outlined in the Saskatoon Agreement were passed. These amendments, which allowed for various methods of billing by doctors, included a clause allowing physicians to opt out of the plan — one which would later meet with controversy and open the door to extra-billing.[33] These amendments also precluded having doctors on salary, instead allowing a fee-for-service billing system, a point raised in the Romanow Commission report of 2002. Nonetheless, the Saskatoon Agreement was a turning point not only for the people of Saskatchewan, but also for Canada and other countries. It meant that the day when a person's health would no longer be determined by the thickness of their wallet was at hand.

Just as Swift Current Health Region #1 had been the pilot project for the provincial plan, Saskatchewan's public health care system would now provide the example that, in a few short years, would be adopted nationally.

On the federal scene, as Saskatchewan was in the throes of its public health care debate, Prime Minister John Diefenbaker announced a commission to study the issue of a national health plan. During the course of that announcement in the House of Commons in December 1960, Diefenbaker made public a letter he had received from the Canadian Medical Association (CMA) asking for the inquiry.[34] As early as 1958, a nationwide Gallup poll had found that more than half Canada's population was in favour of public health care. So, in January 1961, the prime minister appointed a prominent Saskatoon judge, Emmett Hall, to lead a Royal Commission on Health Services. The recommendations of the Hall Commission have resonated across Canada for more than 40 years. All major health organizations participated, and the Commission studied first-hand health care systems from around the world;[35] it wrote 26 background research reports, before presenting findings in June 1964 — two years after the Commissioners had begun their inquiry.

The scene that the Hall Commission encountered as it prepared for public hearings reflected in many ways the challenges that the Saskatchewan government was encountering in its quest to establish public health care in that province. Both the SMA and the CMA endorsed public health care as early as 1933; the CMA, in 1934, had actually lobbied the federal government, trying to convince the government of the day that "medical care was as basic a need as clothing or food".[36] But by the time the Hall Commission prepared to go on the road with public hearings, the organization representing Canada's doctors had changed its tune. In the early 1950s, the CMA had entered the business of private health insurance and created Trans-Canada Medical Services, a coordinating body for doctor-sponsored provincial insurance plans. In 1960, while more than 7.5 million Canadians had no health coverage at all, another four million were covered by 11 doctor-sponsored insurance plans. Those plans melded with those of private insurance companies offering health cover-

age, and in 1959 the two groups formed the Canadian Conference on Health Care. The CMA and private insurers offered this organization as being an adequate and satisfactory vehicle for national health insurance, hoping that the Royal Commission would find in favour of the new organization. While the CMA had urged the Prime Minister to strike the Royal Commission, it was hoping that public funds would be channeled through private insurance schemes to pay for coverage of those who could not afford to pay on their own — essentially public subsidization and private control.

Justice Hall was given free reign to choose his Commissioners — and the views of the Commissioners were varied, with individuals from corporate, medical, and economic backgrounds. Hall also let it be known early on that the commission had no intention of taking sides in the dispute in Saskatchewan or of simply debating Medicare. He emphasized that the commission was set to inquire into all health services, and he worked hard to maintain its independence. He also refused to follow up on the CMA's suggestion that it would be pleased to secretly vet the reports prior to final publication.

When the unanimous Report of the Royal Commission on Health Services, now popularly referred to as the Hall Commission report, was released in 1964, it gave the idea of public health care a stamp of approval. Put simply, Hall noted that private health insurance plans excluded millions of people: they charged too much for administration and refused to cover some people, either because of pre-existing health conditions, inability to pay, or because the contracts were simply terminated by the insurance company. Hall's proposal was essentially the Saskatchewan model, allowing universal coverage on a fee-for-service basis. Each province was encouraged to develop its own model, with the federal government providing 50 per cent of the cost.

Medicare becomes a national program

But the Royal Commission report went much further than basic public health care. It included recommendations on prevention of disease, a prescription drug plan, eye care and eye glasses, an air ambulance service, and free dental care for expectant mothers and children under 18; it also called for new university medical and dental schools. The report was filled with statistical data that projected costs of public administration well into the future — calculations that, while heavily criticized at the time, were very close to what would actually be paid over the next 20 years. While in 1961 all health services cost 5.2 per cent of Gross National Product (GNP), Hall argued that more should be spent for a comprehensive system; he predicted that his proposal for health coverage would cost no more than 6.4 per cent in 1971 and 7.4 per cent in 1991. "The only thing more expensive than good health care is inadequate or no health care,"[37] he pointed out.

The Hall report also called for public administration, noting that it was far cheaper and more efficient than if handled privately. Administrative costs in Saskatchewan had always been below five per cent — usually between 3.9 and 4.6 per cent — as compared to private administration which ranged from 16 to 24 per cent and did not cover all people. The Saskatchewan data also noted that the length of hospital stay and costs per patient were actually less when there were no deterrent fees, as there were in British Columbia and Alberta. "And so," noted T.C. Douglas in a 1979 speech, "Mr. Justice Emmett Hall came to the same conclusion that we in Saskatchewan had years before — that deterrent fees are nothing else but a tax on the sick."

The report's first volume also included a visionary Health Charter for all Canadians.[38] That Charter affirms the Hall Commission's view that health care is a right, but it also alludes to what we now call the "social determinants of health" (see Chapter Two). It notes that the primary objective of national policy should be to achieve the highest standard of health, and that would include improving on other factors that affect health such as housing, nutrition, water, and air pollution.

Despite the depth of its arguments, the Hall Report did not escape severe criticism from the private sector, including the Canadian Medical Association. But Hall often challenged his critics in public presentations. He also went beyond a purely humanitarian view of health care and took the view that improved health care was an investment in "human capital", essential for economic progress.

By the time the 1964 Commission report was released, the Conservative government of John Diefenbaker had been replaced by a Liberal federal government led by Lester B. Pearson. These changes, and a split within the Liberal ranks, caused some delays. But legislation allowing for Medicare passed the Canadian House of Commons in December 1966; enabling legislation came into effect July 1, 1967. British Columbia joined the plan in 1968, with other provinces following suit between 1969 and 1971. Finally, in 1972, the Northwest Territories and the Yukon also joined.

While more than 40 years after its release the Hall Report is still held up as a beacon of what is possible, it also seems that the price paid for hard-won rights is constant vigilance. During the course of the past 30 years, Canada's Medicare system has been attacked in a number of ways — some more transparent than others. In 1979, Canada's national Medicare program was little more than 10 years old but already problems of underfunding — considered a main cause of the woes that the public health system has faced over the years — were creating controversy. Instead of continuing to fund health care at 50 per cent through block funding, in 1977 Ottawa brokered a deal with the provinces to provide

cash grants along with a share of income tax collected. In return, provinces could disperse the money to health programs as they saw fit. Those changes in the funding formula, and dealing with a system of fee-for-service, are what many believe are at the root of health care problems — and have largely led to the more recent controversies over the adequacy of Canada's public health care system.

In 1980, Emmett Hall was called once again by the federal government to report on the state of Medicare in Canada. Some doctors in Saskatchewan had begun to extra-bill patients, and colleagues in other provinces were following suit. While several issues arose during the less than two years that Emmett Hall took to research and write this report,[39] released in 1980, he focused on extra-billing. Hall found that provinces had acted responsibly in the level and manner in which health money was being spent, citing that administration fees in most provinces were at 2.5 per cent, but that doctors — through extra-billing — were opening the door to expanding private health care; this was creating a two-tier health care system, one for the rich and one for the poor.

Hall recognized the threat of extra-billing for what it was — and while noting that doctors deserved "reasonable compensation," he also noted that, according to legislation, fee schedules were negotiated with the practitioners and the state did not have the right to unilaterally determine them. He also noted that in 1978 doctors were making four times the wages of an industrial worker. Still, he ventured no further on challenging the levels of compensation for doctors. When negotiations on fee schedules failed, Hall recommended that disputes be settled through binding arbitration. While it took a few years for action on Hall's controversial recommendation, his report is credited with leading to the passage of the 1983 Canada Health Act — federal legislation that effectively banned user fees for hospital and physician services.

In 1964 and in 1980, just as now, doctors guarded the fee-for-service structure jealously. Talk of putting doctors on salary surfaces from time to time, but seems to be diverted by talk of public-private partnerships, doctor shortages, and wait times for treatment. The Canadian Health Coalition (CHC), a civil society organization that works to defend public health care, emphasizes that health workers should be paid on a salaried basis, not the fee-for-service system used by physicians, some health care providers, and private laboratories. Fee-for-service (payment for the number and type of services provided) encourages over-booking, over-prescribing, over-treating, and the concentration of physicians in urban areas at the expense of rural areas, according to the CHC.

During the late 1980s and the 1990s, Canada's national health plan was ignored by successive federal governments and suffered from chronic underfunding.[40] Issues of cost-sharing and jurisdiction, as well as deficits

and debt at both the federal and provincial levels during these decades, may have been at the root of this incredible negligence and reluctance to tackle health care issues head-on. Perhaps some hoped the neglect might lead to the implosion of Canada's public health care system — and the example it could provide to those living in less fortunate regions of the world of what is possible when effort and monies are pooled for the public good.

Assessing the route traveled to achieve the right to health care in Canada, it becomes increasingly clear that, in order to maintain that right, a society must be constantly ahead of the challenges created by private interests.

Since the late 1990s, there have been a number of worrisome trends and episodes in our quest to improve Canada's health care system, and there is fear on the part of many that we may be in the process of throwing the baby out with the bath water. Recent surveys have underscored Canadians overwhelming support for public health care. More than 85 per cent of Canadians want the federal government to have a strong role in developing common standards for health care delivery and services.[41] As well, 69 per cent of Canadians are willing to pay higher taxes to improve the public health care system.[42]

While Canadians are barraged with constant reports of wait times, doctor shortages, and excessive public health care costs, there are just as many reports published that should allay those fears by spelling out solutions to the problems and assessment of actual costs — all within the public health system.

In April 2001, yet another Saskatoon lawyer and former Saskatchewan premier, Roy Romanow, was called upon to lead a Royal Commission Report into the state of health care in Canada. That eloquent report further updated the Hall Commission reports and gathered health statistics from across the country and the world. The Romanow Report[43] undertook extensive consultation with Canadians during its 18-month duration, both in public hearings and through online forums. When the final report was released in November 2002, *Building on Values — The Future of Health Care in Canada* confirmed the value and future of Canada's public health care system. Romanow found that Canadians see a public health care system as a right of citizenship, as a public good, and not as a "privilege of status or wealth," and that, in fact, Canadians are getting very good value for their tax dollars. The report noted that "Medicare has served Canadians extremely well" — both in terms of efficiency and costs of care. Romanow compared Canada's system to several countries around the world, including the United Kingdom, Australia, and Japan, concluding that our public health expenditures are in keeping with those of other countries with public systems.

Health care statistics comparing Canada to other countries – 1993-2003*

Country	Total Health Care Expenditures *% of gross domestic product* 1993	2003	Health Care Funding from Public Sector *per cent*	Average Growth Rate from 1998 to 2003 *per cent*	Health Expenditures per Capita *$US*	Practising Physicians per 1000 Population *number*	MRI Scanner Units per Million Population	Life Expectancy at Birth *years*
Canada	9.9	9.9	69.9	4.2	3,003	2.1	4.5	79.7
France	9.4	10.1	76.3	3.5	2,903	3.4	2.8	79.4
Germany	9.9	11.1	78.2	1.8	2,996	3.4	6.0	78.4
Italy	8.0	8.4	75.1	3.1	2,258	4.1	11.6	79.9
Japan	6.5	7.9	81.5	3.0	2,139	2.0	35.3	81.8
Switzerland	9.4	11.5	58.5	2.8	3,781	3.6	14.2	80.4
United Kingdom	6.9	7.7	83.4	5.7	2,231	2.2	5.2	78.5
United States	13.2	15.0	44.4	4.6	5,635	2.3	8.6	77.2

* Data are from the Organisation for Economic Co-operation and Development, *Health Data 2005: Statistics and Indicators for 30 Countries.* (Available at http://www.oecd.org/document/30/0,2340,en_2825_495642_12968734_1_1_1_1,00.html). Data are for 2003 or the most recent year available. The figure for magnetic resonance imaging (MRI) scanners in the United States is an underestimate because it refers to the number of hospitals that have at least one scanner, rather than the total number of scanners.

The cost of health care in the US is close to twice Canada's per capita cost, and an increasing number[44] of Americans — close to 46 million — have no health coverage at all.[45] Romanow found that the public share of health spending in the US "private" system is more than 60 per cent of total health care expenditures. "This has been described as tantamount to paying for national health insurance and, in return, getting a fragmented system with significant gaps in coverage — the worst of both worlds. While the United States' health care system is usually portrayed as largely private, a more apt description is 'public money, private control'."

The Romanow report found that Canada's public health care system is "as sustainable as we want it to be" — and that governments have it in their power to improve upon the system to ensure its future. It also emphasized the need for a health care system based on preventing illness — what T.C. Douglas called phase two of the public health care system — rather than simply treating it. The debate should not be about whether or not private health care would be better, but rather on how to innovate to ensure an improved public system — one that is comprehensive and cohesive across the country. Romanow challenged the use of private clinics, particularly for diagnostic purposes, and recommended that these services be included within the Canada Health Act. He found no evidence to support further privatization of the system, either through user fees, de-listing of services, or a parallel private system.

Whether the reports have been at the provincial or the federal level, from the Sigerist report and the Thompson Commission in Saskatchewan, to the Hall Reports of the 1960s and the 1980s, through to the recent Romanow Commission Report, there have been few that have promoted the "commodification" or "privatization" of health care. That said, in the last few years there have been some reports or initiatives that have pushed for "hybridization" of the public health care system. While in the 1980s, the hot-button issue was user fees, the key issue these days is wait times and medical human resources. Many Canadians live in fear, justified or not, of not being able to access necessary medical care in time to deal with a personal health crisis. Waiting lists for diagnostic tests or surgery, or simply not being able to find a family doctor, are now issues across the country. As well, the costs of medical services that have been de-listed by the provinces or medical services that have never been publicly funded (such as prescription drugs) are on the rise.

Just as the Romanow Commission was wrapping up its work in October 2002, the Kirby Report[46] was released. For two years, the standing Senate committee on social affairs, science and technology studied the state of the Canadian health-care system and the federal role in that system. Its recommendations were wide-ranging and encouraged the Canadian government to review the role of the Canada Health Act and the five guiding principles of Medicare — public administration, universality, comprehensiveness, accessibility, and portability. More specifically, the Kirby Report recommended that the federal government clarify the principle of public administration, noting that the principle should cover the administration, but not necessarily the delivery, of health care. In keeping with that argument, the Kirby report makes several recommendations which would include "partnering" with private insurers or agencies to deliver care or a prescription drug plan. One might well wonder how a system set up using these recommendations would differ from the US medical system criticized by Romanow — "public money, private control".

Senator Michael Kirby's role as chair and lead on the committee that prepared the report has been challenged, since Senator Kirby is also on the Board of Directors of Extendicare, a for-profit company based in Markham, Ontario, that owns hundreds of nursing homes across North America. Several groups, including the Canadian Health Coalition noted Kirby's participation as chair as a conflict of interest, and traced the quality of care provided by Extendicare to its elderly residents.[47]

There are, no doubt, those who yearn for the lucrative possibility of doing business in health care. Canada spent approximately $130 billion on health care in 2004.[48] Just over $90 billion of that money was spent by governments delivering public health care. Almost $40 billion was spent on private health care. Shirley Douglas, spokesperson for the Canadian

Health Coalition, Canadian actor, and daughter of Tommy Douglas, calls the public portion of health care spending "a $90 billion golden egg", noting the health industry wants to get hold of it. "We in this country have forgotten our history…we have forgotten what a medical bill is," says Douglas. "We have this strange idea that health care is free…that the government gave it to us. It is not free — we have paid for it…we pay for it — through our taxes. This health care system did not come out of sentimental times. This public health care system came out of fierce battles…with tremendous opponents…and they are still here. You may not have personally fought for it, but your family did."

There has also been movement at the provincial level to pressure the federal government to allow for private agencies to deliver medical care. In Alberta, a plan called the "Third Way" would challenge the five principles of the Canada Health Act by allowing doctors to work in both the private and public health care systems and by allowing patients to pay cash or buy insurance to avoid wait times. Both recommendations are currently on hold by the federal government, which worries about the electoral ramifications of such blatant moves toward privatization.

In Quebec, the challenge to the Canada Health Act comes through the establishment of private clinics. There are more than 90 operating in Quebec, many offering diagnostic care — creating what is essentially a "two-tier" system for those who can afford to pay for what is perceived to be faster private care. Many believe such clinics are the beginning of privatization and of two health care systems, one for the rich and one for the poor.

These provincial moves were given the green light on June 9, 2005, when the Supreme Court of Canada ruled on what has become known as the Chaoulli Decision.[49] This ruling states that the Quebec charter allows for the purchase of private health care for procedures already covered by publicly-administered Medicare. The plaintiffs in the case — a Montreal patient, George Zeliotis, and Dr Jacques Chaoulli, who wanted to set up a private clinic — asked Canada's top court to strike down sections of the Quebec Hospital Insurance Act that prevent people from buying health insurance for medical procedures covered by the public health plan.

The Kirby Report also recommended that the provinces pay for private treatment if the patient isn't treated within a certain timeframe. While the 'hot-button' issue of wait times is of genuine concern, there is sound analysis by several policy-makers providing information on how to deal with the current hold-ups within the public system. Health policy analyst Michael Rachlis[50] compares the bottlenecks to a crowd trying to get into a hockey arena. While there is a line-up at the door, once you have your ticket and are past the gate, there is a seat for everyone. So it is with health care wait lists. What is needed, according to Rachlis, is action

to streamline minor and low-risk elective surgeries through specialized publicly-funded clinics. Rachlis provides examples of two such clinics, Toronto's Queensway Surgicentre and Winnipeg's Pan Am Clinic. "The Canadian debate has wrongly assumed that the only such clinics are for-profit businesses," notes Rachlis. Rather than call for privatization of services each time there is a problem to be solved in the public system, solutions can be handled within Medicare, he suggests.

There are also other pressures on the public system that need to be dealt with if the commercialization of the health care system is to be stemmed. For one, human resource needs have to be addressed. There has been a reduction of 50 per cent in nursing graduates since the early 1990s and, with the average age of nurses increasing, there is a growing shortage. This has led to criticism over Canada's "poaching" of health care workers from developing countries (see Chapter Four). Meanwhile, there is no consensus on whether there is a shortage of physicians in Canada, but the distribution of physicians across the country varies, often leaving rural and remote communities without the necessary professionals to provide even basic health services.

To address issues of funding, the federal government signed a deal with the provinces in September 2004 to provide an additional $41.3 billion in health care funding over 10 years. While this was touted as a plan that would fix public health care, money is only one aspect. Equally important are three other facets: ensuring that the Canada Health Act and its five principles of Medicare are followed by the provinces, increased training of health care professionals, and working to reduce the skyrocketing costs of pharmaceuticals. Romanow noted that many families face bankruptcy trying to cover the costs of expensive, but necessary, prescription drugs. And there have been calls for governments to create a publicly funded and controlled Pharmacare program[51] to ensure equal access to prescription drugs.

The cost of prescription drugs is the fastest growing category of health care spending, with drug costs having reached 17.5 per cent of total health care expenditures in 2005 — almost double the 9.5 per cent reported in 1985.[52] In 2005 alone, costs of prescription drugs rose by 11 per cent to almost $25 billion. Since 1997, prescription drugs have accounted for the second-largest share of health care spending, after hospitals. If these costs are not brought under control, many believe they will lead to a new health care crisis. In 2006, the Ontario provincial government announced reforms to curb health care costs, in particular the spiraling costs of pharmaceuticals. But negotiating volume discounts, encouraging pharmacists to stock less-expensive generics, and moving to regulate the price of generics is seen as a challenge to the brand-name drug industry.

The Canadian head of GlaxoSmithKline has warned the Ontario government that it might pull its branch plants out of Ontario if the reforms go ahead.[53]

At the same time, there is growing concern about the health care industry's practice of marketing pharmaceuticals to healthy people through fear-inducing advertising techniques, in order to expand the reach and profit line.[54] Access to medicine and exploitation by the pharmaceutical industry — Big Pharma — is a global problem, no matter whether we are discussing health catastrophes related to HIV/AIDS in Africa, resistant strains of tuberculosis in Russia, or Fabry's disease in Canada.

While there are clearly challenges to preserving Canada's publicly-funded health care system — and the need for constant vigilance to maintain it — there is also an urgency to move forward, both here at home and internationally, toward a more preventive and sustainable system based on the social determinants of health.[55] The existence of Medicare allows a society to concentrate on the social determinants, and this is considered by many to go hand-in-hand with a publicly-funded and administered health care system. Ensuring that Canada's health care system remains firmly in the public sphere is seen as important to the development of Canadian communities, as well as those communities in the South.

In 2006, a group of Canadian medical doctors formed a national organization – Canadian Doctors for Medicare (CDM) — calling on physicians across the country to help strengthen and protect public access to high-quality health care. "Physicians know that Medicare faces challenges similar to those in many developed countries," notes Dr Danielle Martin, a Toronto family doctor and chair of the CDM's Board.[56] "Many Canadians don't have access to a family doctor. Many more know a friend or a family member who has waited too long for a diagnostic test or treatment. The emergence of a parallel private tier would only make these problems worse for most of our patients. These problems are best solved within the framework of universally accessible, publicly-funded Medicare."

Dr Sylvia Estrada-Claudio, a doctor from the Philippines, agrees that public health care is crucial to development. And she adds that further privatization of Canada's public system could have drastic consequences in the South. Dr Estrada-Claudio is a co-founder of Likhaan, a national women's health organization, which, for several years, has partnered with the Canadian non-governmental organization Inter Pares.

She points out: "We have a saying back home, that when the overdeveloped north sneezes, we get pneumonia. The recent attempts in Canada to privatize health care by creating a two-tier system and to evade the federal government's accountability for enforcing the Canada Health Act are the sneeze. Let me tell you what the pneumonia looks like…many

Filipinos never have to deal with long wait times because they never get into the system. It is obvious to me that many of our local struggles are against a global problem. So I say resist the privatization of health care services in Canada and hold the Minister of Health here accountable to the Canada Health Act. Make Canada rebuke those who would take away a high standard and universal health care. We will be grateful for your victories in the Philippines."[57]

LOIS L. ROSS is Director of Communications and Publications for The North-South Institute. Lois proudly notes that she was born in southwestern Saskatchewan — the area of Canada that is credited with creating the first health projects in "social medicine". For more than 20 years, Lois has worked in the field of communications, as a writer, author, editor, journalist, broadcaster/webcaster, and photographer. Part of that time has been spent working in the area of community and international development in Canada and in Latin America. Prior to accepting the position with The North-South Institute in December of 2000, Lois was Director of Communications and Political Action with the Public Service Alliance of Canada. Previous to that she spent several years as a National Representative in Communications at the Canadian Labour Congress. Lois is the author and co-author of three non-fiction books: Prairie Lives: The Changing Face of Farming; Harvest of Opportunity: New Horizons for Farm Women; and, Assault on the Worker: Occupational Health and Safety in Canada. Her short fiction works have also been published in several anthologies, and both national and international magazines have published her feature articles.

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http://archives.cbc.ca/300c.asp?id=1-73-90
CBC website on health care.

http://scaa.usask.ca/gallery/medicare/
Saskatchewan Council of Archives and Archivists, Medicare – A People's Issue, a site that mentions key players.

http://www.dufourlaw.com/ndp/tommy.htm
Tommy Douglas speech, given in Ottawa in 1979.

www.healthcoalitions.ca Audio speech by Tommy Douglas given on the 50th anniversary of the federal NDP on the Canadian Health Coalition website.

Endnotes

1 "French Health Reform: Doctors Without Borders go into Paris clinics to fill gap," by Tom Sandborn, The Tycee.ca, April 5, 2006. The same article notes: "Le Monde, one of France's leading newspapers, editorialized in August of 2004, that 'all the reforms that are proposed in France today lean toward an American style "reform" '."

2 *Pathologies of Power-Health, Human Rights and The New War on the Poor*, by Paul Farmer, University of California Press, 2005.

3 See "Prairie Giant: The Tommy Douglas Story" two-part television series aired on CBC Television March 12 and 13, 2006. Produced by Minds Eye Entertainment, Regina, Saskatchewan. http://www.cbc.ca/tommydouglas/

4 *Tommy Douglas – The Road to Jerusalem*, by Thomas H. McLeod and Ian McLeod, Hurtig Publishers, Edmonton, 1987.

5 Social determinants are social factors which determine the quality of a person's health. Such factors include education, employment, income level and working conditions, and the environment (such as air and water quality). For more information see: http://www.who.int/social_determinants/strategy/QandAs/en/index.html

6 A "cutter" was a horse-drawn sled used by rural residents during prairie winters before the use of automobiles became affordable and common.

7 That 12-year-old boy would eventually become my father.

8 *Steps on the Road to Medicare – Why Saskatchewan Led the Way*, Stuart C. Houston., McGill-Queen's University Press, 2002.

9 A homestead was a land grant of 160 acres. A homesteader needed to live on the land for six months of the year, erect a permanent shelter, and farm at least 15 acres of the land within three years of arrival in order to retain homesteading rights. Women were not allowed to apply for a homestead.

9 *Prairie Lives: The Changing Face of Farming*, by Lois L. Ross, Between the Lines, 1985.

10 On the prairies of western Canada, a dugout generally means a small reserve of run-off water, conserved in an area which has been dug out for that purpose. Most farms had a least one dugout to ensure clean water was available for humans and animals.

11 British Captain John Palliser was sent to examine the Plains and Parkland regions of the province.

12 It is here, in this expanse of land bordered by Leader to the north, the Alberta border to the west, and by Maple Creek and the US border to the south, that Health Region #1 was created to help consolidate the Saskatchewan government's move to public health care.

13 *Perspective, Private Health Care in Canada*, by Robert Steinbrook M.D. April 20, 2006, The New England Journal of Medicine; downloaded from www.nejm.org on April 20, 2006. Also, *Canada's health care system – reform delayed*, A.S. Detsky and C. D. Naylor, The New England Journal of Medicine.

14 Ross, *Prairie Lives*.

15 In the early years of the province, public health was a branch of the Department of Agriculture. That branch, however, under the leadership of Dr Maurice M. Seymour, brought in various measures to deal with communicable diseases ranging from typhoid fever to bovine tuberculosis, and summer dysentery. In January of 1929, Saskatchewan became the first province to cover the health care costs of the diagnosis and treatment of TB patients.

16 A township consists of 36 sections, with each section being 640 acres. In the early 1930s Dr C. S. McLean, Dr Schmitt's successor in the municipality of Sarnia, drove 14,000 miles to make 1,400 house calls, saw another 1,500 patients in his office, and attended 50-70 maternity cases. (see Steps on the Road to Medicare)

17 Houston, *Steps*, page 34.

18 Ibid., page 35.

19 Elected municipal officials.

20 Badgley & Wolfe, *Doctors' Strike*, page 14.

21 Within two days of the election, the Saskatchewan Premier — eager to put the CCF campaign platform into practice — had contacted Dr Henry E. Sigerist, a medical physician and professor of Medical History at John Hopkins University in the US, to request that he head a health study commission. Sigerist, who was originally from Switzerland and had been to Canada to speak on several occasions, supported

what he called "social medicine" — the structure that determined the distribution and delivery of care — and had followed attempts to set-up state-supported medicine in various parts of the world, including the Soviet Union. Sigerist also believed very strongly that the social and technological advances in medicine needed to develop together to avoid inequities. (See article *Sigerist in Saskatchewan.*)

22 Public assistance provided for basic family needs.

23 Speech by Tommy Douglas given in Ottawa in 1979.

24 Houston, *Steps*, page 143.

25 Gruending, Dennis. *Emmett Hall – Establishment Radical.* Fitzhenry & Whiteside, 2005.

26 The municipal doctors system and the hospitalization program, and the creation of Health Region #1.

27 *What Happened to the Health Program*, by Dr Henry Sigerist, John Hopkins University, June 18, 1940.

28 Portion of Saskatchewan Medical Association publicity kit as quoted in "Doctors' Strike."

29 Badgley & Wolfe, *Doctors' Strike.*

30 T.C. Douglas had resigned as Premier of Saskatchewan in order to become the leader of the newly-formed federal New Democratic Party.

31 Max J. Skidmore. *Social Security and Its Enemies.*.

32 Mark Gayn: *Doctors vs. the People*, Volume 195, Issue # 0002, July 28, 1962, accessed via The Nation Digital Archive; Peter Calamai: *Medicare dubbed second-rate*, The Windsor Star, June 22, 1989, accessed via FP infomart.ca, February 8, 2006.

33 Extra-billing is when doctors choose to bill additional fees, over and above those established in the fee guide set by the profession and the provincial medical care insurance commission.

34 Gruending (*Establishment Radical*) notes that the CMA was hoping to have a private system of insurance endorsed nationally to preclude expansion of the Saskatchewan model.

35 The Commission, either singly or in groups, studied the programs and practices in other countries including the United Kingdom, France, Holland, Sweden, Switzerland, Austria, Italy, the US, the then USSR, Australia, and New Zealand. The two volume report of analysis and recommendations was also based on more than 400 individual and organizational submissions presented at public hearings held in each Canadian province and the Yukon.

36 Gruending, *Establishment Radical*, page 102.

37 Ibid., page 112.

38 The Health Charter for Canada was initially proposed for adoption by the Royal Commission on Health Services in Volume 1 of its report in 1964.

39 *Canada's National-Provincial Health Program for the 1980s— 'A Commitment for Renewal,'* by The Hon. Emmett M. Hall, C.C., Q.C., Special Commissioner – Health Services Review 1979 – report published in August of 1980.

40 The calculation of federal funding for health care varies depending on whether it is based on cash contributions and tax points, or simply on cash transfer to the provinces. Either calculation concludes a substantial drop in federal funds transferred to the provinces to fund the Canadian public health care system. Total federal expenditures (cash plus tax points) for hospital and physician expenditures has ranged from a high of almost 60 per cent at the end of the 1970s to a low of slightly more than 41 per cent at the end of the 1990s. Federal "cash only" transfers for the same period have ranged from a high of close to 47 per cent to a low of 14.6 per cent. (see Romanow report, page 66)

41 Health Care in Canada Survey 2001.

42 Health Care in Canada Survey 2002.

43 *Building on Values – The Future of Health Care in Canada*, Commission on the Future of Health Care in Canada, Roy J. Romanow, Q.C., Commissioner, Final Report, November 2002, ISBN 0-662-33043-9.

44 *Percentage of Uninsured Americans Rising*, by Theresea Agovina, Associated Press, April 26, 2006.

45 Even those with private health insurance are not guaranteed adequate health coverage in times of need. As many as 400,000 American families file for bankruptcy each year because of medical expenses. In an insurance system based on user pay, those who need the most care — essentially those who over time are least likely to be able to pay — actually pay the most. Many have health insurance, until they become chronically ill or need expensive prescription drugs to survive. See the front page story of a young, middle-income family from Indiana: "When Even Health Insurance Is No Safeguard", by John Leland, New York Sunday Times, Early Edition, October 23rd, 2005.

46 *The Health of Canadians – The Federal Role.* Final report of the Standing Senate Committee on Social Affairs, Science and Technology, Chair, The Hon. Michael J.L. Kirby, October 2002 – web access: http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/SOCI-E/rep-e/repoct02vol6part8-e.htm#APPENDIX%20A

47 See *Extendicare is not a model for Medicare*, a submission to the Standing Committee on Social Affairs, Science and Technology, by the Canadian Health Coalition, December 2001 – accessible at: http://www.healthcoalition.ca/kirby.html see also: http://www.extendicare.com/governance/directors.html

48 *Health Care in Canada*, a report released by the Canadian Institute for Health Information, on June 8, 2005.

49 http://www.cbc.ca/story/canada/national/2005/06/09/newscoc-health050609.html

50 *Public Solutions to Health Care Wait Lists*, Michael M. Rachlis, Canadian Centre for Policy Alternatives, December 2005.

51 *Moving Forward – Alternative Federal Budget 2006*, Canadian Centre for Policy Alternatives.

52 Canadian Institute for Health Information, Annual Report, May 2006.

53 *Can Ontario stand up to Big Pharma? Brand-name drug firms deliver threat*, Thomas Walkom, Toronto Star, April 29, 2006.

54 *Selling Sickness. How Drug Companies Are Turning Us All into Patients*, Allan Cassels and Ray Moynihan, Greystone Books, Canada, 2005; see also: *Ill-Health Canada: Putting food and drug company profits ahead of safety*, Michael McBane, Canadian Centre for Policy Alternatives, 2005.

55 *Creating Social and Health Equity: Adopting an Alberta Social Determinants of Health Framework*, Philip O'Hara, Edmonton Social Planning Council, May 2005. Available online at www.edmpsc.com

56 *Physicians launch call to strengthen and protect Medicare*. Accessed May 29, 2006, Ottawa – see: www.canadiandoctorsformedicare.ca

57 Message delivered at Health, Justice and Democracy, the Annual General Meeting of Inter Pares, April 24, 2006. See www.interpares.ca