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**Navigating a Course between Scylla and Charybdis:
Quebec Voluntary Hospitals, the Market and the State,
1940 to 1960**

Mary Anne Farkas

**A Thesis
in
The Department
of
History**

**Presented in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy at
Concordia University
Montreal, Quebec, Canada**

September 1997

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ABSTRACT

Navigating a Course between Scylla and Charybdis: Quebec Voluntary Hospitals, the Market and the State, 1940-1960

Mary Anne Farkas, Ph.D.
Concordia University, 1997.

This dissertation examines the development of hospitalization insurance in Canada and Quebec in the period from 1940 to 1960, focusing on the debate over health policy that began during the Second World War – when broad government-funded social programmes were being proposed – to 1960, when Quebec became the last province to join the national hospitalization insurance programme. It considers policy development on both the federal and provincial levels, as well as the response of two Montreal-area hospitals and their professional organizations to the perennial budget deficits and to the solutions proposed by government.

It also examines the ideologies behind the choices that were made, both on the political level and in the hospital sector. Of particular interest is ongoing debate between two forms of liberalism: *laissez-faire* and state-interventionist. The dominant tendency for much of this period was the *laissez-faire* approach, that is, the belief that, overall, the market could proffer the best solutions to the problems of access to and financing of hospitals. This approach dominated both levels of government and, in the form of the liberal voluntary ethic, the hospitals as well. The other approach, which believed the state had a significant role to play in social welfare, was subordinate through much of the period, but eventually came to dominate.

The hospitals themselves are an important focus of this study, particularly the contradiction between the desire of the voluntary hospital boards to keep their institutions autonomous from the state, and their incapacity to find adequate and durable solutions in the marketplace.

ACKNOWLEDGEMENTS

I wish especially to thank Dr. Mary Vipond, my dissertation supervisor, for her constant advice and support. She was always ready with help, all the while giving me the space to write my own dissertation. I also want to thank Dr. Othmar Keel, also of my committee, for his ongoing advice and support and for challenging me with an alternative vision. And I want to thank Dr. Ronald Rudin, Dr. Daniel Salée, and Dr. Heather MacDougall of my committee, for their helpful insights and suggestions.

Many friends and members of my extended family gave me ongoing support and encouragement. I thank them. My two sons, Martin and Robin, put up with too many years of their mother's absences, both physical and intellectual. I thank them. And I want to thank my husband, Simon Horn, for all the years of moral support and debate over the content of my dissertation. Finally, my parents, Nicholas and Theresa Farkas, did not live to see the end of this process. But long ago, they put me on the road, confident that I would reach my destination.

This work is dedicated to the memory of my friend and colleague,
Keith Lowther.

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ABBREVIATIONS

ANQ: Archives Nationales du Québec

AR: *Annual Report*

CJPH: *Canadian Journal of Public Health*

DBS: Dominion Bureau of Statistics

HSL: Hôpital St-Luc

MA: McGill Archives

MGH: Montreal General Hospital

NAC: National Archives of Canada

TCH: *The Canadian Hospital*



(Courtesy of Dr. F. Tees)

A. P. 10

Quebec Public Charities

(R. S. Q. 1941 — Chap. 187)

Indigent's
number _____Hospital
number _____

Year _____

Form A

1.—(Section 23, § 1)

APPLICATION FOR ADMISSION OF AN INDIGENT PERSON TO A PUBLIC CHARITABLE INSTITUTION

(Date and place) _____

To the authorities of Public Charities. The undersigned applies for the admission of an indigent person

Into _____ Name of the applicant _____
(Name of the Institution).Name of the indigent person _____
(In the case of a married woman or a widow, give her name in full and also the name in full of her husband).His occupation _____ His age _____ His present domicile _____
(Indicate the municipality in which the domicile of the indigent person is situated).His previous domiciles _____
(Indicate the municipality or municipalities in which the two previous domiciles of the indigent were situated).

I, the undersigned, being duly sworn, do declare that the foregoing information is true, and that the person above named is indigent.

Sworn before me at _____

(Signature) _____

this _____, 19 _____

(Post Office address of applicant) _____

(Signature) _____
J. P. (or Com. of the S. C.)

Witnesses _____

Form B

2.—(Section 23, § 2)

CERTIFICATE OF THE MUNICIPAL AUTHORITIES ESTABLISHING THE ABSOLUTE INDIGENCY

(Date and place) _____

I, the undersigned _____ of _____
(Mayor, councillor or alderman or any other person authorized to deliver such certificate, in the mayor's absence).

in the county of _____ being duly sworn, declare to the best of my knowledge, after having

been credibly informed, that _____
(Name in full, age and occupation of the indigent person. In the case of a married woman, her name in full as well as that of her husband must be given).

is indigent and must be placed in a public charitable institution. I further declare, subject to the provisions of section 34 of the Quebec Public Charities Act, that the municipality has not obtained, does not obtain and will not obtain any sum of money or other value whatsoever in payment of its share of the hospitalization of the indigent person whose admission is applied for according to Form 1.

I further certify that _____ is an indigent who has no means of support nor any one bound by law or otherwise to provide for his needs according to Articles 165 and following of the Civil Code.

Sworn before me at _____

(Signature) _____

this _____, 19 _____

(Post Office address) _____

(Signature) _____

Form C

3.—(Section 23, § 3)

MEDICAL CERTIFICATE IN THE CASE OF AN INDIGENT SICK PERSON

(Date and place) _____

I, _____ of _____
(physician's name in full)

habitually practising the medical profession and duly authorized as such, being duly sworn, do declare :

I know _____
(Name in full of the indigent person. In the case of a married woman, her name in full as well as that of her husband must be given).I had occasion to visit this person and personally examine him (or her) on the (date) _____
The symptoms I have personally observed lead me to recognize that it is necessary that he (or she) be admitted and treated in a hospitalizing institution.

Sworn before me at _____

(Signature) _____

this _____, 19 _____

(Post Office address) _____

(Signature) _____

INTRODUCTION

On January 1, 1997 the government of Quebec inaugurated a new compulsory public/private drug plan. The core of the plan was a mixture of public and private financing: the indigent and the aged were covered for the most part by public money, while the rest of the population were required to pay for their own insurance, through a private or group plan or through the government plan. This structure strongly echoes plans and proposals vigorously supported by many sectors of society — hospital boards and organizations, private sector interveners, and some federal Cabinet ministers and provincial governments — in the 1940s and '50s, years of debate over the necessity and shape of national and provincial hospital insurance plans. Ultimately, this proposed public/private approach was discarded as more expensive and less equitable than a universal government-funded insurance system.

The intent of this dissertation is to examine the debate over hospitalization insurance in the period from 1940, when broad government-funded social programmes were being proposed, to 1960, when Quebec became the last province to join the hospitalization insurance programme. It is an examination of the development of policy on the federal and provincial level, and of the response of two hospitals, Montreal's St-Luc and Montreal General hospitals, and their professional organizations to the programmes elaborated by government. It is also an examination of the ideologies behind the choices made — both on the political level and by the hospitals and their organizations — and a discussion of the similarity of many of these positions,

a similarity based on a common conception of the relation between the market and the state.

Of particular interest is the predominance and tenacity of the *laissez-faire* liberal approach to the problem, that is, the belief that, overall, the market could proffer the best solutions to the problems of providing both hospitalization for the population and sufficient income for the hospitals to adequately cover their costs. This approach is studied in the context of processes going on in both Ottawa and Quebec City, as governments and organizations representing the public, private enterprise and the hospitals themselves examined the problem of the public's lack of access to hospital care and hospitals' incapacity to cover the costs of this care. These debates and decisions were both influenced by the hospitals, through their national and provincial organizations, and shaped the hospitals' responses to the evolving situation. The hospitals themselves and their trade organizations are a significant focus of this study, more particularly the dynamic between the desire of those individuals or groups supporting and running hospitals as their charitable work to keep these hospitals autonomous from the state, and their incapacity to find adequate and durable solutions in the marketplace. The stance taken by the hospital boards is examined, as are the problems encountered over these years in providing services to the public without an assured means of covering the growing cost of these services.

The years of the Second World War in Canada witnessed one of the periods of most intense debate on health insurance, as the federal Department of Health and

Welfare prepared a national state-financed health insurance plan, part of the government's post-war social welfare package. In 1945 Owen Trainor, President of the Manitoba Hospital Association, offered a rather succinct synopsis of the extremes of the debate to the readers of *The Canadian Hospital*, trade journal for hospital administrators:

There are those who dispute the right or propriety of government interference in any form, with the voluntary hospital. Their opposite number would deny the right to existence of the voluntary hospital and would transfer its ownership and operation to the government. We have here, bluntly stated, the *Scylla* and the *Charybdis* of the hospital problem and it is altogether probable that the safely navigable channel lies somewhere in between.¹

Trainor's comment encapsulates many of the elements discussed in this work. It seemed a good metaphor for the dilemma that hospital boards found themselves in during the period before hospitalization insurance — wedged between the market and the state. It is also a fairly accurate evaluation of the stance of most hospital boards, wishing for some element of state support without the loss of their autonomy.

While two voluntary (i.e., private, non-profit) hospitals — the Montreal General Hospital and Hôpital St-Luc — are closely examined, this is not a hospital biography. Rather, it is an examination of the interplay of forces that resulted in the demand for government intervention, shaped the perspective of hospitals as to what kind of intervention they wanted, and shaped government decisions as to what kind of

¹ Owen C. Trainor, "The Voluntary Hospital in the Future," *The Canadian Hospital*, vol. 22, no. 12, December 1945, p. 26.

intervention they were willing to make. It is an examination of how the ideology of *laissez-faire* liberalism shaped the vision of how the hospital sector should function.

This ideology, which in institutions like hospitals became known as voluntarism — the ethic of giving time and money to charitable works — was also the predominant ideology in Canadian society and in both the federal and Quebec levels of government. Any proposal for a comprehensive state-run health insurance program would have to counter this dominant tendency.

This text is also an examination of the differences and, especially, the similarities of outlook of the two hospitals studied, across the linguistic and religious divide in Montreal. Both were voluntary hospitals, sharing similar viewpoints, despite the national differences.

The time frame of this essay is 1940 to 1960, the period that saw the most intense and protracted debate on hospital insurance and, eventually, the implementation of the programme. The essay is divided into five chapters. Chapter One reviews the literature relevant to the elements to be studied. Chapter Two deals with the structural, legislative and financial situation of the Canadian and Quebec hospital system in 1940. Chapter Three deals with the wartime period, when comprehensive health insurance proposals were on the table. Chapter Four discusses the post-war period, one of economic growth and potential market solutions. Chapter Five discusses the failure of market solutions and the implementation of hospitalization insurance. Each chapter examines the process on the federal and provincial levels, as

well as in the two hospitals being studied. The emphasis varies in the different chapters, depending on the political, social and economic particularities of each time period. Some are more focused on the hospitals, others on the federal or provincial governments. Overall, however, the intent is to show how all these levels were driven by similar ideologies in their confrontation with day-to-day realities, whether of a practical or a political nature.

A few questions should be clarified at the outset. One is the question of the hospital statistics, particularly budgetary figures, used. Quebec did not institute a unified system of budgetary reporting for hospitals until after the implementation of hospitalization insurance in 1961. As a result, accounting methods could vary from hospital to hospital. The Montreal General maintained accurate figures in an accepted form. St-Luc could be more problematic. However, the methods used at St-Luc appear to remain internally consistent over the period. As a result, while it is important to see the figures quoted as approximate, nonetheless they can give an adequate view of the financial problems of the hospitals over the time period studied.

It is also important to note that the two institutions are lay hospitals, not the norm in Quebec, where most hospitals were run by the Catholic Church. However, this dissertation does not attempt to extrapolate the experience of these two hospitals to the situation of Quebec hospitals in general. It is an examination of voluntary hospitals, and the two chosen fit well within the liberal voluntary tradition. The Montreal General Hospital was selected because it was the first English hospital in

Montreal and has played a leading role in Montreal medicine. St-Luc Hospital is a good example of a second-rank lay Catholic hospital in the voluntarist tradition.²

This said, the choice made contained a very definite logic. There is a clear parallelism between the two institutions studied, despite the differences. Both hospitals were lay, founded — at different times — in the same part of Montreal and with similar missions, that is, the treatment of the poor (See Figure 1, p. viii.). They were founded and supported by similar kinds of people, members of the elite in the English- and French-language communities, with similar visions of their charitable work. These shared characteristics make a good basis for comparison. On the other hand, it is the differences between the two communities — different levels of financial support, for example, leading to different choices made by the institutions — that account for the variations. What choices were made, and how they turned out, will be an important element examined and will provide points of comparison of different routes taken and the efficacy of their outcomes. These elements taken together should create a portrait of two voluntary hospitals navigating through difficult times, making choices as to the best means of survival in the context of governmental movement towards the welfare state.

² Notre-Dame Hospital, another lay Catholic hospital, founded in the 1880s, and always a leading, university-linked institution, has been thoroughly studied by others. See Lucie Deslauriers, "Histoire de l'Hôpital Notre-Dame de Montréal 1880-1924" (M.A., University of Montreal, 1984); Yves Belzile, "Syndicalisme et conditions de travail chez les employés de l'Hôpital Notre-Dame de Montréal (1935-1980)" (M.A., University of Montreal, 1991); Denis Goulet, François Hudon, Othmar Keel, *Histoire de l'Hôpital Notre-Dame de Montréal 1880-1980* (Montreal: VLB Éditeur, 1993); François Hudon, "L'Hôpital comme microcosme de la société: enjeux institutionnels et besoins sociaux à l'Hôpital Notre-Dame de Montréal 1880-1960" (Ph.D. diss., University of Montreal, 1996).

Chapter I

DEBATES

This study will examine the genesis of the hospitalization insurance programme in Canada. The examination will focus on three levels: the federal government, the Quebec government, and two Montreal hospitals and their associations. While the actual process of debate and policy formulation is examined, as are the various attempts of the two hospitals to resolve their constant financial problems, the main focus is on the debate between two viewpoints: the dominant *laissez-faire* liberalism, a position shared by many of the players, and a state-interventionist liberalism that grew in opposition to the more market-oriented version. This element – the adherence to market solutions at all levels – was manifested in hospitals as the liberal voluntary tradition. Several elements have to be taken into consideration in order to develop a thorough analysis of this dynamic. Three themes will be discussed here: the vision of welfare provision in Canada, in particular the relative role of the market and the state¹ in health care delivery; the development of welfare measures in Quebec; and the nature of voluntary hospitals.

¹ The debate on the nature of the state is broad-ranging, acrimonious and extremely complex, and well beyond the scope of this text. However, because the role of the state in policy formation is one of the central elements in this text, it seems appropriate to give some indication of the analysis of the state underlying it. I view the state as a product of class divisions in a society, and as such, under the dominance of the dominant class. This does not negate a certain level of autonomy of the state in the actual working out of policy, however, and thus its ability to respond to demands of diverse sectors of the population. The role of the upper levels of state bureaucracy – often more long-standing as a force than governments in power – can be very important in this consideration.

The first point of analysis is the development of the welfare state in Canada. The particular focus of interest is two-fold: the kind of welfare state envisaged, and by whom, and the balance to be struck between state and private agents.

The second point is the development of social welfare measures in Quebec, particularly with relation to health care, in the period under scrutiny (for the most part, the Duplessis era). Of interest here is the position taken by Quebec historians on the nature of the Public Charities Act, the key element of legislation affecting hospital care.

The third point is the nature of voluntary hospitals, and the ideology inherent in them and promoted by their supporters in terms of the role of the hospital — particularly its relation to poor and paying patients — and its relation with the state and the market. Little work has been done on this in Canada, more in England and the U.S. This work will serve as a starting point for the analysis of the hospital sector in this text.

The Welfare State in Canada

Hospitalization insurance in present-day Canada is a significant part of our welfare state structure. In fact, 'medicare' is often referred to as a touchstone of Canadian identity. While medicare in fact is a discrete programme of payment of doctors, it symbolizes in the minds of most Canadians the totality of our universal health care system, including hospitalization insurance. Thus, to better understand the genesis of hospital insurance, it is useful to examine the process of formation of the

welfare state in the post-war period. The development of welfare state social policy implies extracting the provision of certain goods and services from the private sector — from charity in many cases, but in some cases from the market — and transforming them into state-provided services. This is precisely the process by which a programme like hospital insurance is instituted.

Before the implementation of state welfare provisions, a service and payment for that service were both located in the private sector. Hospitals, as charitable institutions, did not stand to make a profit, but did expect if possible to receive payment. The creation of a programme like hospitalization insurance removed the process from the private sector as the state took over responsibility for payment and, potentially, for running the service, or at least regulating it. The creation of welfare programmes in post-war Canada meant deciding how to redefine the relationship of public to private, of state and market in the area of social policy. This is the element that is most relevant to this text.

In order to understand the evolution of the hospital viewpoint it is useful to look at the development of both the federal and Quebec governments' approach to the welfare state. Why look at the federal level of government if health insurance is under provincial jurisdiction? The federal level cannot be neglected because in this period of policy formation the major impetus came from Ottawa, first in the form of the Heagerty plan in the early 1940s, followed by Paul Martin's Dominion/Provincial grants starting at the end of the same decade, and finally with hospitalization insurance

in 1957.² In addition, both the hospitals under examination here played active parts in the major national hospital association, the Canadian Hospital Council (later Association), an organization that was constantly lobbying the federal government to develop policy favourable to hospitals, and responding to government initiatives. It is therefore essential to look at some of the literature on the welfare state in Canada. It is of course equally necessary to consider the provincial level because the ultimate decisions regarding health care reside with the provincial government. Of prime interest is the debate in Canada and in Quebec on public/private apportionment of elements of programmes. What was being debated here was the apportionment of responsibility to the state on the one hand, and to the private sector on the other, whether this was voluntary or church-run hospitals, or non-profit Blue Cross insurance plans and private for-profit insurance companies.

With these questions in mind, a survey of literature on the development of the welfare state in Canada and Quebec brings up several useful elements. Some general works, as well as works exploring specific aspects of welfare state development,

² Provincially, Saskatchewan led the way in the institution of hospital insurance and played a significant role in pushing the federal government to take up the issue. However, it was the national programme which allowed other provinces to offer hospitalization insurance to their citizens. On Saskatchewan, see Malcolm G. Taylor, *Health Insurance and Canadian Public Policy* (Kingston: McGill-Queen's University Press, 1987), chapter 2; see also Duane Mombourquette, "An Inalienable Right: The CCF and Rapid Health Care Reform, 1944-1948," *Saskatchewan History*, vol. XLIII, no. 3 (Autumn 1991), pp. 101-116.

including health insurance, will be examined together, with a focus on their shared characteristics.

Malcolm G. Taylor's *Health Insurance and Canadian Public Policy*, Antonia Maioni's dissertation, "Explaining Differences in Welfare State Development: A Comparative Study of Health Insurance in Canada and the United States," Robert Bothwell's "The Health of the Common People," and Dennis Guest's *The Emergence of Social Security in Canada* can be grouped together because they give an overview of the political process of the development of welfare policy — the major programmes in the case of Guest, and health insurance in the case of Taylor, Maioni and Bothwell.³ As such, they are essential starting points for understanding the development of social welfare and health insurance in Canada, at least on the policy study level. Each does, however, contribute different elements of understanding.

The first three works are discussions of the development of our present comprehensive state-funded medical insurance system (in the case of Bothwell, the article is restricted to the wartime debate). They give insight into the political process involved, and in particular the forces arrayed in support and in opposition. Taylor's work is a detailed study of the policy process involved in the evolution of the Canadian health insurance system. Maioni, in her comparative study of the

³ Taylor, *ibid.*; Antonia Maioni, "Explaining Differences in Welfare State Development: A Comparative Study of Health Insurance in Canada and the United States" (Ph.D. diss., Northwestern University, 1992); Robert S. Bothwell, "The Health of the Common People," in John English and J. O. Stubbs, eds., *Mackenzie King: Widening the Debate* (Toronto: Macmillan of Canada, 1978), pp. 191-220; Dennis Guest, *The Emergence of Social Security in Canada* (Vancouver: University of British Columbia Press, 1980).

development of the Canadian and American health care systems, focuses on certain structural differences — the parliamentary system with its party discipline for example — and the role of forces like the CCF-NDP in moving the system forward. Bothwell's article is an examination of the internal workings of the bureaucracy and the formal political process, with some insights into the individuals involved. These three works thus focus on political process. Though they do, to varying degrees, give indications of social forces, that is the various "interest groups" — unions, doctors, hospital associations, insurance companies — which took positions on welfare or health insurance proposals, these works do not really look beyond the formal political process to explain the specific development or jettisoning of programmes. None examine the ideological underpinnings of the decisions taken.

Guest, in his analysis of the evolution of the welfare system from Confederation, situates the development of social programmes in an economic and political context. By applying the categories of "residual" and "institutional" to the measures developed in the Canadian context, he gives us useful tools for understanding the nature of these measures. The residual concept, relief in this case, is explained as follows:

Any help given was of a gratuitous nature, there being no thought of a right to assistance. This minimal, temporary type of service, offered at the discretion of the social welfare agency, meeting need only after evidence had been presented that all other avenues of help had been explored, was typical of what has been termed a residual concept of social security.

In contrast, the institutional concept of welfare identifies social security organizations as "a first line of defence," and recognizes that in an urban-industrial society,

the risks to an individual's social security are part of the social costs of operating a society which has provided higher standards of living for more people than ever before in our history. ...Society should not allow the costs of its progress to fall upon individuals and families, but should protect and compensate people who experience more than their fair share of the costs.⁴

Implicit in this is the understanding that the individual has a right to these programmes — unemployment insurance, for example — provided that he/she has fulfilled the requirements. Unlike residual programmes, there is no stigma attached to use of these programmes.

These concepts are very useful in terms of analyzing the proposals made over time for hospitalization insurance. Even more useful is the ideological framework that Guest identifies as the source of residual concepts:

A residual role for social security programmes harmonizes with the *laissez-faire* theory of government — the “least government is the best government.” It is supported by those values of an individualist, free-enterprise philosophy which stress self-reliance, the duty incumbent upon families to care for their own, and the threat to freedom inherent in the extension of government activities, particularly where these directly affect the lives of individuals and families. The whole system of beliefs encapsulated in the term “Protestant ethic” are also aligned with this limited conception of social security.

The private market, it is claimed, operates with a rough kind of justice by rewarding work, foresight, and thrift. Normally, the individual and his or her family may claim their fair share of needed goods and services through the market system if they exercise these desirable traits. More importantly, if people are lax, improvident, and foolish, they are punished by their inability to obtain the goods and services they need. Where such behaviour leads to a request for help from some public welfare agency, the residual concept of social security continues the punishment by providing assistance in a manner which stigmatizes and degrades the recipient. Thus both the market system and the residual

⁴ Guest, *op. cit.*, pp. 1-2.

social security system combine to act as powerful motivating forces to teach the habits of industry and thrift which, it is suggested, enhance the prosperity of the individual, the family, and the community.⁵

Of the four authors, Dennis Guest is most cognizant of these ideological notions that underlay the resistance to the development of the modern welfare state, which was a movement away from the market towards the state. In a later article, he singles out the forces resistant to more comprehensive welfare policy as being in fact concerned about effects these policies would have on the market.

Despite the powerful political appeal of comprehensive social security, the plan for post-war reconstruction was dictated by a group of conservative-minded individuals in Ottawa, comprising a majority of the federal cabinet supported by an elite group of civil servants. They attacked the Marsh Report's proposals as beyond the powers of the British North America Act because of the commanding role assigned to the federal government but they were probably most offended by the emphasis on social responsibility and the Report's implied criticism of the individualistic, free-enterprise system.⁶

While Guest referred to these individuals as "conservative-minded," the stance he describes is that of *laissez-faire* liberalism.

Finally, one work on the medical profession is also useful when examining the relationship of health care to the market and the state. The medical profession has been very active in Canada in its attempts to safeguard its position as an autonomous, entrepreneurial profession. While the situation of doctors is not strictly analogous to

⁵ *Ibid.*, pp. 2-3.

⁶ Dennis Guest, "World War II and the Welfare State in Canada," in Allan Moscovitch and Jim Albert, eds., *The Benevolent State: The Growth of Welfare in Canada* (Toronto: Garamond Press, 1987), p. 217. The Marsh Report, produced during the war, proposed a comprehensive welfare system similar to that being proposed by Lord Beveridge in England.

that of hospitals, there is a strong element of shared ideology, and in fact, shared tactics. In this sense, David Naylor's analysis of the Canadian medical profession's contradictory attitude towards the state is useful as a parallel to understanding the hospital viewpoint and strategy towards state intervention. As Naylor points out, the medical profession, through its organization the Canadian Medical Association, consistently attempted to have the state take responsibility for indigent patients, especially during difficult economic times like the 1930s. Yet, its main thrust in its relations with the state, especially in good times, was to attempt to protect the medical marketplace from state incursion. The main tactic used was the development and promotion of non-profit medical insurance plans for the public as an alternative to state programmes.⁷ This was copied by hospital associations — in the form of non-profit Blue Cross hospital insurance programmes in the U.S. and Canada. Naylor's clear elaboration of the medical strategy opens up interesting paths for the analysis of hospital strategy.

Most welfare state historiography, including the works cited above, considers the Second World War as the crucible of the Canadian welfare state. In his article "Paradise Postponed," Alvin Finkel criticizes the tendency in the welfare state historiography of the war period to focus too much on the conflict between the federal and provincial governments as the source of failure for the proposed

⁷ C. David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance 1911-1966* (Kingston: McGill-Queen's University Press, 1986). See, in particular, chapter 4 on the medical profession during the depression, and chapter 6 on the development of private alternatives.

programmes.⁸ Finkel examines the debates inside government, situating the failure of the 1945 Green Book proposals (for a post-war welfare state) in the political and economic changes of the early post-war period, rather than on federal-provincial conflict. For Finkel, the essential element is the fact that the post-war period appeared to be one of strong economic growth rather than depression, and with this growth assured, the economic elites felt they did not need the support of Keynesian mechanisms to ensure social peace. The market would be adequate in most areas.

Finkel's point is that the concern inside government — particularly in Finance, the Bank of Canada and the Cabinet — was not whether there was a need for extended social welfare measures, but whether or not the market was sufficiently strong to support post-war recovery. Some elements inside government suggested an interventionist Keynesian approach. They held the belief that

the goals of full employment and an end to poverty took precedence over the right to earn profits, and required that the state had sufficient economic power to regulate the overall operations of the private-enterprise economy and the ability to provide a comprehensive program of social welfare.⁹

These were men like the civil servants described in Doug Owram's *The Government Generation*, transplanted political economists who believed in an enhanced role for government in Canadian life.¹⁰ The other main approach to Keynesianism was,

⁸ Alvin Finkel, "Paradise Postponed: A Re-examination of the Green Book Proposals of 1945," *Journal of the Canadian Historical Association*, New Series, vol. 4 (1993), pp. 121-122.

⁹ *Ibid.*, p. 132.

¹⁰ Doug Owram, *The Government Generation: Canadian intellectuals and the state 1900-1945* (Toronto: University of Toronto Press, 1986), especially chapters 10 and 11.

according to Finkel, a more truncated conservative vision, basically of using government to help kick-start the economy in tough times, but leaving most activities to the market.¹¹ The more conservative elements won out, given the post-war economic recovery, and the broad welfare state envisaged by some did not materialize. And to divert attention from the government's responsibility for this shortfall (because the people wanted more social security), the government focused on the split between the central government and the provinces.¹² Ultimately, in Finkel's analysis, it is the market, and *laissez-faire* liberal market ideology, that is triumphant.

The market is not the only element in the private delivery of welfare services. The private non-profit sector has historically been an important source of such services — as in the hospital sector — and endured as an important element in welfare provision. Lynne Marks, in an essay on public and private poor relief in nineteenth century small town Ontario, has criticized the tendency on the part of Canadian welfare state literature to trace

a relatively direct line from a backward nineteenth century period in which welfare provision was predominantly the responsibility of private charitable institutions, largely run by middle-class women and the churches, towards the gradual development of state responsibility for welfare. Private charity was thus gradually and for many scholars, triumphantly, replaced by public provision.¹³

¹¹ Finkel, *op. cit.*, pp. 132-133.

¹² *Ibid.*, p. 142.

¹³ Lynne Marks, "Indigent Committees and Ladies Benevolent Societies: Intersections of Public and Private Poor Relief in Late Nineteenth Century Small Town Ontario," *Studies in Political Economy*, 47 (Summer 1995), p. 62.

One of the authors she criticizes is Dennis Guest, whom she represents as whiggish in this sense. In fact, Guest, in discussing the residual concept of welfare (residual services often being delivered by private agencies), somewhat optimistically states: "This concept played a major role in shaping policy and programmes in Canada up to the 1940s."¹⁴ In Marks' view, this residual model persisted long after the 1940s. Marks' article is one of a series which attempts to deepen our understanding of the development of public welfare provision in Canada, and of the complexity of its structure. Another, by Mariana Valverde, also examines the public/private mix in welfare delivery. This article is particularly pertinent because Valverde focuses on Ontario's 1874 Charities Aid Act, which introduced the mechanism for funding hospitals later to be used in Quebec: the *per diem*, a daily rate to be paid to the institution for each day each patient was hospitalized. With this measure private institutions, in exchange for some level of constant funding, entered under the supervision of the state. As Valverde notes, "even a small amount of money would buy the government a great deal of control."¹⁵ While the element of control most interests Valverde, what is of interest for us is the means by which a welfare function is performed in the private sector and can remain there, with the help of the state, thus maintaining partially at least the liberal separation of social welfare provision and the state. This is precisely the model that evolved for most of the hospital sector in Canada

¹⁴ Guest, *The Emergence*, p. 2.

¹⁵ Mariana Valverde, "The Mixed Social Economy as a Canadian Tradition," *Studies in Political Economy*, 47 (Summer 1995), p. 45.

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...care ... assistance was present but minimal, leaving

...Little. The ... of ... and ...

... Studies in ... 1985, pp. 19-20.

... Province of ... 1984, p. 11.

before the advent of hospitalization insurance. Margaret Little's discussion of the Ontario Mother's Allowance programme, administered by a joint public-private structure until the 1960s, involving private groups like the Children's Aid Society in the administration of the programme, again shows the endurance of the public/private mix in welfare provisions beyond the 1940s.¹⁶ This arrangement exemplifies the kind of structure frequently found in health care, where hospitals remained private (though non-profit) but were at least in part publicly supported, a structure reinforced by the Quebec government's sole funding programme for the province's hospitals, the Quebec Public Charities Act (PCA).

The Welfare State in Quebec

The 1921 PCA, the central and enduring government mechanism for supporting and regulating hospitals and other charitable institutions from 1921 until the 1960s, provided for government financial assistance to private agencies caring for the indigent (hospitals, hospices, orphanages, sanatoriums, etc.).¹⁷ Any discussion of hospital policy in Quebec in this period must begin with an understanding of the significance of this piece of legislation. Since institutions were required to pay part of the cost for indigent care, and since government surveillance was present but minimal, relying principally on

¹⁶ Margaret Little, "The Blurring of Boundaries: Private and Public Welfare for Single Mothers in Ontario," *Studies in Political Economy*, 47 (Summer 1995), pp. 89-106.

¹⁷ *Statutes of the Province of Quebec*, 11 George V, 19 March 1921.

the institution's internal regulation, this law fits the public/private model discussed by Marks, Little, and Valverde.

Because of ongoing debates in Quebec historiography, the approach taken towards this law by historians is often influenced by their vision of Quebec society before the Quiet Revolution. As historians have noted in recent years, the period before the 1960s, the Duplessis years in particular, has been analyzed through the prism of the Quiet Revolution, and often by the architects of the Quiet Revolution themselves. The implication drawn is that all that passed before the 1960s was backwards, and that 1960 was the threshold of the modern Quebec. Bernard Vigod points this out in his article on the Boucher Report on pre-Quiet Revolution welfare measures, for example.¹⁸ Quiet Revolution protagonists of course were not the only ones to paint a totally negative picture of this period. Sociologist Yves Vaillancourt, for example, uses the term "immobility" (*immobilisme*) to describe this period particularly with reference to social welfare measures.¹⁹ Similarly, Marc Renaud describes the pre-Quiet Revolution health sector as apparently "a most unchanging world with a static

¹⁸ Bernard L. Vigod, "History According to the Boucher Report: Some Reflections on the State and Social Welfare in Quebec Before the Quiet Revolution," in Allan Moscovitch, Jim Albert, eds., *The "Benevolent" State: The Growth of Welfare In Canada* (Toronto: Garamond Press, 1987), pp. 175-185. For comments on limitations of welfare measures, see pp. 178-182. The 1963 Boucher Report was a government-commissioned report on social assistance in Quebec.

¹⁹ Yves Vaillancourt, *L'Évolution des politiques sociales au Québec 1940-1960* (Montreal: Les Presses de l'Université de Montréal, 1988), chapter 4. For a discussion of the nature of society and the debate, see Ronald Rudin, "Revisionism and the Search for a Normal Society: A Critique of Recent Quebec Historiography," *Canadian Historical Review*, vol. LXXIII, no. 1 (1992), pp. 3061. See also the response to Rudin in "Y a-t'il une nouvelle histoire du Québec?", *Bulletin d'Histoire Politique*, vol. 4, no. 2 (Winter 1995) and, for a discussion of modernism versus traditionalism in Quebec society, see Gilles Bourque, Jules Duchastel, Jacques Beauchemin, *La société libérale duplessiste 1944-1960*, (Montreal: Les Presses de l'Université de Montréal, 1994), in particular, pp. 11-54.

pattern of social relations and few and limited state interventions. The main health and other social institutions were rooted into the concept of charity and, ideologically at least, they were still very much anchored to the rural parish."²⁰

The broad debate about the nature of Quebec society before the Quiet Revolution is beyond the scope of this study. What is of interest here are rather specific elements of the broader debate: the nature of the PCA, how it fit into the development of the welfare state in Quebec, and how it affected the development of the hospital sector; and, secondarily, the outlook of the French-Canadian business class with regards to state intervention and social welfare.

The PCA is important in the debate over the historical development of Quebec society because it was the most important social welfare measure before the Quiet Revolution. If it can be categorized as a backward measure, by which the state formalized private and particularly religious control over social welfare, then it helps confirm the general "traditional" – that is backward – nature of Quebec society. If it can be categorized as a cornerstone of the modern welfare state, then it is one indication among others of the modernizing nature of Quebec society before the 1960s.

Marc Renaud, Yves Vaillancourt, and finally Jean-Yves Rivard, *et al.* in their historical overview of Quebec health care for the Quebec Commission of Enquiry on

²⁰ Marc Renaud, "The Political Economy of the Quebec State Interventions in Health: Reform or Revolution?" (Ph.D. diss., University of Wisconsin, 1976), p. 36.

Health and Social Welfare, the Castonguay-Nepveu Commission, (its *Report* being the definitive Quiet Revolution document), all evaluate the PCA as a traditional regime of state support to private charity. Vaillancourt also insists that it was supported by the traditional Quebec petite bourgeoisie and the Church, despite its apparent weaknesses, precisely because it maintained the traditional structures.²¹

Historical "revisionists," though not uncritical of the PCA, tend to see the it nonetheless as the keystone of the Quebec welfare state. In their work, Paul-André Linteau *et al.*, definitely within the "normal" revisionist historiography, refer to it as the "first major piece of legislation in the welfare field," noting, "Whatever the limitations of the act, the provincial and municipal governments were able to use the amusement tax, a meal tax and a portion of the revenue from liquor sales to pay out millions of dollars to charitable institutions. Only the poorest were helped, however, and even they were able to benefit only if they were hospitalized."²² John Dickinson and Brian Young see the PCA as evidence of state participation in the social sector, noting that, though it did not challenge clerical control, the PCA "recognized charitable institutions of public utility such as hospitals and asylums and established a statutory system of subsidies."²³ Of note as well, especially because of its focus on the hospital sector, is

²¹ Renaud, *op. cit.*, pp. 45-56; Vaillancourt, *op. cit.*, pp. 242-244; Jean-Yves Rivard, *et al.*, "L'Évolution des Services de Santé et des modes de distribution des soins au Québec," Annexe II, *Rapport de la Commission d'Enquête sur la santé et de la bien-être social* (Castonguay-Nepveu Commission), (Quebec, 1970), pp. 20-21.

²² Paul-André Linteau, René Durocher, Jean-Claude Robert and François Ricard, *Quebec Since 1930* (Toronto: James Lorimer & Co, 1991), pp. 436-438.

²³ John A. Dickinson and Brian Young, *A Short History of Quebec*, Second Edition (Toronto: Copp Clark Pitman Ltd, 1995), p. 252

the work done by François Guérard on changes in health care intervention in the St. Maurice region from 1889 to 1939. Guérard insists that, contrary to claims by authors like Renaud or Vaillancourt of stasis in the system because the Catholic Church resisted intervention in its affairs, state intervention was in fact growing. Examples he uses date from the depression years of the 1930s, when the government was attempting to control costs. He cites the government appointment of an inspector to ensure adherence to the PCA, and an attempt to use special grants and construction grants as another means to ensure adherence.²⁴ These are hardly indications of strong state control, but nonetheless suggest that the hospital sector was not left completely to its own devices. None of the above discussions, however, give us adequate guidelines for developing an analysis of the PCA.

How should we analyze the PCA? Using insights from Guest, we can say that the PCA is a limited, residual social measure which fits very easily into a *laissez-faire* liberal view of the role of the state. The state gives some measure of aid to institutions taking care of society's weakest, but without upsetting any equilibrium achieved in the marketplace, mainly because these needy individuals are on the margins of the marketplace in any case. Nonetheless, the PCA can also be seen, because of the growing participation of the state, as part of the development of the welfare state. In other words, it is a transitional measure.

²⁴ François Guérard, "Les principaux intervenants dans l'évolution du système hospitalier en Mauricie, 1889-1939," *Revue d'histoire de l'Amérique française*, vol. 48, no. 3 (Winter 1995), pp. 388-392.

Jean-Marie Fecteau gives us some elements of this kind of approach in his discussion of Montreal's 1915 municipal public assistance law which allowed for taxation of public amusement to support private charity initiatives such as refuges and in some cases hospitals.²⁵ As Fecteau points out, this measure — which emerged out of a funding crisis for some public institutions in Montreal — was still charity, but it was an early example of state intervention in social welfare. What is still absent, according to Fecteau, is the concept of the right to such aid, and of public solidarity, that would imply (in Guest's terms) an institutional rather than a residual measure. Still, Fecteau sees this law as a first step toward the state taking on responsibility for intervening in such social welfare measures. This is probably the most nuanced analysis. Fecteau clearly sees this measure as a first step, but also makes clear that "charité devenu publique" is still charity.

Mais on est encore très loin de l'État-providence, qu'il s'agisse de l'intensité de l'intervention ou de l'esprit qui anime les mesures que l'on vient de décrire. Car la distance est énorme entre l'État-providence à venir et cette balbutiante philanthropie d'État. Nous sommes encore sous l'empire de la charité, devenue publique faute de mieux.

... la pauvreté n'apparaît pas encore, dans cette dynamique d'intervention, comme une carence fondamentale du citoyen dont l'État devrait ultimement être responsable. Elle n'entraîne pas cette solidarité nécessaire entre égaux qui débouche sur la reconnaissance d'un *droit* du démuné à être autre, à revendiquer un minimum social dont les pouvoirs publics seraient les garants. En somme, la question n'est pas d'assurer l'intégrité sociale du titulaire de droit, mais seulement de garantir la bonne distribution des services destinés au peuple des pauvres... C'est dire qu'une telle approche ne peut, d'elle-même, déboucher sur une

²⁵ Jean-Marie Fecteau, "Un cas de force majeure: le développement des mesures d'assistance publique à Montréal au tournant du siècle," *Lien social et politiques* — RIAC, 33 (Spring 1995), p. 110.

étatisation de la problématique du dénuement. Pour cela, il faudra que, dans un premier temps, l'État lui-même se reconnaisse le devoir d'intervenir. Ce premier pas sera la loi sur l'assistance publique de 1921.²⁶

In Fecteau's view, then, the PCA is important because it marks the first time the provincial state took responsibility for the care of the indigent. This, it would seem, was an important distinction from poor law-type measures which give responsibility to the local government. However, it is also important to note that, like the Ontario Mothers' Allowance discussed by Little, elements remained that were strongly reminiscent of poor law approaches: the benefit was granted after means testing; though funded by the state, the private sector was involved in its delivery; while there was some level of regulation, it was often self-regulation, and not imposed by state agencies. At the same time, while eligibility for the services was means tested, and some stigma remained, it was not as strong as that associated with poor law measures and poor law hospitals in the U.S. and England. On the basis of the arguments presented in articles by Marks, Valverde and Little, and Fecteau, therefore, we can situate the PCA as a transitional measure, carrying in its structure and application elements of both old-style private charity and the welfare state .

A final question to note is the presence — or absence — of criticisms inside Quebec of welfare provisions during the years prior to 1960. Again, recent work has shown that critiques certainly were made of the weakness of state intervention, or of the lack of improvement of measures already in place. Bernard Vigod notes in his

²⁶ *Ibid.*, p. 111 (Emphasis is in the original).

article on welfare before the 1960s that in fact criticisms of the inadequacy of the PCA and other measures, coming from labour, the Church, the 1930s Montpetit Commission on social welfare, for example, started in the 1920s, and were present from then on.²⁷ Peter Southam points out that criticisms of welfare measures came from both inside and outside the Church, starting in the 1930s after the Papal encyclical *Quadragesimo Anno*. The Church, on the basis of this document, began to demand that the state oversee a fairer distribution of society's wealth. In fact, according to Southam, elements in the Church were more critical of the limited measures than the laity which was more concerned with economic development.²⁸ Lastly, François Guérard notes that in the 1940s and 1950s unions and intellectuals were also growing more vocal in their critiques of the limitations of the health care system.²⁹

Southam's contention that lay elites were not particularly interested in expanded state intervention in social welfare should come as no surprise. (Southam singles out as examples Esdras Minville and François-Albert Angers, two political/economic writers.) As Fernande Roy has shown in her study of part of the francophone economic elite, Montreal French-speaking businessmen at the turn of the century were, despite the traditional stereotype, involved in developing and adhering to economic and political approaches that mirrored the concerns of their English-speaking contemporaries. This

²⁷ Vigod, *op. cit.*, pp. 179-182.

²⁸ Peter Southam, "Réactions québécoises à l'État-providence en émergence: perspectives historiques," *Service Social*, vol. 38, nos. 2-3 (1989), pp. 171-175.

²⁹ François Guérard, *Histoire de la santé au Québec* (Montreal: Boréal, 1996), pp. 71-72.

brings us back to the liberalism that underpinned the establishment of the voluntary hospital tradition. As Roy shows, the francophone business elite expressed belief in the primacy of the individual and his property over the state, and thus the limited role for the state in society.

C'est... sur la base du respect de la propriété privée et de la libre concurrence que doit d'établir l'organisation socio-économique et s'effectuer le partage des rôles et des responsabilités. Pour atteindre au maximum de productivité et de croissance, chaque individu doit pouvoir poursuivre ses activités dans un marché libre, sans entraves collectives ou étatiques. Dans ce domaine privé, les individus sont seulement libres mais égaux — du moins formellement — et par conséquent responsables de leur propre épanouissement et de celui de leur propriété. Accompagnant ici une conception atomiste de la société, on retrouve le présupposé de l'harmonie des intérêts: poursuivant librement leurs intérêts personnels, les agents privés réalisent collectivement la richesse de la nation. De cette primauté accordée à l'individu, il découle que le rôle d'un intervenant collectif, l'État par exemple, sera de préserver l'individu et sa liberté — et donc sa propriété — parce que c'est ainsi qu'on préserve le bien public. L'État joue un rôle important: il assure la sécurité des personnes et des biens, pourvoit à l'administration générale et favorise l'essor économique du pays; toutefois, s'il intervient dans le domaine privé — et les hommes d'affaires sollicitent souvent cette intervention — ce sera dans le respect des responsabilités des intervenants privés. Les gens d'affaires préconisent ainsi une distribution libérale des rôles qui implique une distinction et un partage, mais aussi une hiérarchisation: le premier rôle, fondamental, revient au privé, c'est-à-dire aux individus, et le rôle public, celui de l'État, y est subordonné.³⁰

Logically, very little role was seen for the state in terms of resolving the problems of poverty, other than controlling the poor, and thus protecting private property.³¹ This

³⁰ Fernande Roy, *Progrès, Harmonie, Liberté: Le libéralisme des milieux d'affaires francophones de Montréal au tournant du siècle* (Montreal: Boréal, 1988), p. 190.

³¹ *Ibid.*, pp. 144-46.

is very much the economic liberalism of the anglophone elite. The apparent unity of views of the anglophone and francophone elite at least on the role of the state and the individual in society would corroborate Ralph Miliband's contention that there is essentially more that unites members of dominant classes than divides them.

Specific differences among dominant classes, however genuine they may be in a variety of ways, are safely contained within a particular ideological spectrum, and do not preclude a basic political consensus in regard to the crucial issues of economic and political life. ...In fact, dominant classes have so far fulfilled a great deal better than the proletariat Marx's condition for the existence of a 'Class for itself', namely that it should be conscious of its interests as a class: the rich have always been far more 'class conscious' than the poor. This does not mean that they have always known how best to safeguard their interests — classes, like individuals, make mistakes — though their record from this point of view, at least in advanced capitalist countries, is not, demonstrably, particularly bad. But this too does not affect the point that beyond all their differences and disagreements, men of wealth and property have always been fundamentally united, not at all surprisingly, in the defence of the social order which afforded them their privileges.³²

This should hold true for dominant groups divided by nation or language, such as the English and the French businessmen of Montreal, since they were both functioning in the same economic environment. Roy's francophone businessmen were men who, like their English counterparts, could possibly be involved in charitable enterprises like voluntary hospitals, and who carried with them into the domain of hospital administration the values of *laissez-faire* liberalism.

³² Ralph Miliband, *The State in Capitalist Society* (London: Weidenfeld and Nicolson, 1966), pp. 46-47.

The Voluntary Hospital

The voluntary hospital is a product of modern society, particularly of the rapidly shifting landscape of industrializing society. It is a charitable work set up and run by members of the ruling elite to see to the needs of the sick poor. Voluntarism is the cornerstone of the hospital system in Canada, and the two hospitals studied in this dissertation are part of that tradition. The concept of voluntarism, that is of the individual choosing to participate in charitable activity, or any activity for that matter, was an essential part of *laissez-faire* liberalism, the ideology that was dominant in the period under study. As Doug Owram notes, it was a reaction to the strong state interventionist tradition of the mercantile era.³³ Voluntarism was viewed as a means of safeguarding individual liberty from state coercion, allowing people the choice to participate in these kinds of charitable activities, as it allowed people the choice to seek aid from these institutions. It also was seen as showing that the dominance of the market did not inhibit society from providing for the less fortunate, and therefore that state action was not necessary. This theme runs through much of the historical work on the voluntary hospital tradition in England and the United States, and while not particularly present in historical work done in Canada, it is, however, a theme that

³³ See Owram, *op.cit.*, pp. 28-29. On the state's role in medicine and health care under mercantilism, see George Rosen, *From Medical Police to Social Medicine* (New York: Science History Publications, 1974). Othmar Keel suggests that preoccupations with population health that led to government intervention did not disappear with the waning of mercantilism. See "The politics of health and the institutionalisation of clinical practices in Europe in the second half of the eighteenth century," in W. F. Bynum and Roy Porter, eds., *William Hunter and the Eighteenth-Century Medical World* (Cambridge: Cambridge University Press, 1985), pp. 214-218.

permeates the debates — past and present — in the hospital sector about the hospital in twentieth-century Canada and should be examined.

The hospital system in Canada has always been predominantly a non-profit and, until the second half of the twentieth century, a private charitable system. But throughout Canadian history, there has been some state involvement in hospital care. The earliest hospitals were, of course, those set up by the Catholic Church in New France, the Hôtel-Dieu de Québec, founded in 1639 being the first. Under the French Regime health was considered a private, family matter, or at most a community responsibility. Nonetheless, the state did take an interest in the health of its citizens, an outgrowth of the mercantile outlook that considered a healthy population as part of the nation's wealth. As a result, hospitals in New France were partially financed by the state.³⁴

The Church played a significant role in founding and maintaining hospitals well into the twentieth century, both in Quebec and across the country. But by the nineteenth century the liberal voluntary form of hospital development was also present. Secular groups, usually composed of prominent members of the community, formed committees to raise subscriptions for the founding of non-profit voluntary hospitals. Thus, in the wake of increased immigration at the end of the Napoleonic Wars, prominent citizens of Montreal founded the Montreal General Hospital in 1819, and a

³⁴ Denis Goulet, François Hudon, Othmar Keel, *Histoire de l'Hôpital Notre-Dame de Montréal 1880-1980* (Montreal: VLB Éditeur, 1993), footnote 21, p. 26. See also, Jean-Yves Rivard, *et al.*, *op. cit.*, p. 19.

similar group in York the York General Hospital (later the Toronto General Hospital) in the 1820s.³⁵

These early hospitals, charity institutions, were a response to concern about growing social disorganization, emphasizing both moral and physical care of their wards.³⁶ Hospitals were strictly for the poor; the well-to-do would be treated by their physicians in the comfort and cleanliness of their own home.³⁷ Care and treatment in hospitals was rudimentary, in keeping with a limited range of therapeutics; cleanliness, before the era of Semmelweiss and Lister, was questionable.³⁸

In the last decades of the nineteenth century two trends led to a growing interest in the opening of hospitals. On the one hand came the accelerating growth of urban centres. Increased industrial activity brought growing danger of work accidents,

³⁵ H. E. MacDermot, *A History of the Montreal General Hospital* (Montreal: The Montreal General Hospital, 1950), pp. 1-4; W. G. Cosbie, *The Toronto General Hospital: 1819-1965: A Chronicle* (Toronto: Macmillan of Canada, 1975), chapter 1.

³⁶ See, for example, Charles E. Rosenberg, *The Care of Strangers: The Rise of the American Hospital System* (New York: Basic Books, 1987), p. 4; Rhona Richman Kenneally, "The Montreal Maternity, 1843-1926: Evolution of a Hospital" (M.A., McGill University, 1983), chapter 1.

³⁷ Rosenberg, *op. cit.*; David Gagan, *A Necessity Among Us: The Owen Sound General and Marine Hospital* (Toronto: University of Toronto Press, 1990), p. 11; S. E. D. Shortt, "The Canadian Hospital in the Nineteenth Century: An Historiographic Lament," *Journal of Canadian Studies*, vol. 18, no. 4 (Winter 1983-84), p. 8; Mark W. Cortiula, "Social Class and Health Care in a Community Institution: The Case of Hamilton City Hospital," *Canadian Bulletin of Medical History*, vol. 6 (1989), p. 137.

³⁸ Ignaz Philip Semmelweiss, an obstetrician working at the University of Vienna in the 1840s, concluded from observation that puerperal fever (following childbirth), which is identical to wound infection, was produced primarily by contact with the contaminated hands of doctors and medical students coming directly from the autopsy room to the delivery room. His conclusions, though demonstrated, were not accepted. See Erwin H. Ackerknecht, *A Short History of Medicine*, Revised Edition (Baltimore: The Johns Hopkins University Press, 1982), p. 186. Twenty years later, in Great Britain, Joseph Lister, working on the basis of Pasteur's germ theory, developed antiseptics, a method of preventing wound infection by using carbolic acid. Lister's theory too took several years to gain acceptance. See George Rosen, *A History of Public Health* (New York: MD Publications, Inc., 1958), pp. 315-318.

and the burgeoning numbers of urban dwellers concentrated in small areas, with poor sanitary conditions, invited disease. Both indicated a need for more hospitals for the ill (as well as for improvements in public health).³⁹ At the same time, scientific advances occurred in medicine: anaesthesia for surgery in the 1840s, Pasteur's germ theory, Lister's antiseptics, and Koch's bacteriology in the 1860s and 1870s, new technology such as the x-ray, and the ongoing professionalization of both the medical corps and the nursing corps throughout the later part of the nineteenth century. As a result the treatment of illness became more scientific and more promising. Cities and towns began to consider the building of a hospital in their community as a positive, even necessary modern development.⁴⁰ With these changes, as well, the clientele of hospitals changed, as middle class patients began to fill hospital beds. As a result, there was considerable growth in hospital construction after the 1870s.

Of course these institutions evolved over time, as did the values they promoted. Yet the majority of hospitals in Canada were still autonomous voluntary institutions until the second half of the twentieth century. This role was strongly defended by hospital boards and organizations as government, both federal and provincial, attempted to assert more control over these institutions. Thus, it is important to look

³⁹ Rosenberg, *op. cit.*, pp. 100-109; Gagan, *op. cit.*, in the first chapter, underlines the perceived need for a hospital in Owen Sound as industry developed in the town, bringing in a significant number of workers and their families as well as transients.

⁴⁰ Ackerknecht, *op. cit.*, chapters 16, 18; Rosenberg, *op. cit.*, pp. 148-153.

at the liberal ideology surrounding these institutions, to trace the continuity and evolution of ideas on the role of the voluntary hospital in society.

The two hospitals examined in this text, the Montreal General Hospital and St-Luc Hospital, fit into this voluntary tradition, the first being established in the early nineteenth century to serve the poor, the second beginning as a clinic for poor children in Montreal's impoverished south-east in the early twentieth century. This kind of charitable institution actually originated in Georgian England in part as a response to increasing illness in an industrializing and urbanizing society. Voluntary hospitals grew up in tandem with the poor house hospitals, supposedly serving a different clientele, the "deserving" or "worthy" poor, while the "demoralized" ("unworthy") or most destitute, but also the aged, were relegated to the stigmatizing (and publicly-funded) poor houses.⁴¹ Financing for voluntary hospitals came from donations from the wealthier sectors of society; in return these patrons would have the right to nominate patients for treatment in the hospital and would possibly also have the right

⁴¹ It is essential to understand this stance underpinning the attitude towards the poor: they were in general considered responsible for their fate, and could easily be divided into those with character flaws that resulted in their poverty – the undeserving – and those who were victims – widows and orphans, for example – the deserving poor. In fact, the distinction was not always clear. Both voluntary hospitals and poor houses (and later, poor house infirmaries) were supposedly for the deserving poor. Poor houses were a last resort, based on the less eligibility principle, the aim being to make the poor house so painful and degrading an experience that all possible alternatives would be tried before entry. Thus the able-bodied were expected to steer clear of these institutions while widows, orphans and the infirm could find refuge in them. But the stigma attached to poor houses and the fear, on the part of the elites, of the danger of pauperizing, that is demoralizing, the poor in the poor houses, made them a place to be avoided at all costs. Voluntary hospitals became a welcome alternative to the poor house in both England and the United States. The differentiation also grew over time, as the institutions developed. Underlying all this is the fact that hospitals of any sort were used only by the poor and the working class, not by the middle or upper classes, until late in the nineteenth century. See Stephen Cherry, *Medical services and the hospitals in Britain, 1860-1939* (Cambridge: Cambridge University Press, 1996), pp. 8-9.

to partake in management of the institutions. In the early nineteenth century, this form of organization spread to both the U.S. and British North America, where it evolved to conform to local conditions and attitudes, but carried many of the core values with it.

Once viewed as sterling examples of charitable good works by their patrons, in recent times these institutions have come under more critical scrutiny, particularly in terms of their role in society. It is worth examining interpretations of the English and American voluntary tradition even though most discuss institutions in the eighteenth and nineteenth centuries, because of the continuity in the outlook of the management of these hospitals. This outlook, though transformed by the twentieth century, still has a resonance in the place and period studied here.

• **The Voluntary Hospital in Great Britain**

Traditionally, literature on the hospital sector was restricted to hospital “biographies,” uncritical tributes to the great men – administrators and doctors – and occasionally great women – nursing superintendents or fund-raisers in Ladies’ Benevolent Societies – who made the good work possible.⁴² In recent years, this has changed significantly, with a more critical and nuanced literature emerging on the subject, particularly in England and the U.S. This newer work reflects an attempt to

⁴² Examples of this kind of work in Canada include H.E. MacDermot, *A History of the Montreal General Hospital* (Montreal: The Montreal General Hospital, 1950); D. Sclater Lewis, *Royal Victoria Hospital 1887-1947* (Montreal: McGill University Press, 1967). For an more recent example, see Neville Terry, *The Royal Vic: the Story of Montreal's Royal Victoria Hospital: 1894-1994* (Montreal: Published for the Royal Victoria Hospital by McGill-Queen's University Press, 1994).

deal with a complex of issues related to the social role of these institutions and the ideology underpinning them.

The starting point is Brian Abel-Smith's 1964 work, *The Hospitals, 1800-1948*, the first national synthesis of the history of the institution as a whole.⁴³ His analysis of the development of the hospital system in England is also the first real attempt to bring various strands together, examining the evolution of the two systems, the poor law institutions and the voluntary hospitals, within the broader context of political, economic and social change in England. He is particularly good at showing the role of the medical profession (specialists and general practitioners) in the internal evolution of the hospital system (including the problems of financing), and at drawing the links between political and economic change (the 1834 Poor Law reforms, for example) and the hospital system's development. With his emphasis on the effects of legislative change on hospitals, the state becomes an actor in the process.

However, there is a lack of critical assessment, particularly with regard to the motives for the creation of the voluntary hospital, as exemplified by the following:

The progress of the voluntary hospital movement depended on the willingness of the rich to help the poor, and the money was provided for religious and wider humanitarian reasons. And the scale on which this money was given to hospitals over a period of two centuries indicated a tremendous sense of social duty and responsibility. Gifts were not, however, always disinterested. In some hospitals it was laid down that when purchases were made for the hospitals, preference should be given

⁴³ Brian Abel-Smith, *The Hospitals, 1800-1948: A Study in Social Administration in England and Wales* (London: Heinemann, 1964).

to tradesmen who were subscribers. There were even governors who had a financial interest in providing the hospital with supplies.⁴⁴

This attribution of almost pure charitable motive to those involved in creating this system at that particular point in history is challenged in later works by other authors, who look more critically at the development of these institutions, and who discern different social forces competing to control and orient the voluntary hospitals against the backdrop of the flowering of liberal capitalist England. In this vein, John Pickstone's examination of the development of hospital services in the Manchester region from 1752 to 1946 is situated clearly in the changes in the political, social and economic environment, what he refers to as "the 'political ecology' of hospitals."⁴⁵ As he traces the development of the regional hospital system, he clearly identifies the forces involved: whether it is the 1790s, when Whigs and radicals proposed development of medical services as instruments they could influence; the repressive decades of the French wars and Peterloo, as Manchester grew into an industrial town and these services seemed to serve as barriers to infection and discontent; or the rise of political liberalism in the 1820s, when conservatives, especially Anglicans, promoted these services as a means of hanging on to a hierarchical social order of mutual obligation.⁴⁶

⁴⁴ *Ibid.*, p. 5.

⁴⁵ John V. Pickstone, *Medicine and Industrial Society: A History of hospital development in Manchester and its region, 1752-1946* (Manchester: Manchester University Press, 1985), p. 2.

⁴⁶ *Ibid.*, p. 5.

The elites dominated these institutions and were responsible for their policies. As Roy Porter eloquently affirms, they managed to maintain a certain amount of inter-class cohesion through these institutions, and use them to serve their own interests. Basing his perspective on E. P. Thompson's observation of the passing of the moral economy, and the propertied classes' awareness of the dangers of open class antagonisms, Porter claims that these propertied classes

... fabricated elaborate and spectacular rituals of paternalistic care — specious, but theatrically effective. Thus the severe — indeed increasingly severe — justice and majesty of the law were tempered by displays of the quality of mercy; wage labour was to be softened once in a while by the harvest supper and yuletide largess. An act of conspicuous, self-congratulatory, stage-managed noblesse oblige similarly underlay the infirmary [voluntary hospital]. Poverty, malnutrition, premature ageing, occupational accidents, and diseases would remain the abiding realities of life for the labouring classes, as would the coercive, police functions of the poor law for ensuring a tractable labour force. But the infirmary threw a cloak of charity over the bones of poverty and naked repression. It enabled the polite and propertied to pose as tender souls, as those, indeed, who were fired by a generous disdain for the flinty provisions of the poor law, the workhouse, and the bridewell... Subscribers clearly sought a conspicuous monument of prestigious charity, distinct from the tainting and compulsory housekeeping of the poor law system. By patronizing voluntary hospitals as a separate additional stratum on top of the parish system, donors got the best of both worlds. In the poor law workhouse they showed the hand that disciplined; in the infirmary, the hand that gave...⁴⁷

The development of voluntary hospitals, however, is quite complex, and definitely not linear. Stephen Cherry, for example, takes one aspect of their financing, the contributory societies that developed in the nineteenth century, and demonstrates

⁴⁷ Roy Porter, "The gift relation: philanthropy and provincial hospitals in eighteenth-century England," in Lindsay Granshaw and Roy Porter, eds., *The Hospital in History* (London: Routledge, 1989), p. 152.

how in certain regions with strong working-class presence — East Anglia is the focus of his study — these societies presented a threat to the unilateral control of some institutions by the elite. In this case, the working class wanted nothing to do with the poor house institutions and organized "Saturday funds," or regular collections in aid of voluntary hospitals. With these funds they were able to win a level of participation in the management of these institutions and, therefore, potentially in policy creation. Concretely, this was done by gaining access to positions on the Boards of Governors of certain institutions, and promoting policies friendly to the working class: for example, allowing admission of the unemployed or providing places for the aged, both groups which would otherwise have had to go to poor house hospitals.⁴⁸

... When the Chairman of the [Norfolk & Norwich] Board of Management urged the [Norfolk Hospital Contributors Association] Committee to increase contribution rates at the [Annual General Meeting] in 1938 he was immediately challenged by the Chairman of the latter body: 'working men and women of the area served by the hospital are doing magnificently... and, with such an example, it should be easy for the Board of Management to organise and propel an appeal to our richer brothers and sisters sufficient to augment that sum by their donations'. This is not to suggest that through the contributory schemes working people held the levers of power in voluntary hospitals in the way that friendly societies had done via their medical institutes, or that the schemes were models of participatory democracy. Rather, they achieved a degree of access to hospital authorities who, on occasions, had to consider the paying membership.⁴⁹

⁴⁸ Stephen Cherry, "Beyond National Health Insurance. The Voluntary Hospitals and Hospital Contributory Schemes: A Regional Study," *Social History of Medicine*, vol. 5, no. 3 (December 1992); and "Accountability, Entitlement, and Control Issues and Voluntary Hospital Funding 1860-1939," *Social History of Medicine*, vol. 9, no. 2 (August 1996). These elements are noted, in passing, in both Pickstone and Abel-Smith. Abel-Smith notes, for example, that in 1910 some infirmaries in Newcastle received more than 50 per cent of their funds from workmen's funds. See p. 250.

⁴⁹ Cherry, "Beyond the National Health," pp. 477-478.

The portrait painted by Pickstone, Cherry, Porter, and Abel-Smith — despite, or perhaps because of, differences in their analyses or focus — is one of institutions that were anything but pure good works existing in a political or class vacuum. They were products of specific times, and of specific class configurations and political contexts, reflective of wider debates and conflicts in society, changing as society changed, and responding to different political needs.

In England, voluntary hospitals, unlike their poor house counterparts, depended very little on the state. The major sources of income were privately raised funds. The paying patient did not become a significant factor until after the First World War.⁵⁰ This was not the case in North America, where payment had become significant by the turn of the century. This was one important indication of the transformation experienced by the institution as it crossed the Atlantic. The resulting system in the U.S., despite apparent similarities in structure — a poor law system next to a voluntary one — did diverge in significant ways from its parent in Britain. J. Rogers Hollingsworth, in his comparison of health care structures in the U.S. and U.K., singles out the relative strength of the working class in each country as an important difference in the shaping of the two systems. According to Hollingsworth, the degree of organization of the English working class, even in the nineteenth century, led both

⁵⁰ Abel-Smith, *op. cit.* In 1910 general hospitals received about 2 1/2 per cent of income from paying patients, and special hospitals 12 per cent in London and 17 per cent in the provinces.

to a voluntary system that had to accommodate the interests of working class patients, and eventually to a comprehensive health insurance system.⁵¹ Cherry's work on working-class contributory societies could certainly support that position.

- **The Voluntary Hospital in the United States**

Work done on hospitals in the United States does indicate significant divergences from the British model, the major difference being the relationship to the market, in particular to the paying patient. It is not surprising, therefore, that several U.S. historians of the voluntary hospitals, while discussing the moral imperatives of these institutions in the nineteenth century (ideas transported from England and transformed in the U.S.), have also focused on the market orientation of American voluntary hospitals.

Morris Vogel, in *The Making of the Modern Hospital*, lays out the growth of the disparate elements of the hospital system in Boston, from 1870 to 1930. He notes the role that the voluntary and the city-supported (more akin to poor house) hospitals ascribed to themselves. His focus is the changing emphasis away from hospitals as instruments of social control towards hospitals as centres of science. Along the way, however, he establishes the nature of the institutions in their early years, when they served multiple societal roles, as both an expression of the religious doctrine of stewardship and as an instrument of social stability:

⁵¹ J. Rogers Hollingsworth, *A Political Economy of Medicine, Great Britain and the United States* (Baltimore: Johns Hopkins University Press, 1986), pp. xii-xv, pp. 3-4, p. 9.

Massachusetts General and Children's Hospital formed part of the complex of Boston's Protestant charities that owed their founding and existence, at least in part, to the religious doctrine of stewardship. Social and economic inequalities were legitimized by the notion that God meant them to exist. But the elect, whose heavenly salvation was generally already demonstrated by their earthly riches, held their wealth only as God's trustees. With their wealth came the obligation to aid the less fortunate. The poor provided their economic betters the opportunity, the privilege actually, of spending God's wealth in a way that continually re-emphasized their own chosen state.⁵²

While this question of moral stewardship was important, as Vogel points out, the institution also had other roles. It was an early form of workmen's compensation, supplying a number of free beds to companies who supported the hospital. He notes that these "beneficiaries of industrialism [the cotton mills, for example] used the hospital to ease distress among the victims of the industrial process and promote the process as well."⁵³ In this sense, since the employers were providing a service for their workers, the hospitals were seen as a "guarantor of social stability," providing "the working classes with evidence that the wealthy were aware of their responsibilities."⁵⁴ These arguments echo those made by both Porter and Pickstone regarding English voluntary institutions.

Charles Rosenberg, in his work on the American hospital system, *The Care of Strangers*, discusses some of the same aspects, emphasizing the role of voluntary institutions in the nineteenth century as instruments of social or moral rehabilitation.

⁵² Morris J. Vogel, *The Invention of the Modern Hospital: Boston 1870-1930* (Chicago: University of Chicago Press, 1980), pp. 14-15.

⁵³ Vogel, *op. cit.*, p. 6.

⁵⁴ *Ibid.*, p. 27.

This was usually translated into a moral stewardship, in particular with regard to fighting pauperization of the working class, by charging all patients a small fee. The financial aspect takes on more than one level of importance according to Rosenberg: as well as fighting pauperization, it becomes a source of funding for the hospitals. Private rooms, for the well-to-do who wanted to be treated in hospital, became an important source of income. In addition, Rosenberg singles out the creation of the semi-private ward around the turn of the century which responded to the need for something better than the ward for those "intelligent and sensitive" patients who could not afford a private room but could afford the respectability of a non-ward shared accommodation.⁵⁵ These developments were important steps in the movement of the hospitals towards a market-orientation. And, as in the English voluntary hospitals, by the early twentieth century American voluntary hospitals "selected among an available patient population, avoiding chronic and contagious ills..."⁵⁶

In the twentieth century, emphasis on moral stewardship receded with the imposition of scientific medicine by physicians and the mass entry of the middle class patient into hospitals. The vestiges of concern about "pauperization" certainly remained, however, as is evident in the desire to maintain indigents as a separate and identifiable group — usually by insisting that all those who could pay for hospital services from their own pocket or through group insurance plans should do so. In

⁵⁵ Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), p. 260.

⁵⁶ *Ibid.*, p. 326.

addition, there was a consistent attempt to separate the “non-deserving” poor from the “deserving” — the one group to be maintained in the state institutions, the other to be allowed access to voluntary hospitals (if they could pay).

The final point to be made about the American voluntary hospital system is the growing emphasis placed on the market ethic in the twentieth century. Rosemary Stevens fully explores this theme in her book *In Sickness and in Wealth* as she juxtaposes it with her contention that voluntary hospitals, while carrying “symbolic and social significance as embodiments of altruism, social solidarity and community spirit,” have nonetheless taken on the ethos of business enterprise.⁵⁷ Stevens makes the clearest statement on the nature of the voluntary hospital in the United States, emphasizing the specific political role it played historically as a bulwark of *laissez-faire* liberalism against increased government activity in general and socialism in particular:

Voluntary hospitals have long served as the preferred alternative to a government hospital or health-care system in the United States, a country which has made no serious commitment to egalitarian goals as a basis for providing social services. But this theme tells only part of the story, because voluntarism in the United States is not merely an alternative to government but an entrenched aspect of American corporate capitalism. The voluntary hospitals are not fall-back organizations, existing only because government has not acted. They are instruments of America’s version of the capitalist state — social structures established to maintain, interpret, and extend it, as essential in their way as business corporations.⁵⁸

⁵⁷ Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989), p. 6.

⁵⁸ *Ibid.*

Stevens explains the growing business orientation of American voluntary hospitals, even though they were still considered as charities. The result hinges on the decision to focus on paying patients before the turn of the century.

The pay system made voluntary hospitals peculiar hybrids economically. They were "charities" in terms of the sources from which they drew money for buildings and other capital investments. Capital came almost entirely from private gifts, endowments, and donations until after World War II, and predominantly from these sources until the 1970s. In terms of day-to-day operations, however, the early-twentieth-century hospital was more like a business. The more attractive the hospital was to paying patients, the greater its income; the greater its income, the greater the level of medical facilities and amenities that it could offer, and in turn, the greater its attraction to paying patients, who might otherwise be treated at home. Hospitals had a clear incentive to build the demand for hospital services; that is, to behave as successful, competitive enterprises in which the goal was expansion of units sold, including surgical operations and filled private beds.⁵⁹

This business orientation, coupled with the existence of poor law institutions for those patients not deemed acceptable for voluntary hospitals, made it possible for voluntary hospitals to grow as business-oriented institutions while maintaining their charitable veneer. In fact, Stevens noted that, at the time of writing (the late 1980s), 70 per cent of short-term hospital beds in the United States were in voluntary hospitals.⁶⁰

As viewed by the above authors, the British and American voluntary tradition, far from being a simple philanthropic endeavour, harboured a variety of motives and intents. A system which began as an attempt to palliate some of the ills of nascent industrial capitalism evolved in England into a complex social institution with different

⁵⁹ *Ibid.*, p. 33.

⁶⁰ *Ibid.*, p. 5.

classes contending for control. In the United States, it became a mainstay against state medicine, and while maintaining an image as a charitable concern, took on very much a business orientation.

- **The Voluntary Hospital in Canada**

As there were differences and similarities between the English and American voluntary tradition, the same can be said for Canada and the U.S. In Canada, as elsewhere, the system that evolved was dependent on local conditions and legal structure. While still British North America, the Maritime colonies had a poor law system, but few institutions that could be called hospitals before Confederation. In the Canadas, where there was no poor law, the dominant model was the Church-run hospital such as the Hôtel-Dieu hospitals in Montreal and Quebec City, or the voluntary Toronto General and Montreal General hospitals.

The system that evolved was a unitary one where the state played a role fairly early on, and (at least in theory) all were treated — though not necessarily equally. Since there was only one system, it could be said that the different strands of the voluntary/poor house tradition were internalized: the function of both poor house and voluntary hospital were to be found in the single institutions. Unlike in the U.S. or England, for example, there were no or at best few poor house institutions to take those rejected by the voluntary hospitals. As a result, it was more difficult for the hospitals to be selective of their clientele. The fact that the state did partially subsidize hospitals, a situation that became prevalent in most provinces in the later part of the

nineteenth century, also made it more difficult to reject patients. This is a point made by Terry Boychuk in his dissertation comparing hospital systems in the U.S. and Canada. Talking about a later period, the 1940s-1950s, when private insurance was becoming more prevalent and potentially a model for hospital funding, he notes:

The rise of voluntary [private] hospital insurance had not dissolved the moral bond between hospitals and the government embodied in the subsidy laws of the six provinces not operating public hospital plans. These subsidy laws still reaffirmed the principle that necessitous hospital care should be available to all without respect to patients' financial means or insurance status. The provinces still protected hospitals from any threat to solvency implied in the fulfilment of this purpose.⁶¹

In other words, unlike in the United States, a kind of contract existed between government and hospitals in Canada. Hospitals took in the indigent and were promised support in this task from the state. This was not a steadfast rule, however. In fact, in some cases it was the state that dictated what kind of patient a voluntary hospital could serve. In Ontario, for example, with the passing of the Charity Aid Act in 1874, the government apparently attempted to make distinctions between appropriate and inappropriate patients. In their book on the Victoria Hospital in London Ontario, for example, authors John R. Sullivan and Norman R. Ball note that the Ontario government cut funds in 1876 under the Charity Aid Act provisions if unsuitable patients ("old, chronic and incurable patients," for example) were in hospital instead of

⁶¹ Terry Boychuk, "The Hospitals of Canada and the United States: From the Beginning to 1969" (Ph.D. diss., Princeton, 1994), p. 208.

in an almshouse.⁶² While there was no poor law in Ontario, this was an example of English poor law thinking. However, particularly when there was no alternative, hospitals took it upon themselves to accept all patients.

Voluntary/poor law ideologies were also internalized in Canadian hospitals along with the social role played by both types of institution. The indigent poor did not have quite the same treatment as paying patients: the moral improvement that hospital governors and employees attempted to impose on their indigent patients in the nineteenth century would not be attempted on the middle-class paying patients. As this kind of moralism receded in the twentieth century, new manifestations of differential treatment developed: using only ward patients as teaching materials was one example; the continued inspection and verification of indigent status was another.

This kind of moral stewardship, in this case towards unwed mothers, is discussed by Rhona Kenneally in her work on the Montreal Maternity in the nineteenth century.⁶³ Judith Young, in her article on the Toronto Children's Hospital brings out the anti-working-class moralism evident in the board's difference in attitude towards working-class and middle-class patients, also in the nineteenth century:

Although many patients received free treatment, parents or friends were encouraged to contribute to the maintenance of the children if they were able. The Ladies Committee was "unwilling to foster pauperism ...[so] strictly enforced the rule of remuneration." Religious fervour

⁶² John R. Sullivan and Norman R. Ball, *Growing to Serve ...A History of Victoria Hospital, London, Ontario* (London: Victoria Hospital Corporation, 1985), p. 25. Boychuk also makes the point that the 1874 Charity Aid Act resulted in a fairly well-established regulatory structure in Ontario; see *op. cit.*, pp. 71-72.

⁶³ Kenneally, *op. cit.*, chapter 1.

influenced the foundation of the hospital but allowed for limited sympathy with the plight of poor families. Drunkenness and failure to live by religious principles were considered to be at the root of the problems of the poor. Such sentiments were expressed in early annual reports, where children were described as living in "an atmosphere of filth, misery and evil, ...[with] sickly and scrofulous constitutions inherited from their drunken and tainted parents."⁶⁴

Young also notes that visiting rights were based on class position: working-class parents, obviously a detriment to their children, were allowed a one-hour visit a week to their sick children until the 1950s, while parents of children in semi-private or private rooms could visit every day.⁶⁵

The works by Kenneally and Young, examinations of the social ramifications of the voluntarist tradition on the patient, are part of a new development in hospital historiography in Canada. The literature on hospitals in Canada has, until recently, been quite limited. In 1990 J. T. H. Connor, in a review essay on recent works on hospitals, noted that while work had become more nuanced and complex in U.S. hospital history, Canadian work still tended somewhat towards the hospital biography, often because it was an "in-house" or commissioned work.⁶⁶ This has begun to change — in fact Connor notes some exceptions: Colin Howell's book on the Victoria General Hospital in Halifax, for example, which places the hospital's development within a

⁶⁴ Judith Young, "A Necessary Nuisance: Social Class and Parental Visiting Rights at Toronto's Hospital for Sick Children 1930-1970," C. David Naylor, ed., *Canadian Health Care and the State: A Century of Evolution* (Montreal: McGill-Queen's University Press, 1992), p. 86. (Porter makes the same argument for England; see *op. cit.*, p. 167.)

⁶⁵ *Ibid.*, pp. 88-91.

⁶⁶ J. T. H. Connor, "Hospital History in Canada and the United States," *Canadian Bulletin of Medical History*, vol. 7 (1990), p. 95.

larger societal context.⁶⁷ In Quebec, an area not touched by Connor, Normand Perron's 1984 book on the Hôtel-Dieu de Chicoutimi is another work that does not ignore social and political context.⁶⁸

Since Connor's article, more works have appeared that place hospital histories in a context, and deal with issues both internal and external. David Gagan, François Rousseau, and Denis Goulet *et al.* have published works about individual institutions that are much more comprehensive, situating them in their socio-economic context, discussing relations between the founders/administrators, medical staff, patients, and at times the state and the market. This is especially important, considering that the growth of state intervention is a key issue in twentieth century.⁶⁹ In Quebec, in the case of Rousseau and Perron, the studies are of Catholic-order-run hospitals, and so discuss a very different dynamic than that found in lay voluntary hospitals. The work of Goulet *et al.* on Notre-Dame Hospital in Montreal is important because of Notre-Dame's role as the first and most prominent lay Catholic hospital. In the same vein, François Hudon's comprehensive dissertation on Notre-Dame, which pays considerable attention to the financing of the hospital as well as the hospital's relation to the state

⁶⁷ *Ibid.* See Colin Howell, *A Century of Care: A History of the Victoria General Hospital in Halifax, 1887-1987* (Halifax: Victoria General Hospital, 1988).

⁶⁸ Normand Perron, *Un siècle de vie hospitalière au Québec: Les Augustines et l'Hôtel-Dieu de Chicoutimi 1884-1984* (Sillery: Les Presses de l'Université du Québec, 1984).

⁶⁹ David Gagan, *A Necessity Among Us: The Owen Sound General and Marine Hospital, 1981-1985* (Toronto: University of Toronto Press, 1990); see also David Gagan, "For 'Patients of Moderate Means': The Transformation of Ontario's Public General Hospitals, 1880-1950," *Canadian Historical Review*, vol. LXX, no. 2 (1989), pp. 151-179; François Rousseau, *Le Croix et le Scalpel: Histoire des Augustines et de l'Hôtel-Dieu de Québec*, vol. II: 1892-1989 (Sillery: Septentrion, 1994); Denis Goulet, François Hudon, Othmar Keel, *Histoire de l'Hôpital Notre-Dame de Montréal, 1880-1980* (Montreal: VLB Éditeur, 1993).

and civil society, is also an important contribution to understanding the functioning of this institution in society.⁷⁰ Most of these works, and Hudon and Gagan's in particular, pay some attention to the complexities of financing hospitals, highlighting the constant difficulties they encountered in meeting their costs. And they all underline how important income from private and semi-private patients became, especially since indigents and chronic patients were not rejected. However, while there is considerable merit in examining an institution more broadly within the changing economic, political and social landscape, overall, the focus is still to provide a rounded history of a single institution. In addition, while there is some attempt to deal critically with the outlook of the boards running these institutions, particularly in relation to their views on the treatment of different classes of patients, this is not a central concern of these works. While financing is presented as a constant problem, in general the view of the boards towards different financial options, or the ideological underpinnings of their choices, is not considered.

Class as an analytical tool is extremely useful in uncovering the ideological preferences of hospital elites. This was an important element in the critique of voluntarism found in the work done in England and in the United States. This question, particularly the gap between the class of the patient (often poor or working class) and that of the administrators, medical staff and nurses, has recently become an

⁷⁰ François Hudon, "L'hôpital comme microcosme de la société: enjeux institutionnels et besoins sociaux à l'Hôpital Notre-Dame de Montréal 1880-1960" (Ph.D. diss., Université de Montréal, Montreal, 1996).

issue explored in some Canadian scholarship. Young and Kenneally, in their discussion of moral stewardship of patients mentioned above, explore the class attitudes of the administrators and governors towards their lower-class patients.⁷¹ Mark W. Cortiula's article on the Hamilton City Hospital documents the different treatment of working-class and paying middle-class patients.⁷² Other works, by Gagan, and Goulet *et al.*, for example, also chart the changing nature of the class component in patient composition, emphasizing the growing importance for hospital finances of the paying patient.⁷³ However, what is still lacking or at best undeveloped is the linking of this element to the general attitude that predominated in society - that is the dominance of *laissez-faire* liberal thinking in how social welfare - including health care - should be delivered. While this theme runs through much of the historical work on the voluntary hospital tradition in England and the United States, it is unfortunately not adequately discussed in historical work done in Canada. It is, however, a theme that permeates the debates - past and present - in the hospital sector about the hospital in twentieth-century Canada and should be examined. This is one of the primary aims of this essay.

While the works discussed above are definitely breaking out of the old hospital biography mould, they are still all hospital- or institution-centred. With the possible exception of Hudon's dissertation, which attempts to focus more on the relationship of the hospital to the outside world, little has been done to analyze the hospital sector

⁷¹ Young, *op. cit.*; Kenneally, *op. cit.*

⁷² Cortiula, *op. cit.*

⁷³ Gagan, *A Necessity Among Us*; Gagan "For Patients of Moderate Means": Goulet, *et al.*, *op. cit.*

from a broader position, taking into account the evolving relationship of the hospitals to the state and the market, or to examine the ideological stance of the hospitals within the context of constant financial constraints, on the one hand, and the changing social welfare landscape, on the other. This is the intent of this study. The elements discussed above — the persistence of the *laissez-faire* liberal voluntary tradition in the hospital sector, of liberalism in society in general, and of the divergent visions of the welfare state in Canada and in Quebec— will be used to situate the debate within the hospital sector and between the hospital sector, the market and the state.

Chapter II

HEALTH CARE AND HOSPITALS IN CANADA AND QUEBEC, 1940

In order to understand the evolution of hospitalization insurance, the hospitals' response to it and their role in its development, it is necessary to have an overview of hospital services in Canada and Quebec and the legal framework in which they operated at the beginning of this period. The intent of this chapter is to give the reader the necessary understanding of these 'technical' elements in order to understand the argumentation developed in subsequent chapters. It will therefore examine the legal and constitutional framework — both provincial and federal — that regulated hospitals, the sources of hospital financing, and the hospital trade organizations. The two hospitals studied in this text will also be introduced.

Hospital Financing and Regulation

- **Legal/Constitutional Structures**

Hospitals in Canada, as noted in the previous chapter, were for the most part private, non-profit institutions. Many were opened as charitable institutions, but by the twentieth century they had become, for the most part, scientific institutions, even though they continued to carry on charity work. Who actually built these institutions and took responsibility for them relates directly to the accordance of jurisdiction and responsibility for hospitals as defined at the time of Confederation in the British North America Act. Health and welfare, in keeping with the traditions of the English Poor Law, were seen to be the responsibility of the family, local community, or church,

rather than of the state. Equally, most responsibilities for health and welfare, where the government might have a role, were considered local and private, and thus within the provincial sphere.¹ Specifically with regard to health care, the federal government took responsibility only for questions of a national nature: matters relating to immigration, such as quarantine, or naval hospitals and later veterans' hospitals, and native peoples under the Indian Act.² Provincial governments were assigned the establishment, maintenance and management of all other hospitals, asylums, charities and eleemosynary (dependent on alms) institutions.³ In fact, again following in the tradition of the English Poor Law, where the parish was ultimately responsible for health and welfare, much was left to the municipalities, but with no compulsion to oversee these responsibilities. As a result, in Quebec, the task of building and maintaining hospitals was left almost exclusively in private hands, particularly those of the Catholic Church, while in general across the country it was left to the municipalities, or more often to voluntary groups of citizens, to set up voluntary hospitals.

¹ Elisabeth Wallace, "The Origin of the Social Welfare State in Canada," *The Canadian Journal of Economics and Political Science*, 16 (1950), p. 384. As Wallace notes, "The Act did not impose any obligations to provide welfare services upon either the Dominion or the provinces, but simply allocated, with less precision than its framers had hoped to achieve, the various spheres of jurisdiction, any subsequent action being permissive, not mandatory." *Ibid.*

² Article 91, *British North America Act*, 1867.

³ Article 92, *British North America Act*, 1867; R. E. Wodehouse and J. J. Heagerty, "The Health Section of the Department of Pensions and National Health in Canada," in R. D. Defries, ed., *The Development of Public Health in Canada* (Toronto: University of Toronto Press, 1940), p. 143.

- **Government Contributions**

While most hospitals set up towards the end of the 19th century were voluntary hospitals, other forms of hospital development also emerged in the early years of the twentieth century. The major form, found in most provinces, was that of publicly financed hospitals set up by municipalities (municipal hospitals), in some cases the federal government (marine hospitals, for example), and, rarely, the provinces. (The Victoria General Hospital in Halifax was the only provincially owned hospital in Canada before 1930.)⁴

In the west, state intervention proved essential. The scarcity of long-established elites willing to contribute large houses or undertake fund-raising for the establishment of hospitals meant that few voluntary hospitals existed before the turn of the century; those that were established were built in the larger settlements, often by the Catholic Church.⁵

As a result of the scarcity of voluntary institutions, municipal government was virtually obliged to step in. In the early years of the twentieth century various provinces and territories enacted laws providing for municipal hospitals. In Saskatchewan, for example, the Town, Village and Rural Municipality Acts, passed in 1908 and 1909, authorised municipalities to contribute towards facilities such as hospitals, and to use taxation revenues to build and contribute to the maintenance of

⁴ G. Harvey Agnew, *Canadian Hospitals, 1920 to 1970: A Dramatic Half Century* (Toronto: University of Toronto Press, 1974), p. 2.

⁵ *Ibid.*, p. 152.

these institutions. In fact, as well as contributing to building these hospitals, municipalities (in some cases several municipalities jointly supported 'union' hospitals) would provide free care for their residents.⁶ Alberta also developed a municipal hospital system with the passing of the Municipal Hospital Act in 1917.⁷ In other towns across Canada it was possible to find hospitals constructed with municipal funds, even without a specific municipal hospital act in effect.

In Newfoundland before it joined Canada, the small population and the lack of any local government outside of the capital led the Dominion Government of Newfoundland to assume responsibilities for hospital services, normally a municipal responsibility. The result was the Cottage Hospital and Medical Care Plan, started in 1935, which was a government sponsored and operated pre-payment plan. The plan was not self-supporting, but heavily subsidized.⁸ Finally, there were outpost or Red Cross hospitals, small clinics run by nurses, found in remote areas.⁹

⁶ Joan Feather and Vincent L. Matthews, "Early Medical Care in Saskatchewan," *Saskatchewan History*, vol. XXXVII, no. 2 (Spring 1984), pp. 46-47.

⁷ Malcolm R. Bow and F. T. Cook, "Public Health in Alberta," in R. D. Defries, ed., *op. cit.*, p. 120.

⁸ See Leonard A. Miller, "The Newfoundland Department of Health," in R. D. Defries, ed., *The Federal and Provincial Health Services in Canada*, Second Edition (Toronto: Canadian Public Health Association, 1962), pp. 21-25. A pre-payment plan requires a premium from those covered by the plan to ensure services.

⁹ See, for example, for the case of Ontario, Hospitals Division of the Department of Health, *The Hospitals of Ontario: A Short History* (Toronto: 1934), pp. 232-233.

There were also a small number of private hospitals scattered across the country, either set up and run by companies for their employees or as for-profit institutions run by nurse-operators or in some cases by physicians.¹⁰

Those hospitals established under government auspices, municipal hospitals, for example, could expect some form of continued financial support from that government. However, the many voluntary hospitals were constantly forced to look for financing to be able to maintain their services. Their major source of financing was contributions in various forms: subscriptions, donations, legacies and fund-raising events. Yet throughout the nineteenth century there was already an element of government funding for voluntary institutions, at least in some cases. In 1832 the colonial government granted the town of Kingston £3000 for the construction of a hospital, and the Toronto General Hospital benefited from government grants as early as the 1830s and municipal grants for indigents in the 1850s.¹¹ In Quebec, hospitals received block funding on a more-or-less regular basis from the colonial and later the

¹⁰ This information appeared in *The Canadian Hospital*, vol. 16, no. 8 (August 1939): The George Boisvert Memorial Hospital was opened in Baie Comeau in July. The hospital was owned and operated by the Quebec North Shore Paper Co. In another article in *The Canadian Hospital*, vol. 21, no. 3, (March 1944), "Possible Effect of Health Insurance on Hospitals," Dr. Harvey Agnew noted: "In Canada there are 245 proprietary hospitals or nursing homes with an average capacity of 12 beds. Unlike in the United States, the great majority of proprietary hospitals in Canada are operated by nurse-proprietors, not by medical clinics or individual surgeons." p. 84.

¹¹ *Ibid.*, p. 15; W. G. Cosbie, *The Toronto General Hospital, 1819-1965: A Chronicle* (Toronto: Macmillan of Canada, 1975), p. 67.

provincial governments.¹² Provincial funding for Notre-Dame Hospital accounted for almost 12 per cent of revenue in the first decade of its existence (the 1880s) and over 16 per cent in the second decade.¹³ At the beginning of the twentieth century, about \$73,000 was voted annually for some 100 hospitals in Quebec.¹⁴

Nonetheless, financing was a problem almost from the beginning for voluntary institutions, and even in the early years there were concerns about the low level of government contributions, concerns that would continue at least until the advent of hospitalization insurance. Even as the Toronto General opened the doors of its new building in 1856, for example, its trustees were worried about the inadequacy of the fixed annual provincial grants and the refusal of the municipal government to provide for the large number of indigents who came to the hospital.¹⁵

In 1874, Ontario hospitals gained a certain minimum level of financial security when the provincial government passed the Charity Aid Act, which provided hospitals included on an established list a *per diem* (daily) rate of 20 cents for all patients

¹² In 1818 the Augustine Sisters obtained £6,000 from the government for construction of a new building. This was the result of two years of attempts on the part of the Sisters. See François Rousseau, *La Croix et le Scalpel: Histoire des Augustines et de l'Hôtel-Dieu de Québec (1639-1989)* Tome I, 1639-1892 (Sillery: Septentrion, 1989), p. 167. The Montreal General Hospital received £250 from the Legislative Assembly in 1823. In 1857 the Provincial grant reached \$5000, and remained close to this level until 1921. See H. E. MacDermot, *A History of the Montreal General Hospital* (Montreal: The Montreal General Hospital, 1950), p. 34. See also Margaret Kirkpatrick Strong *Public Welfare in Canada* (Chicago: University of Chicago Press, 1930), p. 45.

¹³ Lucie Deslauriers, "Histoire de l'Hôpital Notre-Dame, 1880-1924" (M.A., University of Montreal, 1985), p. 88.

¹⁴ This figure comes from the First report of the Director of Public Charity, 1923, cited in Jean-Yves Rivard, et al., "L'Évolution des Services de Santé et des modes de distribution des soins au Québec," *Rapport de la Commission d'Enquête sur la santé et le bien-être social* (Castonguay-Nepveu Commission), Annexe II (Quebec, 1970), p. 30.

¹⁵ Cosbie, *op. cit.*, p. 67.

hospitalized. An additional 10 cents *per diem* per patient was also granted if total provincial contributions did not exceed one-quarter of total revenues from sources other than the government.¹⁶ In the Northwest Territories, the government began granting aid to hospitals for both indigent and paying patients in 1892.¹⁷ In British Columbia, as early as 1886 the sum of \$19,000 was paid out to hospitals making special claims for help, with grants increasing over the years. In 1902 legislation was passed authorizing aid on a patient-day basis for all hospitals complying with certain conditions, the most important being that they admitted and treated indigent patients. Municipalities were also required to contribute.¹⁸

A description of the varied sources of funding of the Toronto Hospital for Sick Children at the turn of the century lays out the complexities of obtaining funding for hospitals:

Local and provincial authorities provided some subsidies that augmented public donations. This became the usual practice in recognition of the "charitable services" rendered by private hospitals. HSC [Hospital for Sick Children] was placed on the provincial "Schedule of Charity Aid" in 1881, and two cents per day was provided for each child. By 1894 the provincial government was paying 36 per cent of the cost of maintenance at thirty-four hospitals, including HSC. Out-patient and in-patient services were free to those "absolutely" unable to pay, providing they had a "circular" from a clergyman or doctor. Payment for indigent

¹⁶ *The Hospitals of Ontario*, pp. 17-18. David Gagan, in his book, notes that "[i]n fact, 90 per cent of the days of care required by these patients [1890s] was subsidized by the provincial and municipal governments under the Charity Aid Act (1874) which provided for annual provincial grants-in-aid to hospitals of 20 cents per day for all patients and 25 cents for indigent patients." See David Gagan, *A Necessity Among Us: The Owen Sound General and Marine Hospital* (Toronto: University of Toronto Press, 1990), p. 14.

¹⁷ Feather, *op. cit.*, p. 44.

¹⁸ Harry M. Cassidy, *Public Health and Welfare Reorganization: The Postwar Problem in the Canadian Provinces* (Toronto: The Ryerson Press, 1945), pp. 45-46.

patients was provided by municipalities. In 1906, "to protect against imposition," an inspector visited the homes of one hundred patients to "determine if needs were valid."¹⁹

In the twentieth century, funding continued to grow in piecemeal fashion. Most provinces did pay a *per diem* grant to voluntary hospitals that averaged around 50 cents per patient, and covering in fact between 20 and 30 per cent of hospital non-capital costs. In most cases, these grants applied to all patients.²⁰ Quebec was one of the exceptions, maintaining its ad hoc block grant funding system to general hospitals. At this time priorities were elsewhere, with the provincial government devoting 90 per cent of the health budget to asylums.²¹ It was only after 1921 that the Quebec government started paying a *per diem* rate to hospitals for indigent in-patients.

By the 1940s most provinces provided payment for all hospitalized patients. British Columbia, Alberta, Saskatchewan, Ontario and Nova Scotia provided *per diem* payments for all hospitalized patients. Manitoba provided *per diem* payments for ward patients; Quebec provided *per diem* payment for indigent patients; and New Brunswick and Prince Edward Island provided lump sums to hospitals. Municipalities

¹⁹ Judith Young, " 'A Necessary Nuisance': Social Class and Parental Visiting Rights at Toronto's Hospital for Sick Children 1930-1970," in C. David Naylor, ed., *Canadian Health Care and the State: A Century of Evolution* (Montreal: McGill-Queen's University Press, 1992), p. 87.

²⁰ Agnew, *op. cit.*, p. 149.

²¹ I. Gow, *Histoire de l'administration publique québécoise, 1910-1970* (Montreal: Les Presses de l'Université de Montréal, 1987), p. 126; James Ian Gow, "Histoire de l'Administration Québécoise; Chronologie des programmes de l'État du Québec (1867-1970)," Notes de recherche #1 (Montreal: Département de Science politique, Université de Montréal, 1981), p. 111. Nonetheless, government funding could be a steady source of financing. Montreal's Notre-Dame Hospital received an annual subvention which ranged from \$1400 to \$3000 in the first years of its existence (1881-1889) stabilizing at \$5000 in 1890. See Denis Goulet, François Hudon, Othmar Keel, *Histoire de l'Hôpital Notre-Dame de Montréal 1880-1980* (Montreal: VLB Éditeur, 1993), p. 70. Between 1900 and 1920, government subventions accounted for 10 to 17 per cent of revenues. Deslauriers, *op. cit.*, p.98.

in most provinces were held responsible for some payment for indigents.²² In addition, many provinces covered hospitalization resulting from work accidents under workers' compensation schemes, beginning in 1914 in Ontario.²³

• Paying Patients

While every province and indeed many a city or town had some form of funding for hospitals, the problem was that the system was a patchwork of methods, public and private, and, even with a multiplicity of funding sources, the result was usually inadequate nonetheless. The problem of financing was thus a constant, continuing into the twentieth century, with hospitals and their boards exploring various avenues: more government funding, higher rates, and various forms of hospital insurance.

One solution, in keeping with a *laissez-faire* liberal vision of the role of the hospital, was to bring in more paying patients. And, with the evolution of medical science towards the end of the century and the public perception of hospitals changing from that of charity institutions to houses of science, it became more and more possible to attract the middle classes, who had previously stayed away.²⁴ In the second half of the nineteenth century hospitals were already exploring the possibility of

²² NAC, RG 29, Department of National Health and Welfare, vol. 1072, file 502-3-4, pt. 1, *Report of the Board, Provincial Commission of Inquiry into Hospitals* (Lessard Commission), Second Part, "The Legal Problem of Public Charity," pp. 17-21.

²³ Agnew, *op. cit.*, pp. 152-3.

²⁴ See Gagan, *op. cit.*, pp. 12-13; S. E. D. Shortt, "The Canadian Hospital in the Nineteenth Century: An Historical Lament," *Journal of Canadian Studies*, vol. 18, no. 4 (Winter 1983-84), p. 9.

bringing in paying patients, and thus reducing the cost of running the institutions. As a result, existing hospitals began to create private rooms, and new institutions included them in their plans. The new Toronto General Hospital building, opened in 1856, already included wards for private patients, and the Kingston General Hospital was advertising private rooms as early as 1862.²⁵ In 1881, the Montreal General Hospital opened a new building with room for a few private patients; a new wing with private wards was finally completed in 1913 after several years of planning. The Royal Victoria Hospital in Montreal, completed in 1894, included private medical and surgical beds, and a pavilion for private patients, made possible by a bequest for that specific reason, was completed in 1916. Notre Dame Hospital, opened in the early 1880s, had 50 beds for "poor patients" and between 15 and 20 beds for paying patients when it opened its doors. The Owen Sound General and Marine Hospital opened in 1893 with private rooms as well as public wards.²⁶

Over time, paying patients actually became a major source of revenue. The transformation of the patient base at the Owen Sound Hospital over a fifteen-year time frame gives a striking example of the potential importance of paying patients:

In a typically busy month at the turn of the century, public ward patients outnumbered private and semi-private patients four-to-one, and less than 25 per cent of the hospital's total income was derived from the fees of paying patients of any sort. Donations and government subsidies for both indigent and paying public ward patients constituted the bulk of the hospital's operating and capital funds. Five years later, this

²⁵ Cosbie, *op.cit.*, pp. 66-67; Shortt, *op. cit.*

²⁶ MacDermot, *op. cit.*, p. 4, p. 82; D. Sclater Lewis, *Royal Victoria Hospital 1887-1947* (Montreal: McGill University Press, 1969), p. 27, p. 138; Goulet *et al.*, *op. cit.*, p. 49; Gagan, *op. cit.*, p. 19.

situation had been substantially altered. Fees paid by patients for their maintenance accounted for more than half of hospital revenues beginning in 1905 (nearly 70 per cent by 1915).²⁷

Montreal's Notre-Dame Hospital also did quite well, with over 50 per cent of its income coming from private patients in 1920.²⁸ At the Montreal General, patient revenues in 1920 accounted for 61 per cent of total revenues.²⁹ While such figures could mean a growth in the number of paying patients and a decline in indigents, it could also indicate inadequate funding from government. In any case, neither the Owen Sound, the Montreal General, nor Notre-Dame could balance their books over the long term, in part because of the burden of carrying much of the cost of indigent patients, but also increasingly because of growing costs due to scientific and technical advances.³⁰

As the elite of the medical profession, centred in the big cities and working in university-affiliated hospitals, pushed for state-of-the art equipment and moved towards increasing specialization, practitioners in less prestigious institutions and their lay administrators and boards attempted to follow, in order to enhance their prestige and that of their institutions, and as a consequence to entice paying patients to their wards.

²⁷ Gagan, *op. cit.*, p. 39.

²⁸ François Hudon, "L'hôpital comme microcosme de la société: enjeux institutionnels et besoins sociaux à l'Hôpital Notre-Dame de Montréal 1880-1960" (Ph.D. diss., University of Montreal, 1996), p. 241.

²⁹ MacDermot, *op. cit.*, p. 89.

³⁰ MacDermot, *op. cit.*, Hudon, *op. cit.*, pp. 576-7. Hudon notes that Notre-Dame did not run deficits between 1921 and 1928. After 1928 the deficit was a constant feature, growing 54 times in the years from 1921 to 1960. The Owen Sound Hospital seems to have been the most able to balance its books, but also had to deal with deficits in some years. See Gagan, *op. cit.*, p. 64.

While this was a complex and ongoing process, one of the milestones was the standardization programme initiated by the American College of Surgeons in the early 1920s to help upgrade hospitals. Canadian hospitals enthusiastically embarked on the programme. Among the major requirements were: written pre-operative diagnoses, recording of details of each operation, a satisfactory laboratory department run by a competent pathologist, an adequate radiology department supervised by an acceptable radiologist, adequate maintenance and completion of clinical records, monthly staff meetings and, later, a required ratio of autopsies performed to number of deaths, improved qualifications of technicians, and a trained dietician to supervise the food service.³¹ These changes inevitably implied increased costs, which, if possible, were passed on to the paying public. In fact, in Canada hospital rates increased by 90 per cent between 1913 and 1928.³²

This growing emphasis given to science in the hospital, and the resulting growth of costs led to the emergence of a new problem: the 'middle class,' now interested in being served in the hospital precisely because of the increasingly scientific nature of hospital treatment, began to encounter difficulties in paying for these increasingly costly services. In a 1943 brief to the federal government, the Canadian Medical Association would remark on the increase of costs in hospital:

The extent and value and accuracy of medical knowledge and skill have increased tremendously, but at the same time the cost of this service has also become an increasing burden. The major increase has been due to

³¹ Agnew, *op. cit.*, pp. 32-33.

³² Gagan, *op. cit.*, p. 78.

the increasing complexity and delicacy of diagnostic methods and to the increased utilization of intricate apparatus and highly skilled personnel in treatment. ...In five or six decades the cost of providing hospital service which would be abreast of expanding medical knowledge has gone up from 75 cents per patient per day to an average of around \$3.00 per patient per day.³³

This problem would continue to perturb both hospitals and prospective patients for years to come. At this stage, alternatives for the patient, other than paying out of pocket were limited to some local arrangements as broader Canadian insurance schemes to cover hospital costs were only beginning to surface in the 1940s.

Over the years, various groups — unions, co-operatives, medical associations, hospitals and political parties among others — did look with some hope to other methods of assuring coverage of hospital costs. One important potential source was group hospitalization insurance. In 1941, a report to the federal Advisory Committee on Health Insurance outlined the existing programmes in the provinces. Prince Edward Island, New Brunswick and Quebec were reported to have none. In the other provinces, plans varied, including industry-based plans — the collieries in Cape Breton Island, for example; co-operatives in Antigonish, N. S. or mining areas in Alberta; hospital-provided plans in a few cities; voluntary groups in some other cities; municipal hospital plans as in Alberta; non-profit group plans offered to companies and operated

³³ Canadian Medical Association, "The Canadian Medical Association and Health Insurance; A Submission to the Special Committee on Social Security of the House of Commons," *CJPH*, vol. 34, no. 7 (July, 1943), pp. 301-2. As a point of comparison, the average weekly wage for industrial workers in Canada in 1940 was \$24.94, in 1945, \$32.04. A week's hospitalization at \$3.00 per day (1943 rate) would eat up most if not all of a worker's weekly wage. For wage figures, see Yves Vaillancourt, *L'Évolution des Politiques Sociales au Québec, 1940-1960* (Montreal: Les Presses de l'Université de Montréal, 1988), Tableau 5, p. 60.

by medical associations in some provinces; and independent group hospitalization plans operating in several towns in British Columbia. The author of the report also mentioned that the Ontario Hospital Association had set up a committee on hospital insurance, with the intention to launch their plan in February 1941. This was probably the first Blue Cross-type plan in Canada.³⁴ It should be noted that, in commenting on the situation in British Columbia, the author of the report remarked that an official of the B.C. Health Insurance Commission stated in 1938 that "the plans now in existence, with one exception, are not paying their way. In answer to this, the Secretary of more than one plan has said that even where the plan loses money, the hospital still does not lose as much money as if they had no plan."³⁵

In the absence of any broad insurance programme or adequate government funding, hospitals were faced with the problem of attempting to cover the costs they incurred for treating indigent patients with available revenues: some from government, some from private patients. The 1939 "Report of the Committee on Hospital Finance" of the Canadian Hospital Council noted that the average annual number of indigent days in hospital was over 6,500,000, with the cost calculated to be around \$2.75 per patient day. As a result,

we, in an average year, give nearly \$18,000,000.00 worth of service to those patients placed in the category of indigents. By this we do not wish to infer that this is our contribution, for we find that grants from all sources offset this gross expenditure by approximately \$13,000,000.00,

³⁴ NAC, RG 29, vol. 1063, file 502-1-1, pt. 7, "Health Insurance and Group Hospitalization in Canada," January, 1941.

³⁵ *Ibid.*, p. 7.

so our net contribution is in the neighbourhood of \$5,000,000.00 per year.³⁶

After discussing provincial and municipal variations in subsidies, the "Report" noted,

the problem with which we are concerned at this point is that the total contributions from all sources are not sufficient to allow the hospitals to treat their indigent poor without penalizing the sick who are trying to pay their way.³⁷

The general experience of hospitals in the first decades of the twentieth century was that of scrambling to find funding from various sources. They were remarkably successful in their quest, managing to solicit regular funding from government, and in particular developing a paying clientele. Yet, as Table 1 indicates for the year 1932, revenues did not cover costs, and hospitals were confronted with deficits.

³⁶ "Report of the Committee on Hospital Finance," The Canadian Hospital Council *Bulletin* No. 34 (1939), p. 3.

³⁷ *Ibid.*, p. 4.

Table 1			
Hospital Receipts and Expenditures, 1932			
Receipts, 1932/General Public Hospitals			
	Receipts from paying patients \$	Total maintenance receipts \$	Total receipts \$
Quebec: 54 hospitals	2,470,340	5,837,321	7,936,320
Ontario: 107 /108 hospitals	5,074,784	8,969,783	9,660,620
Canada: 441/ 446 hospitals	12,785,518	25,242,249	28,588,255
DBS, <i>First Annual Report of Hospitals in Canada for the Year 1932</i> , Tables 25, 26, 27, pp. 49-54.			
Total Expenditures, 1932/General Hospitals			
Quebec: 52 hospitals	8,989,188		
Ontario: 108 hospitals	10,444,275		
Canada: 446 hospitals	31,023,771		
DBS, <i>First Annual Report of Hospitals in Canada for the Year 1932</i> , Table 29, pp. 57-58.			

The hospital sector, of course, was not the only part of the health-care system to encounter problems of provision in these years. The general problems encountered in the sector were amply discussed in the 1941 *Report of the Royal Commission on Dominion-Provincial Relations*. Among its conclusions were comments and recommendations on health care provision across Canada. While acknowledging the constitutional division of jurisdiction over health care, and refusing to recommend jurisdictional changes, it noted that in the case of both municipalities and provinces

services could vary widely because of the relative wealth of different areas. The *Report* noted the divergence in provincial expenditure on health activities ranged from a 1936 *per capita* expenditure of \$3.28 in British Columbia to 76 cents in New Brunswick.

The *Report* stated:

The primary reason for these variations is the difference in the fiscal positions of the provinces. The result is however, that there are grave differences in health conditions, and notably in the death rate from such diseases as tuberculosis and from infant and maternal mortality.³⁸

The Commission recommended, however, that health care remain principally a provincial responsibility. While not endorsing the adoption of health insurance by the provinces, the Commission did argue that the reorganization of finances between the federal government and the provinces that it had proposed, "by improving the position of all provinces on current account, should make more possible than heretofore provincial expenditures on health insurance or other welfare measures."³⁹

Another aspect of financing was the shift of responsibility for costs between the various levels of government, particularly as they grappled with the growing financial problems in health care during the Depression. In 1913, the municipal share of government contributions for health and welfare was 53.9 per cent; the provinces' share was 28.7 per cent; the Dominion, 17.4 per cent. By 1940, the municipalities' share was reduced to only 22.3 per cent of the cost, while the provinces assumed 41.5 per cent

³⁸ *Report of the Royal Commission on Dominion-Provincial Relations, Book II, Recommendations*, (Ottawa: The Queen's Printer, 1941), pp. 32-33.

³⁹ *Ibid.*, p. 43.

and the Dominion 36.2 per cent.⁴⁰ This shift in financial responsibility reflected the growing inability, particularly during the Depression years, of the lower levels of government, especially the municipalities, to assume increasing health care costs.

These changes, coupled with the growing costs of treating patients, made it increasingly difficult for hospitals to secure the funds necessary to maintain and improve services. In their attempts to meet these growing demands, hospitals developed various strategies to achieve their aims, maintaining a steady stream of paying patients and ensuring sufficient funding from the various levels of government, particularly for indigents. Hospitals were also obliged to accept some level of government regulation in return for funding. However, at the same time, in tune with the liberal voluntarist tradition, they were uneasy with the possibility of growing government intervention in hospital affairs. Hospitals began to see the value in presenting a unified front on various issues, to develop solutions for problems of hospital financing, and in their solicitation for funds, particularly from government.

- **Hospital Organizations**

Individual hospital boards appealed to the local public and lobbied various levels of government for increased financing. But they also joined together into broader associations to formulate coherent strategies for influencing government and

⁴⁰ Cassidy, *op. cit.*, p. 9.

improving their situation. In Canada, there were two major associations, both with provincial or municipal branches, and both with ties to organizations in the U.S.

The Catholic Hospital Association of the United States and Canada was founded in the United States in 1915, presenting a coherent Catholic position on issues affecting hospitals. By the 1930s, a sentiment existed in the Canadian section that the organization neglected the specific needs of Canadian Catholic hospitals, and a divergence occurred on state intervention – Canadian Catholic hospitals not being quite as antagonistic to the idea as their American counterparts. As a result, in 1939, the Canadian Council of the Catholic Hospital Association (CCCHA) was set up.⁴¹ The organization continued, however, to maintain close ties with its sister organization in the U.S.

The Canadian Hospital Council (CHC – later the Canadian Hospital Association), a lay organization, was formed in 1931 in an amalgamation of various lay and Catholic provincial and regional organizations.⁴² Like its Catholic counterpart, the CHC was closely linked to its sister organization, the American Hospital Association.

Quebec was the only province which did not have a provincial association. Instead it had two organizations, the Catholic Hospital Association of the Province of Quebec and the Montreal Hospital Council (MHC), a lay English and French (Catholic, Protestant and Jewish) hospital organization set up in 1926 to deal with

⁴¹ Agnew, *op. cit.*, pp. 74-76.

⁴² *Ibid.*, pp. 65-69. The Catholic hospitals could belong to both the Catholic Hospital Association and the Canadian Hospital Council and frequently did.

problems facing Montreal hospitals and to work towards the creation of a provincial organization. The MHC was very active in petitioning the provincial government for financial and legal improvements for Montreal hospitals. J.-H. Roy, Superintendent of St-Luc Hospital, became President of the MHC in the mid-1930s and remained in that position throughout the period under study. The MHC was active in the CHC.⁴³

Both national organizations — the CHC and the CCCHA — lobbied and negotiated separately and jointly on an ongoing basis with the federal and provincial governments on various issues affecting hospitals. During the crisis years of the Depression, increased state financial aid was actively sought, particularly as the number of indigent patients increased and the number of paying patients decreased. When the idea of state-funded health care insurance arose in government and among concerned groups during these years, the CHC followed the debate very closely, and made its point of view known to both the federal and provincial governments. In October of 1937, for example, Dr. Harvey Agnew, Secretary of the CHC, communicated to Albiny Paquette, Quebec Minister of Health, and to Quebec Premier Maurice Duplessis a resolution unanimously passed at the biennial session of the CHC. The resolution outlined concern that in the likelihood of “governmental control and socialization of health services,” those involved in the field participate in the formulation of policies, that “the possibility of various forms of voluntary insurance meeting the needs of the people, without recourse to state control, should be fully studied,” and that “any form

⁴³ MGH, Medical Board, Special Meeting, June 10, 1953.

of health insurance which would interfere with the autonomy of our voluntary institutions... or which would interfere with the future development or scientific objectives of such institutions, or which would destroy the spirit of freedom and charity or would place hospitals under political control, should be strongly opposed.”⁴⁴

In December of the same year, Agnew forwarded to presidents and secretaries of provincial hospital associations a draft of the brief to be submitted to the Royal Commission on Dominion-Provincial Relations (the Rowell-Sirois Commission). Significant in this draft was concern over the funding for hospitalization of indigents, the unemployed, “the incurable, the chronically ill or disabled and the aged.” While in the cover letter Agnew explained that consensus within the leadership of the organization was that the CHC “should avoid certain controversial points, for instance, too specific fixing of responsibility for indigent care as between the state and the individual,” in the draft brief the central theme was in fact an insistence on adequate government funding for those who could not pay.⁴⁵ The two major concerns expressed in these letters — adequate funding from the government for non-paying patients (the indigent and the medically indigent, that is the working poor), and

⁴⁴ ANQ E8/3, Ministère des Affaires sociales, Harvey Agnew to Maurice Duplessis, Oct. 19, 1937.

⁴⁵ ANQ E8/3, Agnew to Presidents and Secretaries of all Hospital Associations in Canada, December 15, 1937.

maintenance of independence of hospitals from government control (hence the search for viable alternatives to government funding for non-indigents) — would remain a central part of hospital board thinking during the whole period under discussion.

In fact, hospital boards had some justification for their concerns about government intervention. The various encounters that hospitals had previously had with government contracts — for Workers' Compensation (under provincial jurisdiction), with the Federal Department of Indian Affairs for aboriginal patients, with the federal government for sailors, and with the provincial and municipal governments for indigents, among others — tended to reinforce the ambivalence of board members about further government intervention. The 1939 "Report of the Committee on Hospital Finance" of the Canadian Hospital Council criticized many of these contracts as inadequate to cover costs.⁴⁶ Thus hospitals were caught in a conundrum: they needed further funding and the state was one important source, especially to cover costs of the indigent, but government often paid less than what the hospitals calculated to be necessary to cover costs. Through the next twenty years, hospitals and their associations would continue to lobby for an increased level of government funding, but at the same time attempt to avoid further government regulation by finding other sure sources of income in the private sector.

⁴⁶ "Report of the Committee on Hospital Finance," pp. 6-8.

- **Government Regulation**

Government funding for hospitals, whether adequate or not, inevitably led to further government control of the funded institutions. Mariana Valverde points out that the introduction of the 1874 Ontario Charities Aid Act, which instituted *per diem* payments in Ontario, also brought with it a higher level of government regulation of the funded charities. Hospitals were expected to keep standardized records and were regularly inspected.⁴⁷ The *per diem* grant was essential for this kind of extended regulation to work. Terry Boychuk notes that U.S. health care reformer S. S. Goldwater

...favoured public payments to private charities on a *per diem* basis because the system established a direct correspondence between public service and public subsidies, prevented fraud and waste, and promoted a politically unbiased standing for all hospitals receiving public payments. Goldwater believed that any private hospitals accepting subsidies should become "semi-public institutions," subject to inspection and audit. By contrast, lump-sum grants, the popular form of public subsidies to private hospitals in the U.S., attracted abuse from both hospitals and public authorities, serving to "check the spread of a really useful and desirable form of social cooperation by making it appear to the casual observer that the abuse of the system is inevitable, its proper control and regulation impossible."⁴⁸

In Quebec, though there were laws on the books providing for government inspection before Confederation and then again in 1869, enforcement does not seem to have been effective. Apparently inspection was carried out in insane asylums, but

⁴⁷ Mariana Valverde, "The Mixed Social Economy as a Canadian Tradition," *Studies in Political Economy*, 47 (Summer 1995), pp. 44-48.

⁴⁸ Terry Boychuk, "The Hospitals of Canada and the United States: From the Beginning to 1965" (Ph.D. diss., Princeton, 1994), pp. 77-78.

very little in hospitals.⁴⁹ There seems to have been more sustained effort on the part of hospital boards, at the Montreal General for instance, to carry out regular inspections themselves, in line with liberal concepts of self-regulation.⁵⁰ Because of Church resistance to what they considered undue intervention in their internal affairs, the inspection and regulation aspect of the 1921 Public Charities Act, which introduced the *per diem* structure to Quebec, seems to have been weak as compared to that of Ontario.⁵¹

As François Guérard has pointed out in his study of the St-Maurice region, however, government regulation did play a role, and grew over time.⁵² In fact, government records relating to St-Luc Hospital indicate inspection of the hospital on diverse occasions, starting in 1923 when the inspector made a favourable report on St-Luc, suggesting that the PCA give special aid to the hospital to help with its debt.⁵³ Inspections would also be carried out when an institution made a request to participate

⁴⁹ Quebec government *Sessional Papers* of the late nineteenth century include reports on prisons, but no reports on hospitals.

⁵⁰ In the case of the Montreal General Hospital, see, MacDermot, *op. cit.*, pp. 25, 27.

⁵¹ See Bernard Vigod, *Quebec Before Duplessis: The Political Career of Louis-Alexandre Taschereau* (Kingston: McGill-Queen's University Press, 1986), pp. 83-87; Antonin Dupont, "Louis-Alexandre Taschereau et la législation sociale au Québec," *Revue d'histoire de l'Amérique française*, vol. 26, no. 3 (December 1972), pp. 397-426.

⁵² François Guérard, "Les principaux intervenants dans l'évolution du système hospitalier en Mauricie 1889-1939," *Revue d'histoire de l'Amérique française*, Vol. 48, No. 3 (Winter 1995), pp. 385-395.

⁵³ ANQ, E8, S3, "Hôpitaux," file 10, 2, Hôpital St-Luc, 1922-1938, Report, Re: Inspection Hôpital St. Luc, from Dr. J. B. A. Quintal, Medical Inspector, to Dr. A. Lessard, Director, Public Charities Service, January 15, 1923.

in the PCA.⁵⁴ In addition, public institutions benefitting from the PCA were required to make reports to the government, supplying such information as the number of beds and number of patients treated.⁵⁵ Nonetheless, much was left in the hands of the individual institutions. Marc Renaud points out that in 1961, when the Quebec government inaugurated its hospitalization insurance plan, more than 80 per cent of hospitals, including some of the biggest institutions in Montreal, had no formal budget. Furthermore, hospitals were hostile to the standardizing norms of the Department of Health, in regard to floor space for beds or ratios of nurses per bed.⁵⁶

The main source of continuous inspection and verification of standards for hospitals, in fact, seems to have come more from independent professional structures, like the American College of Surgeons, which set standards and inspected a hospital if it wished to adhere to the College' standards, or the Quebec Association of Registered Nurses, which inspected the nursing schools and working and living conditions of nurses.⁵⁷ Overall, while the hospitals were certainly not left to their own devices, there were gaps in terms of control, both in terms of standards and budgeting.

⁵⁴ See ANQ, E8, S3, "Hôpitaux," file 10, 2, Hôpital St-Luc, 1922-1938, Letter from Dr. J. B. A. Quintal to Dr. Alphonse Lessard, Director of Public Charities Service, May 14, 1928. This very enthusiastic letter follows an inspection visit to St-Luc Hospital.

⁵⁵ Chambre des Communes, Comité spéciale de la sécurité sociale, *Assurance-santé: Rapport du Comité consultatif de l'Assurance-santé*, 1943, p. 416.

⁵⁶ Marc Renaud, "The Political Economy of the Quebec State Intervention in Health: Reform or Revolution?" (Ph.D. diss., University of Wisconsin, 1976), pp. 63-64.

⁵⁷ On the American College of Surgeons, see footnote 31 above; for inspection of nursing schools, see, Edouard Desjardins, Eileen C. Flanagan and Suzanne Giroux, *Heritage: History of the Nursing Profession in the Province of Quebec* (Montreal: The Association of Nurses of the Province of Quebec, 1971), pp. 65-72.

Quebec

In Quebec, until the twentieth century, most hospital care was left in the hands of the Catholic Church and in those of a few lay voluntary organizations. While lay voluntary hospitals were the norm in the English-speaking community especially, they could also be found in the French community in a handful of institutions, notably, Notre-Dame, Ste-Justine, and St-Luc, all lay Catholic hospitals in Montreal.⁵⁸ The search for funding was always a scramble. This situation, inherited from the nineteenth century, would carry on into the twentieth, and with increased industrialization and urbanization, would intensify, requiring more satisfying solutions.

• The Public Charities Act

In 1900, there were approximately 31 public (non-profit) hospitals in Quebec, including 12 in the Montreal region. Two-thirds were run by the Church, the others by lay groups.⁵⁹ This period saw the rapid urbanization of Quebec society, with people from the countryside moving into the city in search of work, often taking insecure, low-paying jobs with long hours in difficult conditions. By 1921, 51.8 per cent of

⁵⁸ A lay Catholic hospital is one that is not owned and run by a Catholic order, though both Notre-Dame and St-Justine both had religious orders involved in nursing. The hospitals were considered Catholic because of informal links with the Catholic Church and professional links with Catholic institutions such as the University of Montreal, and because the majority of the population served were Catholic and French-speaking.

⁵⁹ *Rapport de la Commission d'Enquête sur la Santé et le Bien-Etre Sociale* (Castonguay-Nepveu Commission), Annexe II, "L'Évolution des services de santé et des modes de distribution des soins au Québec," p. 22.

Quebec's population was urban.⁶⁰ The result for many of the new urbanites was poverty and unhealthy home environments, resulting in general poor health coupled with the inability to pay for medical services. Frequently, the individual sought out medical help only when the problem was serious enough to require hospitalization. The situation became acute in the recession that followed the First World War, when one-third of the 45,000 patients hospitalized in the province in 1919 were unable to pay for their hospitalization.⁶¹ The hospitals were unable to assume the costs this entailed, and requested aid from the provincial government.

The Public Charities Act (PCA) was the government response, and it remained the only ongoing provincial response to hospital costs until the advent of hospitalization insurance in 1961.⁶² It was one of a series of measures passed under the Taschereau government in the 1920s that dealt with health care. It should be noted that the other major measures, the new Public Health Act (1922) and the creation of a system of rural county health units (1926) signalled a period of greater state intervention in health issues, even if this was not as clearly the case with the PCA.⁶³ The focus of the PCA was financial aid to charitable institutions. It provided for

⁶⁰ Paul-André Linteau, René Durocher and Jean-Claude Robert, *Quebec: A History 1867-1929* (Toronto: James Lorimer & Co., Publishers, 1983), p. 356.

⁶¹ Pauline Godbout, "Etude de la législation sociale de la province de Québec, 1921-1939" (M.A., École de service social, Laval University, 1954), p. 6.

⁶² *Statutes of the Province of Quebec*, 11 George V, Chap. 79, 19 March 1921.

⁶³ See Gow, *Histoire de l'administration publique*, pp. 126-129. On the growing role of the state, see Georges Desrosiers, et al., *Vers un système de santé publique au Québec: Histoire des unités sanitaires de comté: 1926-1975* (Montreal: University of Montreal, 1991), pp. 20-25, p. 145; See also "Introduction" in Peter Keating and Othmar Keel, eds., *Santé et Société au Québec XIX^e au XX^e siècle* (Montreal: Boréal, 1995).

government financial assistance to private agencies caring for the indigent (hospitals, hospices, orphanages, sanatoriums, etc.). The law required the provincial and municipal governments each to cover one-third of the cost incurred by indigents treated or cared for in the institution. The institution itself would be required to provide the final one-third, an improvement over the total cost it had previously been obliged to assume. In the case of hospitals, the Act covered hospitalization, but not out-patient services or payments to attending physicians. The government could also pay for the building of certain immovables. The government set the *per diem* rates it would pay for each category of institution, and set certain minimum standards for acceptance into the programme, but otherwise, except for requesting occasional reports, it did not interfere with the running of the institutions, a stipulation demanded by the Catholic Church.⁶⁴

More control, however, was exerted on the process of defining who was eligible. The process was clearly a means test, a common requirement in residual welfare measures: the individual asking for admission as an indigent had to prove he or his family did not have the means to pay for hospitalization. This required a series of documents proving indigence before admission was granted: an application for admission made by a relative or other; a certificate signed by the mayor or councillor; a certificate from the *curé* (see Figure 2, p. ix); and a physician's certificate showing state

⁶⁴ Godbout, *op. cit.*, pp. 7-12.

of health.⁶⁵ The Act therefore did provide some financial relief for the institutions treating indigents, but it was a degrading process for those who qualified as indigents, and changed nothing for all other individuals requiring medical care.

Even at the beginning, however, there were complaints about the Public Charities Act from the institutions concerned, not due to the treatment of indigents, but because of the level of funding provided. In 1921, at the Act's very inception, Dr. A. K. Heywood, superintendent of the Montreal General Hospital, commented in the hospital's annual report:

The Provincial Government has decided, how or why remains to be seen, that our costs are \$2.01 per day. With that settled but not agreed upon, we will receive 67 cents from the City and 67 cents from the Provincial Government for each indigent patient residing for six months in this Province, or a total of \$1.34 in all. If we are to continue to function as a hospital, and not as a boarding house for the sick, your Board must be prepared to find an additional \$2.75 a day..." [total *per diem* cost for ward in 1921 calculated as \$4.09].⁶⁶

Interestingly, he pointed out a major reason why the PCA rate schedule might find more acceptance in Catholic hospitals:

It is true that our sister institutions the Catholic hospitals can be run at much less cost, due in large part to the amount of assistance they receive in free labors of their various orders, but in view of the fact for years, in fact for one hundred years, this hospital has treated as many Catholics as Protestants, and this without the assistance of the religious orders, does it

⁶⁵ *Statutes of the Province of Quebec*, 15 George V, Chap. 55, 3 April 1925. In fact, it would appear that patients were not often turned away for lack of documentation, but that municipalities or the local PCA investigators would later reject claims, leaving the hospitals to assume the costs.

⁶⁶ Quoted in MacDermot, *op. cit.*, p. 90.

not seem reasonable that cognizance should be taken of that in the allotting of grants.⁶⁷

Nonetheless, despite evident problems with the level of funding from the beginning, it would seem, according to the *Castonguay-Nepveu Report*, that the PCA was a factor in the opening of more hospitals. In the early years of the PCA, in 1925, there were 77 public hospitals in Quebec, 46 more than in 1900. In 1940, 15 years after application of the PCA, there were 109 in the province, an increase of 32.⁶⁸ The PCA also resulted in a significant shift in the allocation of government funds for health care. In 1921, before the passing of the PCA, the health care portion of provincial government expenditure was 5.15 per cent, with most going to psychiatric hospitals. In 1940 it was 6.41 per cent, with the PCA accounting for 53.16 per cent of the total health care budget, and psychiatric hospitals for 29.38 per cent.⁶⁹

While the PCA did provide more constant funding for hospitals this measure proved to be totally inadequate in dealing with the cataclysm of the Great Depression. The depression, throwing masses of people onto municipal relief rolls, had a negative effect on the people's health. This was true in two senses: the effect of unemployment on the health of the unemployed (in terms of stress, diet, surroundings and difficulty in seeking medical care when needed because of cost), and the overstretching of health care facilities open to the needy.

⁶⁷ *Ibid.*, pp. 90-91. At the end of 1922, the deficit at the Montreal General was even greater than in 1921. *Ibid.*

⁶⁸ Rivard, *et al.*, pp. 22-23.

⁶⁹ Gow, "Chronologie," p. 113, p. 118.

In 1938 Leonard Marsh of McGill University published findings of studies made by a group under his direction on the relationship of health to unemployment in Montreal during the depression years. While it was difficult to show precisely the effects of unemployment on health, the trend seemed clearly towards increased health problems for the unemployed and their families.⁷⁰

The Depression also caused serious problems for those who did fall seriously ill, as there was little recourse for the poor, short of being admitted to hospital as an indigent under the PCA. Marsh noted the lack in Montreal of medical relief. He stated that

... the unemployed have recourse to the free sections of hospitals and to the services of the Victorian Order of Nurses, the Red Cross, etc. But the very shortage of supply in relation to demand, apart altogether from administrative regulations, has limited this recourse only to the completely indigent or to extreme cases. Unemployed persons or their families, otherwise, have not been able to secure the services of a doctor except by throwing themselves on his charity. And no organized machinery has been available through which persons in need of care could be referred to appropriate agencies.⁷¹

As more and more people, unable to pay for private doctors, turned to hospital out-patient departments, the institutions themselves became overburdened, both in terms of numbers of patients and in terms of financial problems. This situation was exacerbated as sources of charity dried up and it became increasingly difficult to obtain the one-third of costs for which these institutions were responsible. The municipalities, themselves under severe stress during the Depression years, could not

⁷⁰ Leonard Marsh, *Health and Unemployment: Some Studies of their Relationship* (Toronto: Oxford University Press, 1938), p. xx.

⁷¹ *Ibid.*

afford their share either — often the provincial government advanced their share, expecting payment at a later date.⁷² During certain periods of the Depression, hospitals, while accepting indigents as in-patients, attempted to divert them from out-patient clinics — services not covered by the Public Charities Act.⁷³ As early as 1929 the Montreal General, for example, began to reject patients of the out-patient dispensary whom it deemed capable of paying a private physician.⁷⁴ Even when out-patient clinics did provide services to the indigent, the results were not necessarily uniform or fair. Wendell MacLeod, at the time a young doctor working with Norman Bethune's health group, noted that at the Royal Victoria Hospital clinics, the woman who determined the patient's ability to pay made her judgement on the basis of how the patient was dressed. "Of course some of us had to point out that in certain cultures, where doctors were highly respected, some of the patients from Europe would put on their very best dress to come. And they would have to pay 25 cents instead of being excused the registration fee."⁷⁵

As elsewhere in Canada, the funding of hospitals in Quebec proved inadequate in the best of times and woefully so in a period like the Depression. At the end of this period, with hospitals trying to recover from the devastation of the Depression, a provincial commission was established to look at the weaknesses of the PCA and suggest improvements.

⁷² Cassidy, *op. cit.*, p. 386; *Rapport de la Commission Provinciale d'Enquête sur les Hôpitaux* (Lessard Report) (Québec: 1943), p. 26.

⁷³ Albert LeSage, "A Propos de l'Assistance Publique," *L'Union Médicale du Canada*, vol. LXV, no. 3 (March 1936), p. 206; J.-E. Dubé, Albert LeSage, "Les Hôpitaux et les Médecins. Rapport au Conseil des Ministres de la Province de Québec," *L'Union Médicale du Canada*, vol. LXIV, no. 11 (Nov. 1935), p. 1184.

⁷⁴ MacDermot, *op. cit.*, p. 112.

⁷⁵ Dr. Wendell MacLeod, interview by author, June 1989.

- **The Lessard Report: A Strong Critique of the PCA**

The work of the PCA was eulogized by more than one public figure. In his *Report to the Rowell-Sirois Commission on social service legislation*, Esdras Minville underlined the ideological coherence of the Act with Quebec culture:

...the Public Charities Act has regard for private initiative in the matter of social welfare; it keeps in force all the provisions of the Civil Code with respect to obligations of persons in that matter, and does not at all affect the autonomy of the social institutions and organizations.⁷⁶

In 1941 the PCA was also praised by the head of the Public Charities division, Dr. Antonio Bossinotte:

Public assistance, through numerous subventions, gave rise to hospitals throughout the province, contributed to the modern equipment of these institutions, founded special hospitals for convalescents, the chronically ill and the incurable, multiplied sanatoria, modernized our crèches, orphanages and hostels, allowed numerous social organizations, charitable societies, school milk donors, maternal assistance institutions, child health federations, benevolent works of all sorts, to be born, to grow, to prosper and, better still, to house, aid, educate, to save. All this is not without influence on health in the province.

... Inquire among hundreds of thousands of the formerly sick hospital patients, repaired, remade, retouched, reanimated, resurrected thanks to public assistance, if their return to their homes did not contribute to the preservation of human capital, to the flowering of the family, which Lacordaire calls the most admirable of governments.⁷⁷

⁷⁶ Esdras Minville, *Labour Legislation and Social Services in the Province of Quebec*, Report prepared for the Royal Commission on Dominion-Provincial Relations (Ottawa, 1939), p. 56.

⁷⁷ Speech to the Canadian Public Health Association: Thirtieth Annual Convention, June 1941. Quoted in "History of health services," *Report of the Commission of Inquiry on Health and Social Welfare* (Castonguay-Nepveu Report), Part Two, Vol. IV, *Health*, Tome I, *The Present Situation* (Quebec, 1970), pp. 20-21.

However, despite these glowing words, the PCA had been shown to have serious flaws. As part of the reformist programme begun by Liberal Premier Adélard Godbout, a commission was set up in 1942 to investigate complaints by Montreal hospitals that the rates paid by PCA, unchanged since 1929, were inadequate and causing serious financial problems for the hospitals, as well as complaints by hospital workers over working conditions and low wages.⁷⁸ The commission, the "Commission Provinciale d'Enquête sur les Hôpitaux," under the direction of Dr. Arthur Lessard, head of the Montreal PCA administration, was to investigate both the economic situation of institutions operating under the PCA and the working conditions in these institutions, and make recommendations to resolve the hospitals' economic problems and to improve the working conditions of the employees. Its mandate was to find ways to improve the actual system, the PCA. It rendered its report on the economic situation of the hospitals in 1943, and its criticisms of the PCA were severe and wide-ranging.

One of the first criticisms made of the Act was of the process of establishing need — that is of ensuring that those who benefited were truly "indigent." The report outlined the various bureaucratic procedures the applicant had to follow. Problems underlined were the lack of sufficient number of inspectors to verify indigent status in Montreal, and delays in hospitalization. The Commission called the process humiliating for the patient and inefficient.⁷⁹

⁷⁸ Vaillancourt, *op. cit.*, p. 172.

⁷⁹ Lessard, *Rapport*, p. 15.

The Commission also had criticisms of the structure and operation of the Act. It noted that the Act allocated state funding for institutions which met qualifications, but did not allow for any state control over the administration of the institutions.⁸⁰ On the other hand, the institutions which met qualifications, while in no way controlled by the government, became more and more dependent on government financing as sources of funds from charity diminished. Organizations such as Federated Charities, which did not include the hospitals, were taking centre stage in fund-raising, leaving organizations like the hospitals out in the cold.⁸¹

Continuing on the negative effects on the institutions themselves, the Commission noted that though hospitals were funded for those patients acknowledged by the government as "indigent," they had to assume total costs for those not accorded indigent status but unable to pay, or for delays in verification of indigent status. Other problems outlined were the lack of funds to develop new out-patient clinics, and in general, the lack of provision for services given in out-patient clinics, services, the *Report* noted, that would reduce the time spent in hospital for many patients. On this question, the report noted that there was no control, under the Act, on the length of hospitalization.⁸² Doctors tended to keep their patients in hospital where they were sure to receive a necessary level of attention and surveillance, rather

⁸⁰ *Ibid.*, p. 10.

⁸¹ *Ibid.*, p. 22.

⁸² *Ibid.*

than to release them to uncertain conditions at home and unsure access to medical help in out-patient facilities.

La Commission, au cours de l'audition de témoins, a constaté que la proportion des malades dirigés vers l'hôpital augmente de plus en plus; on traite de moins en moins le malade à domicile, soit en raison de difficultés inévitables, alors que l'hôpital offre un service de premier ordre, soit à cause d'un manque d'intérêt de la part des membres de la famille, soit en raison du désir du médecin traitant de voir son patient sous la garde de personnes compétentes et expérimentées, soit enfin l'augmentation des populations urbaines. Les faits révèlent une tendance inconnue, il y a vingt ans, à recourir de plus en plus à l'hospitalisation; d'où congestion des institutions.⁸³

The Commission further remarked that doctors of the Commission des accidents de travail (Workman's Compensation Board) insisted in their brief that payment of a fee to community doctors treating indigents at home would lead to a reduction of indigents hospitalized.⁸⁴

The fact that the length of stay in Quebec was longer than anywhere else in Canada would appear to support this criticism. In 1939 the average stay in hospital in Quebec was 18 days, while in Ontario it was 13.3 days.⁸⁵

⁸³ *Ibid.*, p. 16.

⁸⁴ *Ibid.*

⁸⁵ *Ibid.*, p. 28. It is important to note, however, that in Ontario as well, indigent patients stayed longer in hospital than paying patients. Hardisty Sellars, medical statistician for the Ontario Department of Health, in an article on Ontario hospitals, remarked on the long duration of stay by indigents in that province's hospitals, when compared to paying patients. While they made up 26.4 per cent of all patients, they used up 40.5 per cent of patient days. This could mean one of two things: many paying patients would want to leave as quickly as possible in order to avoid heavy costs; in the case of indigent patients, their general condition could be poor, and their doctors might want to keep them in a healthy, supervised environment to ensure a return to health. See A. Hardisty Sellars, "Highlights on Hospitalization in Ontario," *Canadian Journal of Public Health*, vol. 31, no. 12 (December 1940), p. 603.

However, another statistic, the total occupancy rate of beds in Quebec hospitals, showed a lower rate than elsewhere (76.7 per cent in larger hospitals, compared to Saskatchewan, the highest, at 83 per cent).⁸⁶ In fact, according to statistics from 1933 to 1958, Quebec was consistently the province with the lowest rate of hospital admissions (admissions calculated as percentage of population).⁸⁷ Beds were being filled at a lower rate than in other provinces, yet those filled held the same patients longer. The implication was thus that fewer patients were being hospitalized. This surely was not because the people of Quebec were healthier than elsewhere in Canada. It would appear rather that many who did not qualify under the PCA, but could not afford to pay for hospitalization, simply avoided going to hospital. This highlights another criticism made to the Lessard Commission, the fact that it was often the very people who actually paid the restaurant or amusement taxes collected to cover the costs of the PCA who could not themselves pay for hospitalization or for various services offered by the hospital (all services — operating room, x-ray, diagnostic tests, etc.— were charged separately from the room rate), yet were not poor enough to qualify as indigent under the Act:

si l'assisté a gratuitement à sa disposition tous les services techniques de l'institution, le contribuable non-indigent doit rémunérer l'hôpital pour chacun de ces services, au cas où il en a besoin. C'est dire que dans

⁸⁶ "Interesting New Statistics on Canadian Hospitals," *The Canadian Hospital*, vol. 15, no. 5 (May 1938), p. 30.

⁸⁷ ANQ, E168/1, Ministère des Affaires sociales, *Commission d'Enquête sur l'assurance-hospitalisation* (1960), "Statistiques sur les hôpitaux 1933 à 1960"; "Admissions dans les hôpitaux publics en rapport avec la population." The rate of admissions in Quebec in 1936 was 4.5 per cent as opposed to 6.2 per cent in Ontario and 6.3 per cent for Canada; in 1940 it was 5.3 per cent in Quebec, 7.3 per cent in Ontario and 7.4 per cent in Canada.

certains cas, des malades en chambre privée ou ceux à moyens limités en salle publique peuvent hésiter, pour des raisons d'ordre financier, à utiliser des services qui sont fournis gratuitement aux assistés.⁸⁸

To drive the point home further, on discussing the problems of doctors, the report noted that there was no financial compensation for the treating doctor in the hospital, who therefore had to recoup somewhere else, that is in private practice, and that patients of modest means avoided going to doctors until they were seriously ill, and often needed hospitalization. Under another system, without the fear of cost, the patient could have been effectively treated at home. The Commission concluded on this point:

Le médecin, d'après le système actuel peut difficilement s'occuper de médecine préventive dans les classes pauvres; encore un domaine pratiquement inexploré chez-nous et où des interventions s'avèrent nécessaires.⁸⁹

Finally, on the financial situation, the Commission, having already underlined the problems of the institutions in funding their third of the costs, the inefficiency of the PCA resulting in prolonged hospitalization for some and inadequate care for those who did not qualify, and the lack of means to improve services in the hospitals, also noted that the municipalities were unable to assume their part of the costs of the PCA and the provincial government was often obliged to advance the municipalities' share. Often the poor municipalities with the smallest tax base had the greatest number of indigents, and thus the highest costs, while the richer municipalities had few indigents,

⁸⁸ Lessard, *op. cit.*, p. 21.

⁸⁹ *Ibid.*, p. 25.

and thus lower costs. One result of this structural problem was the fact that the application of criteria for qualification for status as indigent, decided by the municipality, was unequally applied: the rules were very strict in some cases and lax in others. The overall result was a large debt to the provincial government. In December 1942, the municipalities owed the provincial government over two million dollars.⁹⁰ As for the hospitals, a financial report to the Commission underlined the indebtedness of hospitals and showed how an increase in the PCA rate of \$1.00/patient would solve much of this indebtedness.⁹¹ This was not mentioned in the final report, perhaps because the Commission rejected the PCA as unworkable and suggested that the government investigate establishing a form of universal medical insurance.

The Commission did highlight the problems faced by Quebec hospitals. An examination of two Montreal voluntary hospitals, the well-endowed Montreal General Hospital and the less financially secure St-Luc Hospital, will illustrate the basic weaknesses of hospital financing in Quebec.

Two Montreal Hospitals

- **The Montreal General Hospital and Hôpital St-Luc**

The two hospitals under consideration here, the Montreal General Hospital and l'Hôpital St-Luc, were both run by lay boards, both set up initially to serve the

⁹⁰ *Ibid.*, pp. 26-27.

⁹¹ Leo Gervais, "Etude sur la situation financière des institutions reconnues d'assistance publique." Report commissioned for the Lessard Commission (Quebec, 1942), p. 34.

populations of working-class neighbourhoods in south-east Montreal (in fact a few blocks from each other), and both had a large local clientele, serviced in public wards and in the large out-patient departments. By the period under consideration, both were linked with universities. The General, however had substantial resources to draw upon, due to its links to the anglophone elite of the city, while St-Luc had fewer resources in the community.

The Montreal General Hospital is the oldest English voluntary hospital in the city, founded in 1819 by English Protestant businessmen on the grounds of the House of Recovery, an institution opened in 1817 by the Female Benevolent Society. It was incorporated in 1823.⁹² Starting with 24 beds in 1819, the hospital moved into a new building in 1822, built for £6000 (collected through public subscription) on land donated by J. Richardson, W. McGillivray and S. Gerrard. The hospital now had 72 beds. In subsequent years, the hospital underwent several expansions. In 1875 the Montreal General Hospital Western Division, with a capacity of 100 beds, was opened on Dorchester Street at Essex. In 1890 the Montreal General opened its nursing school, one of the first in Canada, and has been acknowledged as a leader in nursing

⁹² Goulet, *et al.*, *op. cit.*, p. 69. There was a strong tradition in the Quebec anglophone community of support for institutions like hospitals. See for example, the foundation of the Royal Victoria Hospital by railway financiers George Stephen and Donald Smith, and the foundation of the Sherbrooke General Hospital with the help of Richard William Heneker of the British American Land Company. See Sclater Lewis, *op. cit.*, for the Royal Victoria Hospital, and Bernard Epps, *Le Second Bienfait: Cents ans d'Histoire du Sherbrooke Hospital 1888-1988* (Sherbrooke: Centre Hospitalier de Sherbrooke, 1988), for the Sherbrooke Hospital.

education. The hospital is also a medical teaching hospital affiliated with McGill University (teaching began in 1823). In 1921, the Western Hospital (Atwater) was annexed to the Montreal General.

The hospital has benefited over the years from substantial support from the English elite and people of the province through legacies left it and through active involvement in the running of the hospital itself. Prominent Montrealers John Molson, John Richardson, William McGillivray, Samuel Gerard, John Forsyth, John Molson the younger, Thomas Molson, William Molson and Thomas McCord were among the first governors of the institution.⁹³ Three Molsons, two Redpaths, David Morrice, and Sir H. Montague Allan served as presidents of the Board of Management of the Hospital. Col. Herbert Molson, president from 1922 to 1938, left the hospital a bequest of \$250,000.00 on his death.⁹⁴

The hospital did receive block grants from the provincial government in the nineteenth century. Like other hospitals seeking a stable revenue, the General was concerned with providing private beds. The edifice built in 1881 had private beds, and after several years of planning, the hospital was able to open a private pavilion in 1913. In the 1940s, it had over 600 beds, of which approximately 400 were ward beds, 150 private, and 50 semi-private. Approximately 60 per cent of patient days in the public

⁹³ MacDermot, *op. cit.*, p. 11.

⁹⁴ MA, RG 96, MGH, AR 1938.

wards in 1938 were covered by the PCA. The other 40 per cent were paid only in part, if at all.⁹⁵

Operating expenditures at the beginning of the period under consideration were over one million dollars, as were revenues from patients. Other sources of income, including contributions and interest from investments were about \$250,000 annually, a substantial amount for a voluntary hospital. Nonetheless, the hospital usually ran a deficit, generally under \$50,000 annually, even after revenues from investments and governors' fees were used to reduce the operational deficit. Its endowment and other special funds were valued at close to \$5 million.⁹⁶

St. Luc was always a lay Catholic hospital – neither founded nor run by the Catholic Church, even though it had close ties with the parish and other local clergy.⁹⁷ It began as a dispensary (out-patient clinic) for children in 1908, situated in a poor section of downtown Montreal, near the corner of St-Denis and Dorchester streets, and had since maintained that it had a special role in the succour of the poor of the city. By the 1920s it was a hospital with 89 beds.⁹⁸ The nursing school was opened in 1928. In 1935, the hospital again expanded, despite the Depression, to a capacity of 421 beds

⁹⁵ MA, MGH, Report of the General Superintendent, AR, 1938.

⁹⁶ MA, MGH, *Annual Reports*, 1932-1945. In tables relating to the finances of the two hospitals, figures will be given in constant dollars with 1940=100. Deficits will be given in current dollars as well. In the text, figures will be given in current dollars even though this may be less accurate because it better reflects the psychological effect on administrators trying to deal with revenues, costs and deficits on a yearly basis.

⁹⁷ Usually a clergyman was elected Honorary President. See for example, HSL, Procès-verbal de l'assemblée des membres à vie, le 12 mai 1942.

⁹⁸ H. Lucie Lord, *75 ans... et combien d'histoires!* (Montreal: Hôpital St-Luc, 1984) pp.7-12.

and was affiliated to the medical school at the Université de Montréal.⁹⁹ Clinical teaching began in the early 1940s.¹⁰⁰

St. Luc, as a lay hospital, did not have the resources of the Church to help support it (nurses at St-Luc, unlike the Church-run hospitals, and even some other lay Catholic hospitals, were lay, and thus salaried, for example), nor did it have a large endowment. In fact it seemed to receive only about \$1,000/year as donations. Nor did it have much income from private rooms — there were about 30 private rooms in the 1940s.¹⁰¹

The hospital was dependent on a financially astute administration with close ties to the provincial government. It chose its leaders well. Athanase David was Chair of the Board of Management (Conseil d'Administration) for much of the period under study here. He had been Provincial Secretary under the Liberal regimes of Gouin and Taschereau from 1919 to 1936.¹⁰² As part of his duties (there was no provincial Department of Health, health care coming under the jurisdiction of the Secretary) he had ushered through the Assembly a series of measures that helped modernize health care delivery in Quebec and introduced greater government participation in this domain. Notable among these measures were the introduction of a new Public Health Act in 1922, which created the Provincial Bureau of Health with expanded powers, and

⁹⁹ Lord, *op. cit.*, pp.16, 27, 20.

¹⁰⁰ HSL, Procès-verbal du Bureau de direction, le 24 juillet 1942.

¹⁰¹ Notre-Dame more closely paralleled the Montreal General. It was more able to raise funds in the community than St-Luc, and also had more private rooms. See Hudon, *op. cit.*

¹⁰² *Repertoire des parlementaires québécois* (Quebec: Bibliothèque de la Législature, 1980), pp. 154-155.

the creation in 1926 of the system of government-controlled rural county health units to serve the health needs of rural areas. It was also David who negotiated the compromise with the Catholic Church that resulted in the PCA.¹⁰³

David was a Liberal, a useful connection while the Liberals were in power. His successor as Chair in the early 1950s, when the Union Nationale was in power, was Edouard Asselin, Union Nationale member of the Legislative Council. Both David and Asselin had been practising lawyers, but Asselin was a businessman as well, active in the Chambers of Commerce of Shawinigan and Montreal and also on the boards of several companies, including Trans-Canada Pipelines Ltd., the Bank of Nova Scotia, Abitibi Power and Paper, Hollinger Consolidated, Labrador Mining and Exploration, and numerous others.¹⁰⁴ In the twenty years under study, the hospital adjusted to changing times, choosing its Chairs judiciously to reflect the prevailing political and economic winds.

The hospital did have fairly continuous support from the provincial government (usually fruitful visits on numerous occasions to Premier and Minister of Health for financial aid and loan guarantees for borrowing for big projects). A 1928 letter from Athanase David, the Provincial Secretary, to Dr. Alphonse Lessard, head of the Provincial Bureau of Health, gives an indication of the special place that St-Luc

¹⁰³ Gow, *Histoire de l'Administration publique*, pp. 126-129.

¹⁰⁴ *Repertoire*, p. 10.

occupied in health care. The letter discussed reasons for giving a gift of \$10,000 to the hospital for the purchase of scientific equipment.

Je suis allé visiter l'Hôpital ces jours derniers, et j'ai constaté de visu le splendide aménagement que l'on y a préparé pour les pauvres de la Ville. C'est un des hôpitaux, vous le savez, où nous avons le plus grand nombre de lits à notre disposition, et il m'est arrivé peut-être une dizaine de fois d'y faire entrer de pauvres indigents qui ne trouvaient place nulle part. C'est en considération de cet effort que font les autorités, pour pourvoir à l'hospitalisation des pauvres, que je vous prie de préparer l'ordre en conseil plus haut mentionné. Aussitôt le chèque signé par le trésorier, si vous voulez bien me le faire parvenir, je le remettrai au président de la Corporation.¹⁰⁵

Provincial government support was not enough. As a result, the hospital managed to obtain various contracts with the federal government (for sailors), steamship companies (accidents), and the City of Montreal (for vagabonds).¹⁰⁶ The City of Montreal also contributed funds to the hospital. In 1931, the city agreed to pay an annual subsidy of \$50,200 for twenty years for the hospital to build a new wing containing at least 123 beds. As part of the agreement, the hospital would allow the participation of a city councillor on the Board of Management.¹⁰⁷ Particularly important was the revenue from the provincial Public Charities Act, to which the hospital adhered in 1926.¹⁰⁸ This allowed the hospital to obtain other grants from Quebec to help pay interest on privately obtained loans for expansion. In keeping with its charity tradition, a

¹⁰⁵ ANQ, E8, S3, 10.2, "Hôpitaux du Québec," Hôpital St-Luc 1922-1938. A. David to Dr. A. Lessard, Director, Provincial Bureau of Health, July 12, 1928.

¹⁰⁶ Lord, *op. cit.*, pp. 10-11.

¹⁰⁷ HSL, Procès-verbal, Assemblée du Bureau de direction, le 13 février 1931.

¹⁰⁸ HSL, Procès-verbal, Assemblée du Bureau de direction, le 10 février 1926.

particularly high number of St-Luc's beds were Public Charity beds. Because of this, the hospital administration was acutely aware of both the positive and negative aspects of dependence on state funding. In addition, as of the mid-1930s, St-Luc was responsible for a municipal hospital for contagious diseases, the Pasteur Hospital, which received an overwhelming proportion of its revenues from the municipal government.

In addition to its political connections, the Board of Management had several francophone businessmen among its members, including Honoré Parent, head of the Chamber of Commerce in the 1950s and member of the Royal Commission of Inquiry on Constitutional Problems (the Tremblay Commission). Unlike the Montreal General, which seemed to rely on the English business community for its support, St-Luc tried to cover all bases, with French-speaking businessmen and politicians actively involved in its management. St. Luc was carrying a debt of over \$2.5 million by the 1940s for construction of a nurses' residence and expansion of the hospital in the early 1930s.

While there were significant differences between the two hospitals in terms of the funding base and the relation to the provincial government, both St-Luc and the Montreal General seem to have been very dynamic hospitals. Both were actively involved in local and national organizations, the Montreal Hospital Council (MHC) and the Canadian Hospital Council. In fact, St-Luc, with Roy as president of the MHC, could be seen to be more involved than the General. Both hospitals were very interested in scientific work; both hospitals established blood banks in the early 1940s. St-Luc attained an A classification from the American College of Surgeons, and was

very concerned to maintain it. The General, of course, as a leading teaching institution, had standing with the College as well.

Both the General and St-Luc, despite their very different financial bases, faced constant problems in securing adequate financing. These ongoing problems came to the fore during the difficult days of the Depression. They both chalked up deficits from the overloading of out-patient clinics with indigents in the 1930s. The General had 250,094 visits in 1933, down to 155,043 by 1943. St-Luc had 148,595 visits in 1934 (up from 100,055 in 1932), down to 86,893 in 1939.¹⁰⁹ Both hospitals tried various means to control out-patient visits, including more scrutiny of candidates for treatment. They also made repeated appeals to the government to include out-patient visits in PCA payments. Some relief did come for the out-patient departments in 1936, when the Unemployment Relief Commission of Montreal provided payment to family physicians for medical care of those on the unemployment relief list.¹¹⁰ Incidentally, St-Luc doctors were among those in seven Montreal hospitals who participated in a 1936 "strike" by doctors in out-patient clinics, when they refused to give free treatment to those judged able to pay for services — including the unemployed. This eased the pressure in the out-patient departments for the time. At St-Luc, it was estimated that this action resulted in a diminution by 52 per cent of activity in the out-patient

¹⁰⁹ MA, MGH, Statistics, AR, 1933, 1943; Hôpital St-Luc, Procès-verbaux, Assemblées annuelles des membres à vie, 1932, 1934, 1939.

¹¹⁰ Dr. L. Lamoureux, "Assistance Médicale aux Chômeurs," *L'Action Médicale*, vol. XI, no. 6 (June 1936), p. 774.

clinics.¹¹¹ However, even with some relief to the out-patient departments, the cost of treating indigents was still carried to a great extent by the hospitals. In 1938, for example, two years after the City of Montreal instituted payment for private doctors of the unemployed, total attendance at the out-patient department of the Montreal General stood at 217,675. Average cost per out-patient visit was \$1.01, and average revenue was 34 cents, leaving a loss per visit of 67 cents, or a total operating cost of the department of \$145,832.¹¹² It is clear why the hospitals and their organizations continued to lobby the different levels of government, particularly the province, for relief.

Other economic problems aggravated the situation in the hospitals during the Depression. St-Luc experienced a decline in private patients, a reduction of Commission d'accidents de travail payments (as the number of active workers declined) and an increase in indigent in-patients. At one point at least, in 1931, it had difficulty in getting payments from the city for PCA and city work accidents. In 1934, it was obliged to put on hold improvements in various departments, and put off opening of a radium (cancer treatment) clinic, the \$6000 needed being unobtainable at that time. The General faced a decline in governors' fees, these fees being one way of controlling the deficit. Finally, in 1937, with passage of a minimum wage law (*loi des salaires raisonnables*), both hospitals were looking at potential wage increases without any

¹¹¹ "A Propos de l'Assistance Publique," *L'Union Médicale du Canada*, vol. LVX, no. 3 (March 1936), p. 205.

¹¹² MA, MGH, Report of the General Superintendent, AR, 1938.

increase in revenues.¹¹³ By the outbreak of the Second World War, both hospitals, like most in the province, were in serious financial straits.

Conclusion

The liberal voluntary hospital, run by community leaders, and based on the ideal of community support for the needy and individual responsibility on the part of the rest of the population, was a cornerstone of the hospital system in Canada. However, the state was not absent from this domain. Limited state support, often for indigents, was present from very early on. Over time, the inadequacy of the formula of private financing, with some state help, led to demands for more state support, but without further state control.

In Quebec, the PCA on its own was equally inadequate to meet the needs of the hospital sector, but was even more ineffective as the cornerstone of the health care system as a whole. The combination of government funding and private control was not an unusual phenomenon in Canada or Quebec (the building of the CPR, or the funding of canal or road-building through private contractors, are classic examples). It was evidently, however, not the most equitable or organizationally and financially efficient way to run the hospital system.

The cataclysm of the Great Depression showed the weaknesses of the system as it stood. Hospitals across the country were facing serious financial problems, and despite

¹¹³ This law does not seem to have come into effect. Intense lobbying by the hospital organizations was certainly a factor to stop it. See ANQ E8/3, J.-H. Roy to Dr. Jean Grégoire, January 30, 1941.

significant expenditure, the population was not being served adequately. Hospitals accepted the indigent – those officially on relief – and had to find the funds to cover their costs, or run up deficits. The hospitals covered under the PCA in Quebec, hospitals like the Montreal General and St-Luc, found themselves more and more in debt. The patchwork system of funding for hospitals, made up of private donations, private payment and some government funding, varying by province and municipality across Canada, weaknesses underlined by the Rowell-Sirois Commission Report, resulted in inadequate resources to assure necessary services for the population.

In Quebec, Arthur Lessard, writing in the years immediately following the Depression, commented on the weakness of the system. He concentrated on the importance of the PCA as the government's main field of intervention in health care. The Act, because it excluded the government from any real control of the use of funds, and because it excluded the majority of the population from any benefits, distorted the system. From the hospitals' point of view, the system to that time had meant an inadequate level of funding. A significant segment of the population (those known today as the working poor and then referred to as the medically indigent), because they did not qualify under the PCA, had a very tenuous link to health care services. The system was in serious straits, and needed substantial reform.

Up to this point, the role of the federal government in hospital care had been very limited, leaving most activity to the provinces and municipalities. This would change significantly as Canada moved out of the Great Depression and into the Second World War.

Chapter III

THE WAR YEARS: HIGH HOPES AND LOST POSSIBILITIES

Canada's entry into the Second World War in 1939 would have major long-term implications for all Canadians, and this on many fronts. Suddenly, Canadians were shifted from concerns about the fragile recovery from the Great Depression to a situation of war alert. Through the 1930s the government had avoided intervening too strongly in the marketplace. Now, using the War Measures Act, the federal government expanded its powers and through temporary agreements with the provinces acquired new taxation powers. The government moved into new areas in order to direct the nation's energies to the war effort at home and on the battlefield. Few sectors of society or the economy escaped its reach, certainly not hospitals or health care.

Ottawa Examines Social Security

In a letter written in early 1940, apparently in response to questions about health insurance, Dr. J. J. Heagerty, federal Director of Public Health Services, made the following comments about payment for health care in Canada:

The trend... is towards group medical care and group hospitalization for people of moderate income and free medical care and hospitalization for indigents. The suggestion has not been brought forward that all medical institutions, including hospitals, should be under the control of the Government free of charge, nor does the suggestion appear to me to be a practical one.

I assume that by "government" you mean the Federal Government. If you will refer to the British North America Act, you will find that the general hospitals, charitable institutions, eleemosynary institutions and asylums are exclusively within the

jurisdiction of the Provinces and, therefore, the suggestion that all such institutions should come under the Government — and by Government I assume that you mean the Dominion Government — appears to be impractical. The Dominion Government might make a grant towards institutions of the nature described but the jurisdiction would of necessity be exclusively provincial in character. This very fact militates against centralization under the Federal Government.

Apart from the statutory objection above outlined, there are other very serious objections. A similar plan has been adopted in Russia but it is generally agreed by observers that the status of medical care, including hospitalization, in Russia is below that of other countries, although on paper it looks very good. It is a communistic idea in principle.¹

Heagerty implied that the federal government was not at that time considering any major adventure into any form of national health insurance scheme. In fact, in a memorandum to Dr. R. E. Wodehouse, Deputy Minister of Health and Pensions, in May of the same year, after a long discussion of the constitutional limitations on federal involvement and the inherent difficulties in application due regional differences, Heagerty concluded:

Neither Provincial Governments nor labour organizations have pressed upon the Dominion the desirability of the assumption by the Dominion of legislative responsibility. Those provinces which have enacted health insurance legislation are interested only in obtaining financial aid from the Dominion. It is neither desirable nor practicable for the Dominion to introduce a health insurance scheme.²

In December 1940, in another memorandum to Dr. Wodehouse, Heagerty again pointed out that hospitalization and medical care was a provincial

¹ NAC, RG 29, Department of National Health and Welfare, vol. 1063; file 502-1-1 pt. 6; J. J. Heagerty to Max J. Webster, March 8, 1940.

² NAC, RG 29; vol. 1063; file 502-1-1 pt. 6; J. J. Heagerty to R. E. Wodehouse, May 10, 1940.

jurisdiction, but, because of growing interest, health insurance would probably happen in the not too distant future. He went on to add, somewhat optimistically: "Meanwhile, voluntary health insurance associations and hospitalization groups are meeting the situation by providing medical attention and hospitalization to people of low income groups at a minimum cost."³ Several of the themes that would dominate the debate in the coming years — once the government did indeed decide to venture into these areas — were clearly enunciated in these letters: the constitutional constraints; the resistance to a state medicine (read communist) model coupled, nonetheless, with the hospitals' need for more government funding; the nurturing of private, co-operative (Blue Cross) group plans as an alternative to state intervention; and the question of whether or not these private solutions were an adequate solution for the people. All these themes would reappear in various forms throughout the debates on national health insurance.

Clearly, for the federal government, the single most important task at hand in these years was the conduct of the war. All other activities were to be subordinated to this task.⁴ However, political concerns rapidly made it expedient to devote a certain amount of energy to sketching out the parameters of post-war

³ NAC, RG 29; vol. 1063; file 502-1-1 pt. 6; J. J. Heagerty to Dr. R. E. Wodehouse, Dec. 2, 1940.

⁴ In fact, according to Dennis Guest, one effect of the war in the early years was the curtailment of spending on social services. The federal government's expenditures on health and welfare fell from \$154.1 million in 1939-40 to \$102.7 million in 1942-43. Many provinces and municipalities also curtailed public welfare spending. See Dennis Guest, *The Emergence of Social Security in Canada* (Vancouver: University of British Columbia Press, 1980), p. 105. Of course a high employment situation undoubtedly helped as a significant part of the expenditure was for indigents.

Canada. Central to this was the vision of the welfare state that was to be created. There is general agreement in the historical literature of this period on the elements involved. Canadians, rushing headlong into war after the pain and deprivation of the Depression, wanted something better once the war was over. This was clearly evident in the widespread support for social programmes such as health insurance. In 1944, a Gallup Poll showed that 80 per cent of the Canadian population supported a national government health insurance plan.⁵ This same period witnessed the growth of labour organizations and of the CCF, which also supported social welfare measures. (Health Insurance, for example, was part of the original CCF Manifesto.) Added to this, the elite feared a repetition of the kind of depressed economy that followed the First World War, and the widespread labour unrest that resulted. There were serious concerns that the private sector would be unable to bounce back after the war and carry Canada forward into a period of sustained economic growth. As a result, as Alvin Finkel points out in his article, "Paradise Postponed: A Re-examination of the Green Book Proposals of 1945," in the early years of the war at least, a part of the business elite, along with the Department of Finance and other sectors of the Federal government, saw in the new Keynesian theories of government spending — promoting programmes like public welfare in

⁵ Malcolm G. Taylor, *Health Insurance and Canadian Public Policy*, Second Edition (Kingston: McGill-Queen's University Press, 1987), p. 166.

order to boost the economy — as the way to avoid the problem.⁶ Finally, but importantly, was the shift in powers made possible by the War Measures Act, which allowed the federal government to take over, for the duration of the war, important sources of revenue from the provinces, specifically income tax, corporation tax and succession duties. The possibility that the federal government might keep these revenues after the war opened up the prospect of more national programmes such as health insurance.⁷ As a result, and thanks also to pressure from the Canadian people, the government elaborated a series of social welfare proposals including health insurance.

One individual seems to have played a central role in the initial push for post-war planning for social programmes. Ian Mackenzie, shifted from National Defence to the Department of Pensions and National Health in 1939 and named chairman of the Cabinet Committee on Demobilization and Rehabilitation, was, from the beginning of the war, concerned with questions of post-war

⁶ Alvin Finkel, "Paradise Postponed: A Re-examination of the Green Book Proposals of 1945," *Journal of the Canadian Historical Association*, New Series, vol. 4 (Ottawa, 1993). Doug Owrarn discusses the new attachment to Keynesianism in the higher levels of the civil service. See Doug Owrarn, *The Government Generation: Canadian intellectuals and the state 1900-1945* (Toronto: University of Toronto Press, 1986), chapters 10, 11.

⁷ Dennis Guest, *op. cit.*, pp. 104-141; Malcolm G. Taylor, *op. cit.*, pp. 4-10; Yves Vaillancourt, *L'Évolution des politiques sociales au Québec, 1940-1960* (Montreal: Les Presses de l'Université de Montréal, 1988), pp. 79-101; C. David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance 1911-1966* (Kingston: McGill-Queen's University Press, 1986), pp. 95-134; Antonia Maioni, "Explaining Differences in Welfare State Development: A Comparative Study of Health Insurance in Canada and the United States" (Ph.D. diss., Northwestern University, Evanston, Illinois, 1992), pp. 138-144; David Jay Bercuson, *True Patriot: The Life of Brooke Claxton 1898-1960* (Toronto: University of Toronto Press, 1993), pp. 113-126; Robert S. Bothwell, "The Health of the Common People," in J. English and J. O. Stubbs, eds., *Mackenzie King: Widening the Debate* (Toronto: MacMillan of Canada, 1978), pp. 191-216; J. L. Granatstein, *Canada's War: The Politics of the Mackenzie King Government, 1939-1945* (Toronto: University of Toronto Press, 1975), chapter 7.

reconstruction. Thus, in early 1941, he organized an informal committee to look at questions of reconstruction. In September 1941, the federal government, on Mackenzie's urging, established the Committee on Post-War Reconstruction under the leadership of McGill University Principal F. Cyril James.⁸ After the publication of Britain's Beveridge Report in 1942, the Committee undertook to produce a Canadian social security plan. Produced under the leadership of Leonard Marsh, the *Report on Social Security for Canada*, completed in March 1943, was a comprehensive plan for social security, including a health insurance plan.⁹

Parallel to this, after Mackenzie King had rejected Ian Mackenzie's 1939 suggestion that both unemployment and health insurance be introduced as war measures, in 1940 Mackenzie, on his own initiative, mandated J. J. Heagerty to complete a study on national health insurance. In a process that drew in provincial health officials and various "interest groups," ranging from medical personnel to business, labour and agriculture, Heagerty and his group studied the actual situation of health care in Canada and began to formulate a plan for national health insurance. In February 1942, the process was formalized when Ian Mackenzie obtained Cabinet approval to appoint an Inter-Departmental Advisory Committee on Health Insurance. This committee, headed by Dr. Heagerty, included among

⁸ Owram, *op. cit.*, pp. 279-281. According to Owram there were several reasons for Mackenzie's interest in social legislation, including his political origins in British Columbia where he had been exposed to the reform ideas present in the province, and his desire to prove to Mackenzie King his value as a Cabinet member after his demotion from National Defence.

⁹ Leonard C. Marsh, *Report on Social Security for Canada* (Toronto: University of Toronto Press, 1975).

others an economist, a legal adviser, members of the Dominion Bureau of Statistics and an actuary. Leonard Marsh was also on the committee. There was further extensive consultation of interested parties. Then, in December of 1942, the Committee produced a detailed report and draft federal and provincial bills for a national health insurance programme.

Certain principles enunciated indicated that the plan's intent was both broad and comprehensive. A first principle was that health insurance could be successful only if linked to a comprehensive preventive public health programme. Any health insurance programme would have to include the entire population and require compulsory contributions. To the greatest extent possible, it should be a national plan. The BNA Act prevented Parliament from adopting a single comprehensive national plan, and a constitutional amendment was not considered advisable. It was therefore proposed that the provinces would administer the schemes, for which the Dominion would make financial grants if the provincial plans conformed to a federally approved pattern.¹⁰

In early 1943, the Cabinet's Economic Advisory Committee examined the financial implications of the bill, underlining problems it envisaged given the level of financing required. The Committee suggested that the financial burden would be too great for the provinces. This was not encouraging news to a Cabinet that was

¹⁰ "Social Security Proposals Now Before Federal House," *TCH*, vol. 20, no. 4 (April 1943), p. 13.

already sceptical about expanding social welfare provisions.¹¹ Further study was suggested. As a result, the Cabinet created a House of Commons Special Committee on Social Security to further examine the bill.¹² Groups that had collaborated with the Advisory Committee in the elaboration of the bill now also presented briefs to the Special Committee, exposing their positions on the final bill.

What is striking, when examining this process, is the general consensus around the need for some form of state-financed programme. Of those groups which presented positions, most suggested changes reflecting their own concerns or interests. Nonetheless, most groups were generally favourable. The two labour federations, the Trades and Labour Congress and the Canadian Congress of Labour, both endorsed the plan, as did the Canadian Federation of Agriculture. Both the Canadian Congress of Labour and the Canadian Federation of Agriculture suggested that the most equitable way of financing the system would be through taxation, not through individually paid premiums.¹³ The Canadian Medical Association, which had worked closely with the Heagerty Committee, also endorsed

¹¹ Bothwell, *op. cit.*, p. 202-203.

¹² Taylor, *op. cit.*, pp. 16-20.

¹³ *Ibid.*, pp. 32-34.

the principle of health insurance. They had some differences with the Heagerty plan, but did not oppose it.¹⁴

Interestingly, the Canadian Life Insurance Officers' Association (CLIOA) also endorsed a national health insurance plan, though their brief endorsed financing by personal contributions without government subsidy, thus promoting the idea of personal responsibility for health and reducing potential government expenditure.¹⁵ The Association's endorsement of a government plan can be understood when it is remembered that insurance companies in Canada were not yet involved in any significant way in health insurance plans, and they were interested in the longevity, and thus the good health, of their life insurance clients.¹⁶

The Canadian Manufacturers' Association (CMA) did not take a position for or against the plan, either in the early stages or before the House Committee, though it was solicited on several occasions and apparently was studying the

¹⁴ "The Canadian Medical Association and Health Insurance: A Submission to the Special Committee on Social Security of the House of Commons by the Canadian Medical Association, April 6, 1943," *Canadian Journal of Public Health*, vol. 34, no. 7 (July 1943), p. 304; Naylor, *op. cit.*, pp. 107-115. The major point of difference was that the CMA desired an income ceiling for eligibility, leaving wealthier Canadians outside of the plan. The bill proposed to include all Canadians in the plan. See Naylor, *op. cit.*

¹⁵ Taylor, *op. cit.*, p. 31. See also "Firm Foundations First," by V. R. Smith, General Manager of the Confederation Life Association, *Canadian Journal of Public Health*, vol. 34, no. 10, October 1943, pp. 433-441, where Smith explains the Association's concerns about the viability of a plan under the then-existing division of powers and taxation revenues between the federal and provincial governments.

¹⁶ In fact, some insurance companies provided nursing services for their clients in order to maintain them in good health. See Denyse Baillargeon, "Les infirmières de la Métropolitaine au service des Montréalaises," in Évelyne Tardy et al., eds., *Les Bâtisseuses de la Cité: Actes du Colloque Les Bâtisseuses de la Cité dans le cadre de la Section d'études féministes du congrès de l'Acfas 1992* (Montreal: Acfas, Les Cahiers scientifiques, 79, 1993), pp. 107-120.

question. Heagerty did note that "from private information received it is understood that it may oppose" health insurance.¹⁷ It could, in fact, be assumed that this organization might have substantial misgivings about a national, government-organized scheme. When the Patullo government attempted, unsuccessfully, to bring in a provincial health insurance plan in British Columbia in the 1930s, for example, business, including the CMA, worked against it because of the one per cent payroll tax to be charged to business to help finance the plan. This, according to business interests, would render the province uncompetitive.¹⁸ The CMA journal *Industrial Canada* did not discuss the Heagerty proposals, but did on a regular basis run articles about Blue Cross plans, clearly a preferred alternative to state insurance.¹⁹ The closest the CMA came to taking a position was in the July 1944 issue of *Industrial Canada*. In "The President's Annual Review," F. P. L. Lane commented on the proposed plan:

As regards the proposed new system of health insurance, manufacturers are very much interested; many of the larger firms have instituted private health insurance schemes; and manufacturers generally are sympathetic to the idea of steps being taken to improve the health of the community at large by proper preventive and curative measures. The question in their minds, however, is whether the only national scheme put forward up to the present is not out of line in respect of cost with their experience in connection with their private schemes, and whether there is available anything approaching the hospital facilities or the number of doctors and nurses that would

¹⁷ Maioni, *op. cit.*, p. 148.

¹⁸ Martin Robin, *Pillars of Profit: The Company Province, 1934-72* (Toronto: McClelland and Stewart, 1973), p. 29.

¹⁹ See, for example, Frederick Bell, "Group Hospital Plans Benefit Canadian Industry," *Industrial Canada*, vol. XLIV, no. 7 (November 1943).

be required, if the proposed scheme were inaugurated in the near future.²⁰

It is interesting to note that by this time, Mackenzie King, prompted by members of the Department of Finance, was also voicing serious doubts about the cost of the proposed plan, and others were also pointing out that there would have to be a substantial increase in facilities and medical staff to meet the projected growth in demand for services.²¹

- **Canadian Hospital Council and Health Insurance**

The Canadian Hospital Council (CHC) had hesitations about more government control over hospitals, but it co-operated with the Heagerty Committee from the very first. When it was clear that the federal government was planning to make a study on the subject, the CHC Committee on Health Insurance "undertook the preparation of a series of general principles respecting general health insurance as it relates to hospitals."²² In May of 1942, the CHC met with representatives of the Advisory Committee on Health Insurance and presented their positions, which would remain essentially the same ones later presented to the Commons Special Committee.

²⁰ *Industrial Canada*, vol. XLV, no. 3 (July 1944), p. 105.

²¹ Finkel, op. cit., p. 125; Bothwell, op. cit., pp. 210-211. The CHC was very aware of the need for more hospital beds to meet increased needs under a national health insurance plan. Harvey Agnew discussed the need for more hospital accommodation in "Possible Effect of Health Insurance on Hospitals," *TCH*, vol. 21, no. 3 (March 1944), p. 81.

²² "Principles of Health Insurance Adopted by Canadian Hospital Council," *TCH*, vol. 19, no. 10 (October 1942), p. 23.

Among the principles enunciated, some reflected the hospitals' own concerns about their role and future in the programme. Key among these were concerns that the direction of the plan be kept strictly out of the political forum, with formal input from provincial hospital associations or the Canadian Hospital Council; that hospital organizations be represented on any general advisory council set up; that it would be the "public," that is municipally-owned or non-profit voluntary hospitals that would be eligible to receive insured patients, provided that they conformed to established standards of service; that the chronically ill and indigents be included in the plan; that the hospitals be remunerated to meet the actual cost of providing hospitalization with reasonable allowance for depreciation and expansion of essential facilities; and that those individuals not eligible for compulsory insurance (if there was an income limit) be encouraged to join provincial non-profit plans. In accordance with the general voluntarist approach of keeping those insured under such a plan conscious of their responsibilities, the CHC insisted that the plan be contributory, with payments coming from the insured, the employers and the government.²³

The concerns these positions revealed were based on hospitals' experience with government, and their fears of losing control of their institutions to state

²³ NAC, RG 29, vol. 1114, file 504-2-12, Pt. 1, "Proposed Outline of Principles of Health Insurance Relating to Hospital Participation," prepared by the Canadian Hospital Council, 1942; "Principles of Health Insurance Adopted by Canadian Hospital Council," *TCH*, vol. 19, no. 10 (October 1942), pp. 23-25; "Hospitals and Health Insurance; A Presentation to the Special Committee on Social Security of the House of Commons by the Canadian Hospital Council, April 1943," Canadian Hospital Council, *Bulletin* no. 43 (1943)

bureaucracies. Despite their need for more funding, the hospitals' experience with government funding for indigents, which was always inadequate, and in dealing with government bureaucracies, often a long, laborious process, led to their concerns about embarking on any programme which could possibly magnify their problems. In addition, the long voluntarist tradition of promoting the self-sufficiency of their clients – the patients – made them wary of government providing too much in the way of services to the people.

In their submission to the House Special Committee in 1943, the CHC stated that it was

generally in favour of the principle of health insurance. This is not necessarily the opinion of individual boards of trustees or Sisters' councils, nor of the governmental departments co-operating in the work of the Canadian Hospital Council. Nor does it imply approval of any particular plan.²⁴

However, the principles outlined coincided significantly with the government plan.

It is likely that hesitation came principally from the Catholic Hospital Council, member of the CHC, which had stronger hesitations in general about state

²⁴ Canadian Hospital Council, "Hospitals and Health Insurance," p. 10.

interference and was even more attached to the development of voluntary plans than the lay hospitals.²⁵

During this period, several articles on the importance of voluntary hospitals and the voluntary tradition appeared in *The Canadian Hospital*, indicating concerns about maintaining under a state insurance system the voluntary tradition and all it was deemed to stand for. These articles expressed an array of opinions, but common themes were concern that voluntary hospitals would be threatened by "stateism" and bureaucracy under a government system. Some of the most forceful arguments were presented by Judge N. R. MacArthur, Chairman of the Board of St. Rita's Hospital in Sydney, Nova Scotia. In an article entitled "Voluntary Hospitals Must Be Preserved," he focused on the close link between the voluntary hospital tradition and democracy.

There is to my mind, no community effort that inspires individual responsibility, individual initiative, exertion and diligence and — above all — a personal, sympathetic solicitude for the misfortunes of others, as does the establishment and maintenance of locally-owned and conducted hospitals...

²⁵ In a letter from Harvey Agnew, then Secretary of the Department of Hospital Service of the Canadian Medical Association, inviting Dr. Heagerty to speak at an Ontario Hospital Association meeting, Agnew suggested, "it will be possible for you to clear up many misunderstandings and many misinterpretations, particularly among the Sisters who cannot help but be disturbed in their minds because of the strongly antagonistic attitude taken by the Catholic Hospital Association towards the present social insurance proposals across the line." NAC, RG 29, vol. 1114, file 504-2-12, pt. 1, Dr. Harvey Agnew to Dr. J. J. Heagerty, July 27, 1942. On the Catholic Hospital Association position towards health insurance proposals, see, André Cellard and Gerald Peletier, *L'histoire de l'Association catholique canadienne de la santé* (Ottawa: Association catholique canadienne de la santé, 1990), particularly pp. 86-103.

It would seem that one by one those duties, responsibilities and services that kept our citizens in the earlier days interested in the community and its national life, are gradually but surely being swallowed up in the new philosophy of many; that the state must and should do for us the things that democracy has always urged we should do for ourselves.

... Unless our democratic institutions so function as to enable our people to furnish for themselves, through their own efforts and initiative, many of the social requirements of life without the aid of an over-abundance of state control, I fear for the future of a free people; our vaunted democracy will be but a shell, and our citizenship a mere right to live in one's country.²⁶

This apparent connection between institutions like voluntary hospitals and active democracy — a clear reference to the liberal *laissez-faire* ideology that gave birth to them — was a common thread running through the articles. The insistence on individual responsibility, which was concretized in the demand that individuals be required to contribute to any insurance scheme that was instituted, was a modern version of the principle of stewardship — it was the modern-day fight against pauperization.

While many articles expressed concern about the future role of voluntary hospitals under a state insurance scheme, some, including editorials, expressed belief that a reasonable compromise for the hospitals could be worked out. As one editorial stated in the early days of the Heagerty Committee:

²⁶ Judge N. R. MacArthur, "Voluntary Hospitals Must Be Preserved," *TCH*, vol. 20, no. 9 (September 1943), p. 20. See also: "Province Wide Plan of Hospital Care Insurance Approved for Nova Scotia and P.E.I.," *TCH*, vol. 18, no. 8 (August 1941), p. 23; "Changing Concept of Health Care," (Editorial), *TCH*, vol. 19, no. 5 (May 1942), p. 24; Rev. F. J. Brennan, "National Health Insurance and the Voluntary Hospitals," *TCH*, vol. 20, no. 1 (January 1943), pp. 16-17; Harvey Agnew, "Possible Effect of Health Insurance on Hospitals," *TCH*, vol. 21, no. 3 (March 1944), p. 43.

The majority opinion of the hospital field, as we sense it, is in favour of some sound form of health insurance. But we believe that this sentiment would melt like April snow if it became apparent that any such plan would jeopardize the future and welfare of our fine voluntary hospitals. There is no reason why voluntary and state effort cannot proceed hand in hand — but it will take planning.²⁷

A few years later, when the Heagerty plan was before the public, Owen Trainor, president of the Manitoba Hospital Association — of Scylla and Charybdis note — expressed sentiments along similar lines. He insisted that government participation in the hospital field did not sound the death knell of voluntary hospitals. Calling up the same liberal tradition of the institution, but from a more conciliatory perspective, and insisting that “the basic and essential principles of liberalism are, in no way, inconsistent with real social justice,” he went on to say:

I, for one, am not prepared to believe that it means anything of the kind. The genius of political liberalism is not dead. The traditions of service of the voluntary hospital and its record of achievement, often under adverse conditions will not pass into the limbo of forgotten things. Surely our institutions possess the requisite flexibility to allow of their integration into government plans for the common good without sacrifice of essential liberty.²⁸

By way of action, Trainor insisted that the voluntary hospital reject intransigence towards government, and in fact seek active partnership with governments to ensure that hospital concerns be given adequate consideration.²⁹ This was the stance taken by hospitals and their associations in the discussions on health insurance.

²⁷ “Principles of Health Insurance,” (Editorial), *TCH*, vol. 19, no. 10 (October 1942), p. 34.

²⁸ Owen C. Trainor, “The Voluntary Hospital in the Future,” *TCH*, vol. 22, no. 12 (December 1945), p. 26.

²⁹ *Ibid.*, p. 54.

Overall in the discussions around the Heagerty proposals, there was no total endorsement of the plan from any of the parties involved, but at this stage neither was there clear-cut opposition. Indeed co-operation seemed to be the dominant sentiment. However, as noted above, Mackenzie King began to have serious doubts about the possibility of assuming the cost of implementation, calculated at about \$250 million for a full programme.³⁰ He thus joined the many Cabinet members who had held reservations about the expenditures all along. Many in Cabinet felt that unemployment insurance and family allowances were sufficient in the way of social reform, especially since the economy at the end of the war did not appear to be heading into a downward spiral. Under these circumstances, the more conservative Keynesians were convinced that further economic pump-priming was unnecessary.³¹ And as Donald Swartz notes, Mitchell Sharp commented to him in an interview, "Business didn't want any more."³² Swartz argues that the 1945 *White Paper on Employment and Income*, aimed at reassuring the business community about government policy, focused on the role of the private sector in developing production and employment in the post-war period. There seemed to be no place

³⁰ Taylor, *op. cit.*, p. 53.

³¹ Finkel, *op. cit.*, pp. 125-128.

³² Donald Swartz, "The politics of reform: conflict and accommodation in Canadian health policy," Leo Panitch, ed., *The Canadian State: Political Economy and Political Power* (Toronto: University of Toronto Press, 1977), p. 322.

for the development of government health insurance within this approach.³³ It could be said that the government romance with the welfare state was over, and that health insurance was one of the casualties.

Finally, at the 1945-46 Dominion/Provincial Conference, Ontario and Quebec delivered the formal *coup de grâce* with their refusal to agree to make permanent the wartime taxation agreement, a pre-requisite of the national health insurance plan. This gave the federal government a rather elegant way out of its proposals, and the Heagerty plan was shelved. Hospitals and the Canadian people would have to look elsewhere for solutions to their problems.³⁴

Quebec: The Province Looks at Health Insurance

While questions of health insurance were very much on the agenda in Ottawa, this was less the case in the provinces. The Patullo government had attempted — and failed — to bring in health insurance in British Columbia in the late 1930s.³⁵ In the 1940s other provinces, such as Manitoba, expanded the range of services provided under government auspices. Only Saskatchewan, under the CCF, began to plan for the introduction of a provincial health insurance programme.³⁶

³³ *Ibid.*

³⁴ Bothwell, *op. cit.*, pp. 211-215.

³⁵ Allan Irving, "The Development of a Provincial Welfare State: British Columbia 1900-1939," in Allan Moscovitch and Jim Albert, eds., *The Benevolent State: The Growth of Welfare in Canada* (Toronto: Garamond Press, 1987).

³⁶ "Manitoba Health Plan Outlined by Minister," *TCH*, vol. 22, no. 2 (February 1945), p. 50; for Saskatchewan, see "The Sigerist Report: Health Services Recommendations to the Saskatchewan Government," *TCH*, vol. 21, no. 12 (December 1944), p. 28.

However, in Quebec events were leading the provincial government in similar directions.

In Quebec, 1940 brought a new government, as the Liberals under Adélard Godbout replaced Maurice Duplessis and the Union Nationale. The Liberals were elected on a reform platform. Though health care reform was not part of Godbout's platform, it soon became an issue for the new government. In 1941, after numerous representations to the provincial government by Montreal hospitals and their organizations about the inadequacy of Public Charities Act funding, and after complaints by hospital employees about working conditions, the Godbout government established a commission to examine these two questions.³⁷ The commission, known as the Commission provincial d'enquête sur les hôpitaux, was presided over by Arthur Lessard, head of Montreal Public Charities Act administration. Among the members were Lorne Gilday, Superintendent of the Western Division of the Montreal General Hospital, Sister Allard of the Catholic Hospital Association, and Catholic trade union leader Alfred Charpentier.

The mandate of the Commission was to suggest ways in which hospital revenues could be increased and expenditures decreased, and to recommend, if necessary, amendments to the Public Charities Act so as to improve its operation.³⁸

³⁷ See, for example, ANQ, E8/3, Ministère des Affaires sociales, Letters from J. H. Roy, President, Montreal Hospital Council, to Henri Groulx, Minister of Health, March 5, 1941, June 18, 1941.

³⁸ ANQ, E134-1, Commission provincial d'enquête sur les hôpitaux, Arrêté en Conseil, no 586, Québec, le 13 mars 1942. This was not the Order in Council setting up the Commission. That document, Arrêté ministériel no 2159, 1941, limited investigation to Montreal hospitals. The scope

The Commission's final report, however, took a very different approach. As noted in Chapter II, the *Report* was highly critical of the very premises of the Act, and proposed that it be replaced, under powers accorded to the province by the BNA Act, with "une législation posant les principes d'un système d'assurance-maladie généralisée, comportant un contribution tripartie de l'État, de l'employeur et de l'employé," including coverage for all family members of employees. The *Report* suggested the creation of a new commission to consult interested parties, prepare a plan, establish the ratio of contributions from the three groups cited, work out methods for collecting contributions from self-employed individuals, and recommend appropriate methods of payment of premiums for indigents.³⁹ The proposal was in fact, an outline for a universal provincial health care insurance plan, containing many of the elements present in the Heagerty proposals.

Following up on the proposals of the Lessard Commission, in 1943 Premier Godbout set up a second commission under the jurisdiction of the Minister of Health and Welfare, the Commission de l'assurance-maladie. The chair was Antonio Garneau, a Montreal lawyer. The Commission's mandate was quite broad, including the following:

It shall be the duty of the Commission, after consulting the interested bodies, to prepare a plan of universal health insurance, defining, in particular, the extent of the risks to be covered by such

of the Commission was expanded in 1942. See Yves Vaillancourt, *L'Évolution des politiques sociales au Québec 1940-1960* (Montréal: Les Presses de l'Université de Montréal, 1988), pp. 172-173.

³⁹ ANQ, E134-1, "Recommendations," *Rapport de la Commission provincial d'enquête sur les hôpitaux*, 1943, p. 33.

insurance, the nature of the benefits, the methods of hospitalisation and treatment in the home, the formation of administrative and consultative bodies, the rates at which employers and insured persons are to contribute, the method of collecting contributions and the responsibility for payment of premiums in case of indigence.

The Commission shall also provide for methods of furnishing medical aid to persons unable to benefit by the health insurance plan (such as visitors) and for the incorporation of the health insurance plan in a general plan of social security to include present and future measures.⁴⁰

However, before the Commission could start work on health insurance, it was given a new mandate: to study problems in crèches, and questions of child protection in general.⁴¹ That work was completed by April of 1944, and the commissioners then turned their attention to their original mandate. At the end of April, at the suggestion of the Premier, they accompanied the Canadian delegation to Philadelphia as observers to the International Labour Conference, organized by the International Labour Organization (ILO). There, questions of social security were to be discussed, including "le problème particulier de l'organisation des soins médicaux au moyen de l'assurance-maladie et par d'autres moyens." The Commissioners found the conference very useful, noting in particular a discussion sparked by Canadian trade union leader Percy Bengough on the question of how to implement policies and recommendations in federal states where the jurisdiction responsible for such measures was not the central

⁴⁰ *Statutes of the Province of Quebec*, 7 George VI, chap. 32, 23 June 1943.

⁴¹ ANQ, E8/878-880, Commission d'assurance-maladie de Québec, Procès-verbal de la première séance tenue à Québec, le 29 décembre, 1943.

state. This discussion was to be taken up by the ILO at a future date.⁴² After the conference, the Commissioners travelled to Washington to meet with Arthur Altmeyer, head of the US Social Security Board. As well, C. J. R. Coyle, technical advisor for the Commission, also met Dr. I. S. Falk, head of the Board's Bureau of Research and Statistics, to discuss "la question de la distribution du coût des soins médicaux et les méthodes de classification des hôpitaux subventionnés par l'état ou formant partie d'un système d'assurance-maladie."⁴³ The Commission was clearly turning to the task of planning a programme for Quebec.

Provincial elections intervened, however. Maurice Duplessis and the Union Nationale returned to power in August, 1944 and rapidly disbanded the Commission. The resignations of the Commissioners were accepted, to take effect on December 1, 1944.⁴⁴ Government-funded health insurance did not return to the Quebec agenda until after the defeat of the Union Nationale in 1960.

The sequence of events that began with Lessard's examination of the Public Charities Act and ended with the Garneau Commission was testimony to a process of reform begun in Quebec society in the Godbout years. It was one of many measures undertaken during this period that indicated a government approach that was, like that in Ottawa, more open to increased government intervention in areas

⁴² ANQ, E8/878-880, Procès-verbal d'une séance tenue à Montréal, le 23 juin, 1944.

⁴³ *Ibid.*

⁴⁴ ANQ, E8/878-880, Procès-verbal d'une séance tenue à Montréal, le 22 novembre, 1944.

of social policy.⁴⁵ For Quebec, it was a break with the *laissez-faire* policies of both the Duplessis government and the previous Taschereau Liberal government.⁴⁶

Duplessis' attitude to welfare spending has been disputed, though not his record. Both Gilles Bourque, *et al.*, and Richard Desrosiers would agree that Duplessis used his autonomist position and discourse to fend off federal plans for the development of the welfare state. Bourque, *et al.*, however, identify Duplessis as a *laissez-faire* liberal who was against state intervention in the social arena, while Desrosiers sees him as a conservative. Their common point is their agreement that he was ideologically opposed to expanding the welfare state.⁴⁷ Yves Vaillancourt, while essentially in agreement with Bourque and Desrosiers, does add some elements on the subject of health insurance. Vaillancourt points out that Duplessis' contention that health insurance was impossible, because of the shortage of doctors and hospital beds (the position he enunciated at the 1945-1946

⁴⁵ For a discussion of other reformist policies under Adélard Godbout, see Jean-Guy Genest, *Godbout* (Sillery: Les éditions du Septentrion, 1996).

⁴⁶ As both Bernard Vigod and Herbert Quinn point out, Louis-Alexandre Taschereau was essentially a *laissez-faire* liberal, interested in keeping the economic climate as favourable as possible for investors. This implied limiting, though not completely, social expenditure. For a sympathetic discussion of social policy under the Taschereau government, see Bernard L. Vigod, *Quebec Before Duplessis: The Political Career of Louis-Alexander Taschereau* (Kingston: McGill-Queen's University Press, 1986), pp. 81-89. A more critical approach is found in Herbert Quinn, *The Union Nationale: Quebec Nationalism from Duplessis to Lévesque*, Second edition (Toronto: University of Toronto Press, 1979), p. 32.

⁴⁷ Gilles Bourque, *et al.*, *La société libérale duplessiste 1944-1960* (Montreal: Les Presses de l'Université de Montréal, 1994), pp. 123-124; and "Entrevue avec Richard Desrosiers," Gilles Gougeon, *Histoire du nationalisme québécois: Entrevues avec sept spécialistes* (Montreal: VLB Éditeur, 1993), pp. 116-118.

Dominion/Provincial Conference), was in fact correct. Vaillancourt also agrees with Duplessis' contention that the federal government was attempting a power grab in areas of provincial jurisdiction. However, Vaillancourt also notes, along with Bourque and especially Desrosiers, that Duplessis, in rejecting the federal project, had no intention of replacing it with one of provincial construction.⁴⁸ This in fact is what happened. Duplessis did not act on the issue.

Arthur Lessard's mandate was to find ways of improving the PCA. Indeed, nothing indicated that the administrations of the Montreal General and St-Luc Hospitals expected anything other than more funding from the PCA. Their most radical demands were that government extend payment to out-patient services as well to as in-patients.⁴⁹ In fact Lessard went much further in proposing the replacement of the PCA, a means-tested charity programme, with a universal health insurance plan. This project, to be elaborated by the Garneau Commission, was, at least in its general approach, as broad as that developed on the federal level. Duplessis, with a much less sympathetic approach to state social welfare measures, was quick to end any movement in this direction.

⁴⁸ Vaillancourt, *op. cit.*, pp. 178-179.

⁴⁹ HSL, Rapport du Président, Procès-verbal de l'assemblée annuelle des Membres à vie, 28 mai 1943. The *Annual Reports* of the Montreal General do not even mention the Commission. Instead they repeat annually insistence that the provincial government subsidize the out-patient clinics. See, for example, MA, RG 96, MGH, Report of the Board of Management, AR, 1942, p. 6; General Superintendent's Report, AR, 1944, p. 15.

Hospitals and the War Effort

Although both federal and provincial governments were developing various plans for the post-war period, the daily conduct of the war remained the priority. As government, in carrying out its war effort, seemed to intervene in every aspect of life and business, the hospitals felt very acutely the strains of the war in every area, from shortages of foodstuffs and essential materials, to staffing problems, to the many government regulations aimed at facilitating the conduct of the war. They rose to the challenge, attempting to deliver the services required in a radically altered environment.

- **St-Luc and the Montreal General Confront the War-time Challenge**

Like most Canadian hospitals, St-Luc and the Montreal General emerged from the Depression in an extremely precarious financial situation, after years of dealing with the large number of indigents requiring care, the meagre assistance provided by governments (not to mention frequent delays in making the actual payments), and the difficulties so many “non-indigent” patients encountered in paying their bills.

In 1940, the Montreal General declared operating expenditures of \$1,129,313.29 and revenue from patients of \$882,007.93.⁵⁰ After deducting other

⁵⁰ Figures in the text are in current dollars to reflect the effect on those managers to deal with financing on a day-to-day basis. Figures in tables are in constant dollars or current dollars as indicated.

sources of revenue, including an annual \$25,000 grant from the province, and income from investments and legacies, the net deficit stood at \$44,208.18.⁵¹ In 1945, operating costs were \$1,565,223.39, revenue from patients \$1,314,187.36, and the net deficit stood at \$63,618.74.⁵² (See Table 2) Sources of income not coming from patient service, including contributions, interest from investments, and fees from governors and from medical students, remained stable at about \$250,000 annually during this period. The General was fortunate to have close to 150 private beds and 50 semi-private beds at this time, providing an ongoing source of income. Its endowment and other special funds, valued at close to \$4 million in 1940, were valued at close to \$5 million in 1945.⁵³

St-Luc was carrying a debt of over \$2.5 million in the 1940s resulting from expansion of the hospital in the early 1930s. It was guaranteed an annual grant from the province to aid in covering the cost of borrowing for a new nurses' residence to be built during the war years. In 1940 the hospital's total revenue stood at \$533,122.47 and total expenditures at \$585,777.94, leaving a deficit of \$52,655.47.⁵⁴ In 1945, revenues stood at \$833,000, while expenses were \$877,000, leaving a deficit

⁵¹ MA, MGH, Statement of Revenue and Expenditure for the Year Ended 31st December, 1940, AR, 1940.

⁵² MA, MGH, Statement of Revenue and Expenditure for the Year Ended 31st December 1945, AR, 1945.

⁵³ MA, MGH, ARs, 1940, 1945.

⁵⁴ HSL, Rapport du Surintendant et Trésorier Honoraire, Procès-verbal de la Réunion des membres à vie, le 16 mai 1941.

of \$44,000.⁵⁵ (See Table 3.) St-Luc had little income from private rooms: there were about 30 private rooms and 24 semi-private beds in the hospital in the 1940s. Other sources of income were meagre. In 1940, donations or fees from life members amounted to \$928.32.⁵⁶

Table 2 Montreal General Hospital: Revenue, Expenditures and Deficits 1940-1945 (in 1940 dollars)					
	Revenue	Expenditure	Gross Deficit*	Net Deficit**	Net Deficit (in current dollars)
1940	882,000	1,129,000	282,000	44,000	44,000
1941	854,000	1,155,000	318,000	88,000	93,000
1942	885,000	1,114,000	275,000	48,000	53,000
1943	981,000	1,188,000	262,000	39,000	44,000
1944	1,070,000	1,286,000	270,000	49,000	55,000
1945	1,155,000	1,375,000	266,000	56,000	64,000

Source: Montreal General Hospital, Statement of Revenue and Expenditures, Annual Reports, 1940-45

* Includes other expenditures: Interest and Bank Charges, Custodian's Fees, Appropriation to Bad Debts Reserve, Appropriation to Employees' Benefit Reserve.

** After deduction of fees, donations, endowments, grants, other revenues.

⁵⁵ HSL, Rapport du Trésorier, Procès-verbal de la Réunion des membres à vie, le 28 mai 1946.

⁵⁶ HSL, Rapport du Surintendant et Trésorier Honoraire, Procès-verbal de la Réunion des membres à vie, le 16 mai 1941.

Table 3 St-Luc Hospital: Revenue, Expenditures and Deficits 1940-1945 (in 1940 dollars)				
	Revenue	Expenditure	Deficit	Deficit (in current dollars)
1940	533,000	586,000	53,000	53,000
1941	540,000	592,000	50,000	53,000
1942	575,000	607,000	32,000	35,000
1943	654,000	670,000	17,000	19,000
1944	706,000	745,000	38,000	43,000
1945	732,000	766,000	34,000	39,000

Source: Hôpital St-Luc, Procès-verbaux des réunions des membres à vie 1940-45.

While both hospitals had significant numbers of indigent patients, a much larger proportion of St-Luc's clientele was indigent compared to the Montreal General's. In fact, in 1945 Athanase David, president of the Conseil d'Administration, claimed that St-Luc had the fewest private beds of any hospital in Montreal, and "St-Luc est l'Hôpital qui met à la disposition de l'A.P. [Assistance Publique — Public Charity] le plus grande nombre de lits."⁵⁷ Statistics are not available for 1940. In 1941, however, Public Charities Act patients accounted for 67.51 per cent of patient-days at St-Luc and 33.86 per cent at the Montreal General. In 1947, during the post-war boom, PCA patients accounted for 44.8 per cent of

⁵⁷ "8089 malades hospitalisés," *La Presse*, le 30 mai, 1945, p. 15.

patients at St-Luc and 58.4 per cent of patient-days, while they accounted for 19 per cent of patients at the Montreal General, and 28.4 per cent of patient-days.⁵⁸

- **Confronting a Radically Changed Environment**

One of most startling changes that came with the war was the growth of demand for certain kinds of hospital services. The problem was no longer finding paying patients, it was where to put them. Both hospitals were confronted with a shortage of private and particularly semi-private beds to meet the growing demand. Full employment was putting money into the pockets of Quebecers, and at the same time group hospital insurance was being introduced, providing coverage of semi-private and later ward accommodation in hospital.

The percentage of hospitalization, that is the percentage of beds occupied, was extremely high in both institutions: at St-Luc ranging from 93 per cent in 1940 to 96 per cent in 1945 and at the Montreal General ranging from 84.9 per cent in 1940 to 88 per cent in 1945.⁵⁹ This led to concerns that the institutions would be unable to cope in the case of any emergency situation in the city. At the same time,

⁵⁸ ANQ, E134-1, *Rapport de la Commission Provinciale d'Enquête sur les Hôpitaux*, 1943, Léo Gervais, "Étude sur la situation financière des institutions reconnues d'assistance publique," p. 31; "Hôpitaux Généraux; Résultat des opérations en 1941"; *Quatrième Rapport Annuel du Ministère de la Santé et du Bien-être Sociale*, 1947 (Quebec), "Statistiques des hôpitaux généraux d'assistance publique," pp. 119-120. The discrepancy between percentages of patients and patient-days is due to the fact that PCA patients were invariably hospitalized longer than paying patients because of worries about the suitability or availability of home care upon discharge. (This was one of the findings of the Lessard Commission.) In 1947, for example, PCA patients at the Montreal General stayed on average for 20.8 days, while the average for other patients was 14.3 days. At St-Luc, the respective stays were 23.2 and 17.8 days. *Ibid.*

⁵⁹ HSL, Procès-verbaux des Réunions des membres à vie, 1940-1945; MA, MGH, ARs 1940-1945.

the length of hospitalization decreased over the war years, particularly for ward patients. This was undoubtedly a concerted policy, particularly at St-Luc, where the situation was more critical because of the higher ratio of PCA patients, who were often kept longer in hospital. The decrease was also due in part to improved treatment. (See Table 4.) This of course implied that more patients could be treated in the same number of beds in a given time.

A problem not resolved, which led to long-term stays, was that of chronically ill patients, those who did not respond rapidly or at all to treatment. There was a general shortage of beds available for these patients in non-acute-care institutions, resulting in many being kept in the acute-care hospitals like the Montreal General and St-Luc, adding to the crisis in beds.⁶⁰ In fact, in a statement reminiscent of the approach to these patients taken by the U.S. and British voluntary hospitals — exclusion — the Medical Director of St-Luc made the following comments on the problem of the chronically ill:

Malgré que le taux de mortalité ait été diminué et que le nombre des morts soit moins considérable, le docteur Boucher [Medical Director] ne peut s'empêcher de souligner l'importance pour un hôpital général d'éviter la congestion des services de médecine et de chirurgie par les cancéreux, les tuberculeux, les paralytiques et les gâteux.⁶¹

Despite the uncharitable manner in which Dr. Boucher described the situation, the fact remained that it was another source of significant pressure on the hospitals.

⁶⁰ See for example, MA, MGH, General Superintendent's Report, AR, 1944.

⁶¹ HSL, Procès-verbaux des Réunions des membres à vie, le 12 mai 1944.

Table 4 Montreal General Hospital/St-Luc Hospital Length of patient stay, 1940-1945					
	S-L private patients	S-L average stay - all patients	MGH private patients	MGH average stay - private patients	MGH average stay - all patients
1940	1,019	20.2	3,253	11.9	16
1941	n/a	20.3	3,326	11.9	15.6
1942	1,900	18.5	3,602	11.8	15.3
1943	n/a	n/a	3,793	12.9	15.3
1944	n/a	17.49	3,710	13.9	15.5
1945	n/a	15.64	3,749	14.5	15.5

Sources; MGH, Annual Reports, 1940-45; Saint-Luc, Procès-verbaux, Réunions des membres à vie, 1940-45.

In both hospitals, the number of private and semi-private patients treated increased steadily. In addition, the Montreal General saw a small increase in the number of private beds during the war years, as some beds were shifted from one category to another and limited construction was undertaken. In 1940, there were 144 private, 49 semi-private and 412 public beds, for a total of 605 beds; in 1945, there were 192 private, 49 semi-private and 400 public beds, for a total of 641 beds.⁶² In addition,

⁶² MA, MGH, ARs, 1940, 1945.

more public ward patients were paying for all or part of their hospitalization during these years.

The potential for increased income with more paying patients depended on more than just room rates. All hospital charges depended on the status of the patient, a private patient being charged more for any service than a public patient. At St-Luc, in December 1943, an x-ray of the clavicle, for example, cost \$10.00 for a private patient, \$8.00 for a semi-private patient and \$5.00 for a public patient. An electro-cardiogram cost \$15.00 for a private patient and \$10.00 for a semi-private patient.⁶³

While the hospitals did increase their private and semi-private clientele, and their income, they were constantly confronted with the limits of what they could offer, because they could not significantly expand facilities. In the first years of the war, hospital administrations across the country were both enthused and concerned by the advent of Blue Cross plans, the non-profit group hospitalization plans organized and promoted by provincial hospital associations. In a 1944 article in *The Canadian Hospital*, the Director, Plan for Hospital Care (Ontario), outlined the advantages of Blue Cross coverage.

Groups of employees or members of established organizations contribute small monthly, or other periodic subscriptions to a common fund, which in turn pays for hospitalization when the need arises. The plan preserves personal initiative and independence and adds the co-operative spirit of "all for one and one for all". It retains the values inherent in private medical practice and hospitalization. It

⁶³ HSL, Procès-verbal de la réunion du Conseil d'Administration, le 26 novembre 1943.

is operated as a non-profit service in the public interest.... Benefits are provided for every type of disease, illness or injury. No physical examination or statement of health is required. There is no exemption for pre-existing conditions and no age limit for adults. Once enrolled through a group, a subscriber may continue in the Plan without loss of benefits after he leaves his place of employment.⁶⁴

Rosemary Stevens, in her book on the US voluntary hospital system, defines Blue Cross somewhat more critically as a mechanism that would help hospitals primarily, some groups of patients secondarily:

Structurally, the Blue Cross schemes were corporations founded by corporations (the voluntary hospitals) which responded to the needs of other corporations (employers). As a result, Blue Cross was a "community" scheme, but not a "social-welfare" scheme; notably, it excluded the unemployed, the elderly, and the disabled, as well as agricultural, domestic, and other ad hoc or part-time workers who had no affiliations with the organized workplace.⁶⁵

In Canada these plans followed the same pattern. Organized by provincial hospital organizations, they emerged out of the financial difficulties hospitals endured during the Depression. They were available to companies interested in extending benefits to their employees. Significant sectors of the population were thus excluded. These plans did foster hopes of more stable revenues for the hospitals, and were an alternative to increased government intervention.

Their strength lay in the provision of semi-private hospital coverage for group members and their families for a relatively low premium. While it was very

⁶⁴ Norman H. Saunders, "Hospital Service Plans," *TCH*, vol. 21, no. 5 (May 1944), p. 33.

⁶⁵ Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989), p. 186.

much in the hospitals' interest to promote such plans, the problem was one of adequate supply to meet the anticipated demand. This was noted by the Montreal General Hospital's General Superintendent in his report for 1941:

There has been considerable publicity recently concerning Group Hospitalization. This subject has been carefully studied by the Montreal Hospital Council and an approved scheme would have been launched long ago but for one important fact and that is the shortage of semi-private accommodation for patients in the hospitals. This shortage is especially marked in this Institution. There has been a fear that we would be "selling short" and unable to meet the call. The public is going to demand it and it behoves us to take steps to meet our obligation to the public which supports us.⁶⁶

A Blue Cross plan did go into effect in Montreal in May of 1942. Both St-Luc and the Montreal General adhered to the plan that same year, despite their limited semi-private accommodation.⁶⁷ Resolution of this problem was envisaged only for the post-war period.

In the 1942 *Annual Report*, the Montreal General Hospital's Board of Management underlined the various aspects of the problem of paid accommodation:

The year in review has been an exceedingly active one, for all categories of accommodation have been strained to the utmost. It has been all too frequent to have daily waiting lists of large numbers of those seeking admission to the Hospital. This applies to all types of accommodation but more particularly has it been evident for that of the semi-private type. The question, therefore, of providing additional

⁶⁶ MA, MGH, General Superintendent's Report, AR, 1941.

⁶⁷ In June of 1943, the Association d'hospitalisation, the organism administering the plan, announced that after 13 months of operation, the hospitalization plan had 30,000 members in 467 companies, and had paid out to Montreal hospitals a total of \$61,336.81. See HSL, Procès-verbal de la réunion du Conseil d'Administration, le 18 juin, 1943.

semi-private accommodation is one that continually gives your Board concern but the only complete means of solving this problem would appear to lie in future construction; an enterprise which obviously presents many difficulties in this time due to war conditions.

In September of this year your Board decided to open the 9th floor at the Private Patients' Pavilion for the reception of maternity cases and towards this end certain structural changes are now being effected. It is hoped that we will be in a position to open this new service by the early summer but the difficulty of obtaining supplies and equipment makes it very difficult to name a definite date. When available it will help to relieve, in some degree, the very heavy pressure on the other hospitals of the City for maternity accommodation and answer the very many demands that have been placed upon your Board for the provision of maternity facilities ever since and before the opening of the Private Patients' Pavilion.⁶⁸

The Montreal General maintained the same number of semi-private beds throughout the war, but increased the number of private beds by close to 50. Why this was done is unclear, considering the expressed need for semi-private beds for Blue Cross subscribers. Certainly, however, private beds provided more immediate revenue, and the demand was there. In both 1944 and 1945, the waiting list for rooms in the Private Patients' Pavilion stood at over 200. In 1944, the Superintendent claimed that "only the most serious and urgent cases could be admitted."⁶⁹ In 1945, the third floor in the Pavilion, previously used to house staff, was converted to a patient floor.⁷⁰ At St-Luc, the President of the Board of

⁶⁸ MA, MGH, Report of the Board of Management, AR, 1942. The hospital did open the 9th floor in February of 1944.

⁶⁹ MA, MGH, Report of the Western Division, AR, 1944.

⁷⁰ MA, MGH, Report of the Western Division, AR, 1945.

Management also underlined that hospital's lack of private beds and its waiting lists for accommodation in his 1944 annual report.⁷¹

Of course, the increased patient load in both public and private wards put additional strains on many other sectors of the hospitals as well, particularly given war-time constraints on expansion and on obtaining almost any new equipment.⁷² The situation in the Montreal General's Radiology Department exemplified the complexities of functioning under the prevailing circumstances. Several factors — lack of space, increasing number of patients, and growing complexity of procedures — came together to affect costs.

As the work in both divisions is increasing, and, as the types of examinations are becoming more complicated and time consuming, the need for more space in both divisions is indeed pressing. Because of this it is impossible to do work when it should be carried out, and consequently patients are often kept longer in hospital. This means increased costs which have to be paid either by the patient or the hospital.⁷³

Finally, an additional strain on both hospitals and their staff was the increase of the number of Workers' Compensation cases, an outgrowth of the booming war industry. In his report for 1945, the superintendent of the Western Division noted, for example, that 52 per cent of accidents treated were industrial.⁷⁴ This again was a

⁷¹ "8089 malades hospitalisés," *La Presse*, May 30, 1945, p. 15. According to Senator David, St-Luc had the fewest private beds of any hospital in Montreal.

⁷² Much of the equipment would normally be purchased from Europe, an impossibility during the war. Equipment and replacement parts were available from the U.S. or in some cases Canada, but rationing of certain components often made this difficult or impossible as well.

⁷³ MA, MGH, Report of the Department of Radiology, AR, 1944.

⁷⁴ MA, MGH, Report of the Western Division, AR, 1945.

mixed blessing for the hospitals: on the one hand, these patients were paid for by the provincial government; on the other, the increase was difficult to handle, in both out-patient clinics and emergency departments and on the wards.

At St-Luc, the pressure seems to have been felt most strongly in the emergency department, a fact underlined in the report of the medical director in each annual report from 1941 to 1944. In his report for 1941, he noted "une activité inusitée aux dispensaires d'urgence, d'accidents et d'accidents de travail laissant loin en arrière la moyenne des cinq dernières années."⁷⁵ Ambulance calls rose from 2,300 in 1941 to 3,102 in 1945. While emergency visits grew, indigent patient visits declined, however, because of the improving economic situation in the province. As a result, by 1945, overall out-patient and emergency visits were declining, standing at 78,652, down from a high of 85,749 in 1941. The fact that they did not decline further was due in main to the growth of accident cases.⁷⁶

The situation was similar at the Montreal General, with a growth of Workmen's Compensation cases in the out-patient and emergency departments, and also an increase of surgical in-patient cases resulting from work accidents. It was the Western Division that seemed to be most affected by these pressures. Consultations or out-patient visits for compensation cases rose from 7,887 in 1940 to 13,067 in

⁷⁵ HSL, Rapport Médical, Procès-verbal de la Réunion des membres à vie, le 12 mai, 1942.

⁷⁶ HSL, Rapports Médicaux, Procès-verbaux des Réunions des membres à vie, 1941-1945; "Situation sérieuse à St-Luc," *La Presse*, 29 mai, 1946, p. 29.

1942.⁷⁷ In-patient surgical cases resulting from work accidents increased to the point that, at the Western Division, medical wards were converted to surgical wards in 1942 to accommodate these cases.⁷⁸ Even with this measure, accommodation proved to be inadequate. The following year, the Superintendent of the Western Division reported:

The work of our Public Ward is limited, — it is now entirely devoted to surgical work. The demands upon these wards have not been able to be met, especially the male ward. The turn-over of patients has been slower than it should be. Patients with fractured legs, or others, requiring longer hospitalization, have to be retained as there is no place to send them. We are organized to take care of acute emergencies and it is a sad affair when we have calls upon us to attend to these urgent cases and are unable to respond. This applies to other general hospitals of this city as well as ours.⁷⁹

Fortunately, payment for Workmen's Compensation cases increased from \$2.50 to \$3.00 per day in 1941, thanks to lobbying by the Montreal Hospital Council.⁸⁰ While this did help the hospitals financially, it is worth noting that despite this increase, the *per diem* cost for a public patient at the Montreal General in 1941 was estimated to be \$4.06.⁸¹ The \$1.06 shortfall still had to be covered by the hospital. The *per diem* cost at St-Luc may have been lower; however it is not likely that it was lower than \$3.00.

⁷⁷ MA, MGH, Report of the Western Division, AR, 1942.

⁷⁸ MA, MGH, General Superintendent's Report, AR, 1942.

⁷⁹ MA, MGH, Report of the Western Division, AR, 1942.

⁸⁰ HSL, Procès-verbal de la réunion du Conseil d'Administration, le 12 août, 1941. St-Luc's Superintendent J. H. Roy was involved in the negotiations between the Montreal Hospital Council and the provincial government.

⁸¹ MA, MGH, Statistics, AR, 1941.

The economic growth of the war period did help improve the hospitals' financial situation. The report of the Montreal General's Treasurer for 1943 succinctly underlined the major contributing factors:

Revenue from Patients at \$1,104,000 was \$124,000 more than for 1942. This is a reflection of the times, and is explained by the sustained demand for private and semi-private accommodation and the greater number of public patients who are now in a position to pay the regular charges. Also, there has been an increase in the number of industrial accidents.⁸²

As seen above, St-Luc benefited financially too. Nonetheless, even with these gains, both hospitals found themselves with annual deficits for each year of the war. Rising costs, provoked by the war, were certainly a factor (see below). But hospitals began to look for long-term remedies for their income shortfalls, and they saw more paying beds as the solution. As early as 1943, with some confidence that the growth in demand would not abate with the end of the war, the hospitals began discussing post-war expansion. St-Luc, modestly, planned for a new wing with increased accommodations for private and semi-private patients; the Montreal General decided to follow the proposals of the Reconstruction Committee, set up to study the question in 1944, and consolidate the two divisions of the hospital upon a new single site.⁸³

⁸² MA, MGH, Honorary Treasurer's Report, AR, 1943.

⁸³ MA, MGH, Report of the General Superintendent, AR, 1944, HSL, Rapport du Président, Procès-verbal de la Réunion des membres à vie, le 12 mai, 1944. There seemed to be some justification in the optimism for the post-war period. In the 1944 AR, the Montreal General's Board of Management reported the "the greatest number of patients admitted and the greatest number of hospital days of service given in any year since the Hospital was founded in 1821."

- **Labour: Finding, Keeping and Paying for Labour**

Hospitals were traditionally a low-paying but stable sector for workers.⁸⁴

Though wages were low, workers were generally assured of long-term employment, and certain benefits often accompanied the job, including low-cost meals, and, for some categories of workers, housing (interns, nurses and nursing students, and even general staff, for example). With the onset of the war, however, the labour situation changed radically. Hospitals faced three related problems regarding labour during the war: shortage of manpower, difficulty in finding properly trained workers, and the rising cost of labour.

The immediate problem was the departure for the armed services of doctors and skilled workers such as nurses, physiotherapists, dieticians, skilled orderlies, technicians, and mechanics. This would put a constant strain on hospitals throughout the war, and would lead to changes in the way hospitals functioned. But soon the problem spread far beyond these hospital elites, as all categories of staff left the hospitals for military service and for better-paying jobs in the war industry. Suddenly the hospitals were confronted with a seller's market in labour, and they had few resources with which to compete with sectors that could pay more.

⁸⁴ As a point of comparison, the average weekly industrial wage in Canadian 1940 was \$24.94. Montreal nurses in 1941 earned on average \$17.00/week, and general duty nurses at St-Luc not living in hospital earned \$47.50/month in 1942. At the same time, general workers at St-Luc earned \$25.00/month. See Vaillancourt, *op. cit.*, p. 60; Johanne Daigle, "L'Émergence et l'évolution des l'Alliance des Infirmières de Montréal: 1946-1966" (M.A., UQAM, Montreal, 1983) p. 70; HSL, Procès-verbal, Bureau de Direction, le 17 septembre 1942.

In the *Annual Report* for 1940, Dr. Lorne Gilday, the Acting General Superintendent of the Montreal General Hospital, remarked on the effect of war mobilization on the hospital.

We are proud of our Honour Roll. During the year we had fifty of our Attending Staff, ten of our Resident Staff, twenty-two of our Nursing Staff and eighty-five of our Lay Staff, a total of one hundred and sixty-seven join one or other of the three forces. Besides this a great number of our Lay Staff have left us to work in war industries which has made it a very trying year on the heads of departments, who have had the responsibility of maintaining their various services with constant depletion of staff and difficulty of replacement. In the orderly department alone, where our normal number is 144, we had to employ 212 new men to attempt to maintain that number, let alone find qualified ones. Our best trained orderlies volunteered for service as such in medical units and as soon as others were even partially trained, they followed suit. The turnover in maids reached approximately the same proportion as the demands in the munitions plants became stronger.⁸⁵

The Montreal General was an English hospital, with personnel that had strong ties to England. It would be logical that a significant number of staff would join the forces. But St-Luc, too, saw departures for the war or war industry in the first year, including doctors, five nurses, and several of the lay staff.⁸⁶ After this, the situation became chronic in both hospitals as they scrambled to find and to keep staff.

Increased costs resulted from staff turnover. The head of Dietetics at the Western Division of the Montreal General remarked in 1941 that rapid turnover

⁸⁵ MA, MGH, General Superintendent's Report, AR, 1940.

⁸⁶ HSL, Rapport du Surintendant et Trésorier Honoraire, Procès-verbal de la Réunion des membres à vie, le 16 mai 1941.

meant costly and time-consuming training.⁸⁷ In a six-month period in that same year, 80 per cent of the dietetics staff of the Central Division left for munitions work or the military. The head of that department noted, "At the present time we are employing persons who, under ordinary conditions would be considered unemployable and, further, not since June 1941 has it been possible to even obtain more than 50% of our normal staff."⁸⁸

At the Montreal General, most departments felt the dearth of available labour, especially qualified labour. Each *Annual Report* contained examples of problems on the staffing front. In 1941, trained dieticians and physiotherapists were in short supply as well as nurses and general staff.⁸⁹ In 1942, the *Annual Report* noted a shortage of nurses, various specially trained staff as well as maids, waitresses and orderlies.⁹⁰ In 1943, the Superintendent of the Western Division reiterated the previous year's remarks on the lack of staff and the difficulty in finding reliable workers, but also focused on the shortage of nurses, as more joined the military and others married.⁹¹ In addition, the departments of Metabolism, Pathology, Physical Therapy and Radiology all noted staff shortages. In each case, shortages meant restricting tests and treatments, stopping research or even curtailing clinics, and, on

⁸⁷ MA, MGH, Report of the Dietary Department (Western Division), *AR*, 1941.

⁸⁸ MA, MGH, Report of the Dietary Department, *AR*, 1941.

⁸⁹ MA, MGH, *AR*, 1941.

⁹⁰ MA, MGH, *AR*, 1942.

⁹¹ MA, MGH, Report of the Superintendent, Western Division, *AR*, 1943. While marriage was a constant reason for the turnover of nursing staff, the general shortage of nurses during the war made this particular problem more acute.

rare occasions, refusing treatment.⁹² By 1944, however, the situation seemed in general to be improving, though some sectors, nursing at the Western Division and physiotherapy in particular, were still suffering from staff shortages. As well, solutions seemed attainable for those departments still suffering shortages; more student nurses for the Western Division were recommended to ease the work load of nurses, and the Department of Physical Medicine could look forward to hiring graduates of the new McGill School of Physiotherapy.⁹³

Perhaps the most important element affecting the hospitals' labour situation in 1944 was the passage in late 1943 of the provincial Minimum Wage Commission's Ordinance No. 11, stipulating Minimum Wage standards for employees. Burnett S. Johnston, in his Superintendent's report, pointed out "that the increase of \$100,000 noted in the payroll for the past year is not the maximum which will accrue as a result of the enactment of this long overdue legislation as the

⁹² MA, MGH, Reports of the Departments of Metabolism, Pathology, Physical Therapy and Radiology, AR, 1943.

⁹³ MA, MGH, Report of the Western Division, and Report of the Department of Physical Medicine, AR, 1944. Student nurses were traditionally an essential part of the work force in hospitals, doing much of the routine work as part of their training. See Katherine McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford University Press, 1996); Johanne Daigle, "Devenir Infirmière: Le système d'apprentissage et la formation professionnelle à l'Hôtel-Dieu de Montréal: 1920-1970" (Ph.D. diss., UQAM, Montreal, 1990); André Petitat, *Les infirmières: De la vocation à la profession* (Montreal: Boréal, 1989). The Department of Physiotherapy was also depending on a number of physiotherapy students doing "yeoman service helping out in the clinics. They have enabled the clinic to remain open when it would otherwise have had to close for lack of workers." See AR, *ibid.*

amended rates were effective in 1944 for a period of less than a whole year.”⁹⁴ The ordinance was part of a series emitted by the Minimum Wage Commission starting in 1940, with the aim of decreeing the minimum wage, working hours and apprenticeship conditions of all employees not protected by a collective agreement.⁹⁵ This legislation applied to certain groups in the hospitals, as many were not part of bargaining units. While the wage increases were, as Johnston himself admitted, long overdue, they still added more financial stress to an already difficult situation. The Montreal Hospital Council attempted to negotiate an increase on the PCA rate – which had been raised from \$2.00 to \$3.00 in 1942 – and special grants to help meet this increased expenditure.⁹⁶ In 1945, however, there had still been no change in the PCA rate.⁹⁷

In 1945, despite the return of some staff from overseas, the staffing problem remained endemic, perhaps intimating the shape of things to come in the post-war period, when more opportunities would open up for skilled and unskilled staff in

⁹⁴ MA, MGH, General Superintendent's Report, AR, 1944. The total increase in operating expenditures was \$119,000. The Treasurer noted that “it is hoped that conversations now proceeding with officials of the provincial Government will result in hospitals obtaining financial assistance to partly offset these additional costs.” See Honorary Treasurer's Report, *op. cit.*

⁹⁵ 4 George VI, Ch. 39, cited in James Iain Gow, *Histoire de l'Administration Québécoise; Chronologie des programmes de l'Etat du Québec (1867-1970)*, Notes de recherche #1. Dept. de Science politique (University of Montreal, 1981), p. 97. There were several Ordinances passed over the years, but the Montreal Hospital Council seems to have managed to get some repealed at least in the earlier years. In a letter in 1941 from the Council to the Deputy Minister of Health, the Council claims “Nous avons également obtenu du succès en combattant les Ordonnances de l'Office des Salaires Raisonables; ces ordonnances plaçaient nos hôpitaux sur le même pied que les industries, ce qui était injuste.” See ANQ E8/3, J. H. Roy to Docteur Jean Grégoire, Jan. 30, 1941.

⁹⁶ MA, MGH, Report of the General Superintendent, AR, 1943.

⁹⁷ MA, MGH, Honorary Treasurer's Report, AR, 1945.

the period of post-war economic growth. Nurses returning from overseas were not coming back to the hospital, as other possibilities emerged in expanded public nursing, industrial nursing and federal government employment.⁹⁸ Other staff was still in short supply, despite demobilization, because hospitals could not offer the same wages and working conditions as private industry.⁹⁹ Again shortages curtailed work in certain departments: in pathology and bacteriology the shortage of technical assistance meant that little more than the necessary routine work was done; in dietary there was a great dependence on part-time helpers who required extra supervision; and in physical medicine staff shortages necessitated the limiting of clinics. Unfortunately, those hoped-for graduates from the McGill School of Physiotherapy all went into the Services and to the Department of Veterans' Affairs, leaving the hospital nonetheless optimistic that graduates from the 1946 class would end staffing problems.¹⁰⁰

St-Luc was not as large as the Montreal General and was only in the process of becoming a teaching hospital. Since research was relatively undeveloped, laboratory work was more restricted to routine testing. Nonetheless, the situation at St-Luc was as critical as that at the Montreal General.

⁹⁸ MA, MGH, Report of the Western Division, AR, 1945.

⁹⁹ MA, MGH, Report of the General Superintendent, AR, 1945.

¹⁰⁰ MA, MGH, Reports of departments of Pathology and Bacteriology, Dietetics and Physical Medicine, AR, 1945.

All categories of workers were in short supply. In 1941, it became clear there would soon be a shortage of interns, the young doctors who did much of the routine medical work for a monthly wage. In order to maintain an adequate number, a proposal was made to increase their salary.¹⁰¹ In 1941 as well, a series of wage increases were considered necessary to keep staff from going to better paying jobs. In May, nurses living outside of the hospital were given a raise of \$2.50 a month.¹⁰² In June 16 nursing aides were hired to do the more routine nursing work. Originally they were to be paid \$12.50 a month, but as this did not seem to draw suitable individuals, the pay was raised to \$15.00.¹⁰³ In July, nurses, x-ray technicians, porters and orderlies were given raises.¹⁰⁴ Yet in November, Suzanne Giroux, the Nursing superintendent, informed the administration of problems in nursing: there was a shortage of nurses, particularly those capable of becoming head nurses, and the rate of turnover among nursing aides and orderlies was too high. She proposed wage increases, recruitment propaganda in schools, improved lodging of students and graduates and a higher starting wage (\$30.00) for orderlies. The decision taken was to increase nurses' wages by \$5.00 immediately with another \$5.00 in January, 1942.¹⁰⁵

¹⁰¹ HSL, Procès-verbal, Bureau de Direction, Réunion spéciale, le 7 juin, 1940.

¹⁰² HSL, Procès-verbal, Bureau de Direction, le 16 juin, 1941.

¹⁰³ HSL, Procès-verbal, Bureau de Direction, le 12 juin, 1941.

¹⁰⁴ HSL, Procès-verbal, Bureau de Direction, le 2 juillet, 1941.

¹⁰⁵ HSL, Procès-verbal, Bureau de Direction, le 27 novembre, 1941.

In the following years the situation remained critical. In the Annual Report for 1942 the Treasurer noted: "Nous avons dû également, en raison des conditions de vie actuelle, augmenter les salaires de ceux des membres de notre personnel qui n'étaient pas suffisamment élevés."¹⁰⁶ The situation was felt in several ways. Laboratory work suffered, for example: when complaints were made at a meeting of the Medical Bureau in March of 1942 that lab reports were slow, Dr. Armand Frappier, head of laboratories, noted the need for more personnel, stating that the secretary who typed the reports was regularly obliged to work into the evening.¹⁰⁷ A month later, no personnel had yet been hired, and more complaints were raised about the quality of the work—some errors had been found in reports. Frappier commented that the problem could result from changes in personnel. He suggested that he choose the personnel, and that the personnel be stable.¹⁰⁸ At that same meeting, the shortage of interns was discussed: "Le problème est grave. Il ne reste plus que quatre seniors. On est même menacé de perdre les juniors. L'Armée leur offre des salaires plus élevés."¹⁰⁹ In September of 1942, employees at the hospital gained wage increases ranging from \$5.00 to \$20.00 monthly.¹¹⁰ The attention to wages seemed to have a positive effect. In commenting on the difficulties of the year, Athanase David, president of the Board of Management, noted:

¹⁰⁶ HSL, Rapport du Trésorier, Assemblée annuelle des Membres à vie, le 12 mai, 1942.

¹⁰⁷ HSL, Procès-verbal, Bureau médical, le 12 mars 1942.

¹⁰⁸ HSL, Procès-verbal, Bureau médical, le 9 avril 1942.

¹⁰⁹ *Ibid.*

¹¹⁰ HSL, Procès-verbal, Bureau de direction, le 17 septembre 1942.

En effet, infirmières et membres du personnel répondirent aux appels qui leur furent faits de ce côté [war and war industry], à certains moments, sans mettre en péril notre service soit, mais l'affectant tout de même. Je dois ajouter qu'à notre grande satisfaction, certains membres qui nous avaient quittés nous revinrent après quelques mois. Il est peut-être juste d'ajouter ici que ces retours furent causés, dans une certaine proportion, par les augmentations de salaires que, dans les circonstances, nous crûmes justifiable et même nécessaire d'accorder.¹¹¹

Fortunately for the hospital, in August 1942 the Provincial Government finally increased the PCA rate from \$2.00 to \$3.00. Otherwise, the deficit would have grown substantially.¹¹²

The following year did not show substantial change. There were staff shortages in the labs and among both interns and nurses. The hospital found it necessary again to give wage increases to nurses, this time to keep them from leaving for other better-paying hospitals.¹¹³ Similarly, wages were increased for nursing aids and dietary workers, and nursing students were offered a greater stipend in order to entice more students to the nursing school.¹¹⁴

In his annual report to the membership in May, 1944, Athanase David noted the same problems as the previous year. The Treasurer noted however that about 60 per cent of increase in expenditures for the year were due to salary increases. He also

¹¹¹ HSL, Rapport du Président, Assemblée annuelle des Membres à vie, le 28 mai, 1943.

¹¹² *Ibid.*

¹¹³ HSL, Procès-verbal, Bureau médical, le 11 mars 1943. (Frappier complained of the need for more personnel to do required number of autopsies in conformity with standards of the American College of Surgeons in order to retain good standing; HSL, Procès-verbal, Bureau médical, le 8 avril, 1943).

¹¹⁴ HSL, Procès-verbal, Conseil d'Administration, le 4 juin, 1943.

warned that wage increases expected in 1944 would make it very difficult to keep the deficit down.¹¹⁵

As at the Montreal General, the Treasurer's concerns for 1944 undoubtedly were raised because of the Minimum Wage Commission's Ordinance No. 11, which increased the salaries of some groups of hospital workers. In November the Board of Management calculated that this would mean an additional cost of \$70,000 for salaries!¹¹⁶ In fact, in 1944 the deficit did increase to \$43,294.91 from \$18,632.48 the year before. As the Treasurer explained:

Cette augmentation [in expenditures] est occasionnée en grande partie par la hausse des salaires des employés par suite d'émission de l'ordonnance no 11 concernant les employés d'hôpitaux. La mise en vigueur de cette ordonnance représente à elle seule, approximativement 58 p.c. de l'augmentation, soit \$50,303.48.¹¹⁷

Finally, in 1945 there seemed to be some return to stability. Nurses were returning to the hospital and enrollment in the nursing programme was increasing. The deficit was down slightly, by \$4,000 over the previous year. However, the Treasurer cautioned that continuous wage increases, coupled with the end of price controls at the end of the war, would contribute to a growing deficit in the year to come.¹¹⁸

¹¹⁵ HSL, Rapport du Président, Rapport du Trésorier, Assemblée annuelle des Membres à vie, le 12 mai, 1944. The 1943 deficit was actually significantly lower than that of 1942, due mainly to increased revenues, including the increase in the PCA rate.

¹¹⁶ HSL, Procès-verbal, Conseil d'Administration, le 26 novembre 1943.

¹¹⁷ "8,089 malades hospitalisés," *La Presse*, le 30 mai 1945, p. 15.

¹¹⁸ HSL, Rapport du Président, Rapport du Trésorier, Assemblée annuelle des Membres à vie, le 28 mai 1946.

Both hospitals were strongly affected by the war's personnel needs, though the specifics varied. Along with added costs, and the stress on workers and management as they attempted to bridge the gap between needs and available resources, manpower difficulties also had implications for maintaining services that made money but were also very labour-intensive. The best example was the problem of private patients. The Superintendent of the Western Division exposed vividly the difficulties encountered in maintaining services at an appropriate level in the private wards during the war.

The demand for accommodation in the Private Patients' Pavilion has steadily increased. There were 41,528 hospital days, an increase of 6,305 over 1942 (an increase of 13,852 since 1939).

It is needless to say that this has thrown a terrific strain upon the whole organization. To admit a patient to a public ward it is only required to prepare a bed and bedside table. In the Private Pavilion, it is necessary to clean the room, check the plumbing and electric fixtures, change the chair covers, polish the floor, etc., etc. This cannot be done in a few minutes and requires staff: nurses, maids, orderlies and maintenance men.¹¹⁹

In fact, in 1944, despite growing waiting lists for private rooms, the hospital had to close a private ward for the summer because of a shortage of nurses, depriving itself of necessary income.¹²⁰

Finally, it is worth noting the consequences on staff labouring under wartime conditions in the hospitals. Their problems were only intimated in the

¹¹⁹ MA, MGH, Report of the Western Division, AR, 1943.

¹²⁰ MA, MGH, Minutes of a Special Meeting of the Medical Board, July 10, 1944; MA, MGH, Report of the Western Division, AR, 1944.

reports by department heads throughout this period, but occasionally their own voices surfaced, opening up windows directly onto their experiences. This happened twice in 1943, when the provincial government was informed by complaints on one occasion and by an anonymous letter on another, about working and living conditions of staff, particularly nurses, at St-Luc. In both cases, the Minister mandated Arthur Lessard to investigate the complaints. He investigated the housing for nurses and interns, mainly in old, renovated houses near the hospital, and concluded that the situation was less than favourable. In the worst case, 52 nurses lived in old houses that were badly ventilated during the summer, where pipes burst often, and the nurses shared rooms with up to five others. He concluded:

Je vous avoue bien franchement que l'ensemble de ces logements ne m'a pas laissé une impression bien favorable. Je comprends que c'est la nécessité qui a forcé l'administration à utiliser ces locaux. Je garde cependant l'impression que l'hôpital fait tout en son possible pour rendre ces logis convenables, mais il y réussit plus ou moins, à cause des conditions particulièrement difficiles.¹²¹

The hospital was not unaware of these difficult conditions and was in the process of building a new nurses' residence, which was completed in 1945.¹²²

The same year, however, another situation arose, attracting the attention of the government, again shedding light on working conditions. This time an anonymous letter from "Les Gardes-Malades Graduées de l'Hôpital Saint-Luc" to the

¹²¹ ANQ E8/3, Art. 10, Hôpitaux du Québec, Arthur Lessard to J. Grégoire, March 12, 1943.

¹²² HSL, Rapport du Président, Reunion des membres a vie, le 28 mai 1946.

Minister of Health claimed that 15 nursing students and a number of nurses had tuberculosis and that nurses were being forced to work "jusqu'à la limite de leurs forces."¹²³ Again Lessard investigated the claims. While the totality of the claims was not substantiated, Lessard found that there was some substance to the complaints:

Monsieur le docteur Boucher [chief of staff] admet qu'il y a eu un certain nombre d'étudiantes gardes-malades ainsi que de gardes-malades diplômées qui ont dû abandonner leur service depuis une couple d'années. Quelques unes ont été mises au repos pour cause de déficience physique quelconque, sans qu'il y ait eu tuberculose. Quatre ou cinq me dit-il étaient des tuberculeuses. Sans pouvoir établir d'une façon précise si elles ont contracté la maladie du fait de leur service à l'hôpital, ou pour autre cause... le nombre de quatre ou cinq, dis-je, n'est pas tellement exagéré, si l'on tient compte du surcroît d'ouvrage auquel elles sont astreintes.¹²⁴

Staff was paying a heavy price for their contribution to the continued functioning of the hospital during the war.

Personnel needs were a constant headache during the war for both management and staff. Rising wages and constant shortages of staff, both specialized and general, persisted during the entire time, causing higher costs and stress for both the managers who had to deal with shortages and unqualified workers, and those workers left on the floors who found they had to cover for lacking and inefficient replacements.

¹²³ ANQ E8/3, Art. 10, Hôpitaux du Québec, Les Gardes-Malades Graduées de l'Hôpital Saint-Luc to Henri Groulx, June 2, 1943.

¹²⁴ ANQ E8/3, Art. 10, Hôpitaux du Québec, Arthur Lessard to J. Grégoire, June 30, 1943.

• Rising Costs

Both hospitals faced rising costs on other "necessities" as well as labour, particularly in the early years of the war. Overall, according to *The Canadian Hospital*, there was an 18.8 per cent increase in cost of living from 1939 to the end of 1942.¹²⁵ In some cases hospitals were faced with much higher costs. Increases could be as high as 25 to 30 per cent, and in some cases up to 500 per cent, as special instruments, medication and even materials (such as rubber products produced in the war zones) became increasingly difficult to obtain. Substitutes were often more expensive, and other items were rationed. Radiology exemplified this kind of problem. The radiology departments in both hospitals, finding themselves unable to obtain materials from England or France, turned to the U.S. market where the goods were available, but at a slightly higher price.¹²⁶

Even local goods became significantly more expensive. The price of milk, for example, rose from 22¢ to 38¢ a gallon within just a few years.¹²⁷ The end result was generally rising costs for hospital services, while hospitals were limited in the amount they could raise their rates. The price of coal was rising as well, in great part due to

¹²⁵ "Price Trends," *TCH*, vol. 20, no. 1 (January 1943), p. 42. The journal does not give a source for its statistics. Dennis Guest notes cost of living increases of 4.1 per cent in 1940, 5.8 per cent in 1941 and 4.7 per cent in 1942, based on Statistics Canada sources. See Dennis Guest, *op. cit.*, p. 207.

¹²⁶ MA, MGH, Report of the Department of Radiology, AR, 1942; HSL, Procès-verbal, Bureau de Direction, le 29 mars 1941.

¹²⁷ "Hospitals Seriously Affected by Government Order Fixing Room Charges," *TCH*, vol. 19, no. 2 (February 1942), p. 13; ANQ E8/3, J. H. Roy to Henri Groulx, Minister of Health, June 18, 1941.

the war. According to the Montreal Hospital Council in 1941, it had risen by \$2.65 a ton in six years.¹²⁸

The Montreal General was in a better position than St-Luc to weather these difficulties because of its greater financial resources. As a result, early in the war it managed to make some repairs, buy certain pieces of equipment, and make limited renovations, foreseeing that this would become difficult as the war progressed.¹²⁹ Nonetheless both hospitals encountered rising costs because of scarcities. In 1941, for example, the head of Dietetics at the Montreal General, reporting an 11.4 per cent increase in the cost of food, commented: "Just how long we can continue to control costs it is impossible to state since the government has not as yet placed a ceiling on the general run of food stuffs and in consequence there has been a wide variation in the price of commodities."¹³⁰

The situation did change with the introduction of wage and price controls in late 1942, at least for domestic products. After that the cost of living stabilized for the duration of the war, although hospitals continued to have difficulties with certain hard-to-obtain goods. However, as the Treasurer at St-Luc noted in his

¹²⁸ ANQ E8/3, J. H. Roy to Henri Groulx, Minister of Health, June 18, 1941. In 1940 Yatesboro Slack coal rose in price by 65¢ to \$6.80/ton. St-Luc, Réunion spéciale des membres du Bureau de Direction, June 7, 1940.

¹²⁹ MA, MGH, Honorary Treasurer's Report, AR, 1941.

¹³⁰ MA, MGH, Report of the Dietary Department, AR, 1941.

report for 1945, since controls were soon to be lifted, hospitals could once again look forward to rising costs.¹³¹

Despite all the difficulties and restrictions, this was nonetheless a period of growth and of scientific development, and of continued specialization, reflected in both hospitals but particularly at the Montreal General.

It was during these years that blood banks were established in both hospitals.¹³² At St-Luc, the growing number and complexity of lab tests required additional technicians; standards of the American College of Surgeons regarding the relative number of autopsies performed required the hiring of another anatomopathologist and another technician; a paediatric service was organized; as was a department of pyretotherapy.¹³³ At the Montreal General increased lab work resulted from identification of specific types of bacteria that cause pneumonias, leading to specific treatment.¹³⁴ Blood grouping for transfusions also increased lab work. Starting in 1941, research work was carried out concerning the use of sulpha drugs (important anti-infection drugs prior to the discovery of penicillin) in civilian and military circumstances.¹³⁵

¹³¹ HSL, Procès-verbal, Réunion des membres à vie, le 28 mai 1945.

¹³² MA, MGH, Report of the Secretary, AR, 1941; HSL, Procès-verbal, Réunion des membres à vie, le 28 mai, 1943.

¹³³ HSL, Procès-verbal, Réunion des membres à vie, le 12 mai 1942.

¹³⁴ MA, MGH, AR, 1939.

¹³⁵ MA, MGH, Report of the Secretary, AR, 1941.

- **Government and the Hospitals: Potential for Conflict**

The relationship between hospitals, and their provincial and national organizations, and the different levels of government showed strain on occasion as interests clashed around specific issues. In some cases these issues related specifically to the war effort — wage and price controls, for example, or the National Selective Service (NSS) regulations. (The NSS was set up for the duration of the war to oversee labour needs.) In other cases — unemployment insurance, for example — it was a question of government policy conflicting with the hospitals' perceived best interests.

It was in the first full year of the war that the hospitals faced complications arising from decrees of both the federal and provincial governments. In 1940, with the imminent passage of the federal Unemployment Insurance Act, the hospital community became extremely concerned that hospital employees other than nurses were included in the provisions. The Canadian Hospital Council lobbied the federal government to exclude hospitals, basing its reasoning on the following points: unemployment was negligible in the hospital field; the cost of the plan, from which there would be little benefit, would be a heavy financial burden both to employees and to the hospitals; and public hospitals, being charitable non-profit institutions, should not be required to use their already limited funds on a plan that would be

of little benefit to their employees.¹³⁶ The Council estimated that, if included, public hospitals would have to pay out about \$270,000 annually and their employees about the same amount (possibly leading the workers to demand higher wages in return).¹³⁷ Hospitals were indeed relieved that, in the final bill, public hospitals were excluded.¹³⁸

Personnel, as discussed above, was one major problem for hospitals during the entire period. It was clearly a major preoccupation for the federal government as well, since by 1942 the situation in Canada had gone from significant unemployment to a labour shortage. To deal with this situation, in March of 1942 the government created the National Selective Service programme under the jurisdiction of the Minister of Labour.¹³⁹ Eventually the NSS would be responsible for the allocation of most of the labour force in Canada. Personnel problems in hospitals were already serious by this time.

When the NSS began operation it listed essential services in Canada. Initially, civilian hospitals do not seem to have been on that list, but in April 1942 the CHC requested "some official pronouncement to the effect that the maintenance of

¹³⁶ "Brief of the Canadian Hospital Council to the Special Parliamentary Committee Studying The Unemployment Insurance Act, 1940," *TCH*, vol. 17, no. 8 (August 1940), pp. 10-11.

¹³⁷ "Hospitals Protest Inclusion under Unemployment Insurance Act 1940," *TCH*, vol. 17, no. 8 (August 1940), p. 9.

¹³⁸ "Stop Press," *TCH*, vol. 17, no. 8, August, 1940, p. 10; "Hospital Exemptions Under the Unemployment Insurance Act," *TCH*, vol. 18, no. 8 (August 1941), pp. 41-42.

¹³⁹ Ruth Pierson, "Women's Emancipation and the Recruitment of Women into the Canadian Labour Force in World War II," Canadian Historical Association, *Historical Papers* 1976, p. 142.

adequate hospitalization facilities for war-workers and for the civilian population is an essential service." The clarification from the NSS was that hospitals were an essential service, "free to employ any person" except in certain categories, principally clerical, where men between the ages of 17 and 45 were not to be employed.¹⁴⁰ In July of the same year, there was further aid for hospitals when NSS regulations required many workers, including hospital workers, to stay in their current positions unless a change was approved by a Selective Service officer.¹⁴¹ In September of the same year, when it became apparent that the NSS was reworking its classifications with a more explicit categorization of industries and occupations on a priority basis, the CHC again intervened, asking that civilian hospitals be given "as high a priority rating as the nature of hospital work would justify." E. M. Little, Director of the NSS, responded that hospitals would be given such a priority rating, and that regulations would be applied "in such a way as to make it easier for essential service, such as hospitals, to obtain necessary personnel."¹⁴²

Improvement was not rapid, however. In October the CHC and other health care organizations met with the NSS, on the invitation of Mrs. Rex Eaton, Assistant Director (Women's Division), to discuss personnel needs. They painted a picture of crisis in the health care sector:

¹⁴⁰ "Hospitals Rated as Essential Service: Statement from Department of Labour Clarifies Status of Hospital Personnel," *TCH*, vol. 19, no. 5 (May 1942), p. 13.

¹⁴¹ "All Workers Pegged in Present Positions by New Order," *TCH*, vol. 19, no. 7 (July 1942), p. 33.

¹⁴² "Essential Nature of Hospital Work Confirmed by National Selective Service," *TCH*, vol. 19, no. 10 (October 1942), p. 29.

The composite story was a depressing one and very much the same all over — an increasing shortage of sub-staff, a lack of skilled nursing help and lack of tangible assistance to date from most local Selective Service officers. Most hospitals have raised wages, sometimes two and three times, and have improved housing and working conditions, yet still there is a scarcity of help.¹⁴³

Unfortunately, the best the NSS could offer was assurance that the hospitals were ranked as high as they could be, and advice that working conditions should be improved as much as possible.¹⁴⁴

In fact, despite assurances that everything possible was being done, the hospitals faced recurrent problems with local NSS officers. In December 1942, *The Canadian Hospital* reported:

The employment situation in hospitals is not showing the improvement which was anticipated when the new National Selective Service regulations came into force last September. Repeated complaints are received that no help is being provided. Where potential employees are discovered, they are frequently being ordered elsewhere when they go to get their permit. Instructions seem conflicting. The hospital representatives were definitely told in Ottawa on October 22nd that for female help hospitals ranked right with war industries; regional officers have since denied this.

... hospital personnel frequently attack hospitals, meaning administrators and trustees, in the press and elsewhere, as if the hospitals were to blame for the present conditions.

One of these days some hospital may precipitate an issue. In sheer desperation, it may (1) close down completely or (2) decide to pay the inflated wages now paid in temporary war industry and raise the price of all beds one or two dollars a day to meet this added cost. It might even close down its public or low cost wards.¹⁴⁵

¹⁴³ "Personnel Needs of Hospitals Placed Before National Selective Service: Mrs. Eaton Holds Fact-Finding Conference," *TCH*, vol. 19, no. 11 (November 1942), p.17.

¹⁴⁴ *Ibid.*

¹⁴⁵ "Employment Situation Acute," [Editorial], *TCH*, vol. 19, no. 12 (December 1942), p. 22.

In fact in January 1943, *The Canadian Hospital* reported the closure of three hospitals in Alberta because of a lack of trained personnel, particularly doctors. Another hospital in British Columbia had also closed down in October.¹⁴⁶

The problem of staffing, despite the best efforts of the NSS and the hospitals, was not resolved adequately for the duration of the war. There is a certain irony, however, in the fact that one result of the work of the NSS (whose creation was supposed to simplify procedures) was the establishment in 1943 of a Personnel Office at the Montreal General Hospital. As noted by the General Superintendent, "The purpose of this Department is to deal with the numerous rules and regulations instituted by National Selective Service."¹⁴⁷

The problems encountered with wages and prices before wage and price controls took effect have been discussed above. One instance of the kind of "Catch 22" situation the hospitals faced occurred in January 1942, when the Controller of Services under the Wartime Prices and Trade Board ruled that public hospitals could not raise their charges for room accommodation, but must at the same time "maintain these services without any reduction in the quality or standard of the services rendered." Rates were to be returned to those prevailing "during the period September 15 to October 11, 1941."¹⁴⁸ *The Canadian Hospital* recited a

¹⁴⁶ "Hospitals Close Down for Lack of Personnel," *TCH*, vol. 20, no. 1 (January 1943), p. 13.

¹⁴⁷ MA, MGH, Report of the General Superintendent, AR, 1943.

¹⁴⁸ "Hospitals Seriously Affected by Government Order Fixing Room Charges," *TCH*, vol. 19, no. 2 (February 1942), p. 13.

litany of problems past and present that would be worsened by the new decree: hospitals had resisted raising prices through the first two years of the war; hospital costs had risen by 25 to 30 per cent compared to 15 per cent in the cost of living; while hospitals were exempt from giving a cost-of-living bonus to employees, the rising cost of keeping labour annulled this benefit; private beds were full, no increase in income could be derived from that source; training to replace skilled labour was expensive; worn-out equipment, which was often more expensive to run, could not be replaced; and hospitals across the country reported that they were providing services at less than cost.¹⁴⁹ Rapid intervention by the CHC had the ruling reversed by March 1942.¹⁵⁰

Other difficulties emerged at different intervals. In April 1941, the CHC complained of difficulty of collecting accounts for the hospitalization of soldiers' dependants. The government did not consider itself responsible for these accounts, and was not receptive to CHC demands that a group plan be set up for soldiers' dependants or that deductions be made at source for these costs. The government did agree to send out notices with the monthly allowance cheque to dependants pointing out that the family was responsible for hospital costs.¹⁵¹ The hospitals also faced a constant barrage of rulings by control boards limiting the use of different substances. In one month, *The Canadian Hospital* listed rulings on the following

¹⁴⁹ *Ibid.*

¹⁵⁰ "Hospital Rates Released from Ceiling Restrictions," *TCH*, vol. 19, no. 3 (March 1942), p. 25.

¹⁵¹ "Hospitalization of Soldiers' Dependants," [Editorial], *TCH*, vol. 18, no. 4 (April 1941), p. 28.

items: sugar, linoleum and cork, canned goods, potatoes, coal tar, manpower, beef, pork, coal, coke, natural gas, and chartered buses.¹⁵² Finally, construction, which was not controlled initially, became increasingly difficult, particularly after the United States came into the war since many building materials came from the U.S. In September 1942, the Department of Munitions and Supply informed the CHC that permits were being refused for all but the most essential and simple construction because of restrictions on material and equipment. Even some projects already under way were likely to remain unfinished until after the war.¹⁵³

Hospitals were also confronted with rulings of the provincial government. Pre-eminent among problems, as discussed above, were ordinances from the Minimum Wage Commission and other decrees regarding salaries and working conditions of employees. In 1940, after the Quebec government decreed a raise in salaries for cleaners in Montreal hospitals and other non-profit institutions, the Montreal Hospital Council pleaded with the Minister of Health to do something to ease the situation of hospitals in the metropolis, where costs were higher but PCA payments the same as for the rest of the province. One suggestion made by the Council, giving the federal action on hospitals and unemployment insurance as an example to copy, was to exempt all hospitals in the province from social legislation: "nous n'aurions pas, à chaque fois qu'une loi ou une taxe est imposée, à

¹⁵² "New Rulings by Control Boards," *TCH*, vol. 19, no. 4 (April 1942), p. 14.

¹⁵³ "Hospital Construction Presents Difficulties," *TCH*, vol. 19, no. 10 (October 1942), p. 32.

revenir à la charge pour demander d'être exemptés."¹⁵⁴ This suggestion was turned down.

Nor did the government follow up on the request that it pay for indigents in the out-patient clinics. This was a consistent theme on the part of both individual hospitals and the Montreal Hospital Council. In the same letter, Montreal Hospital Council president (and St-Luc superintendent) J. H. Roy emphasized the situation in Montreal hospital out-patient departments:

... dans nos cliniques externes seulement, le nombre des consultations varie, dans nos différents hôpitaux, entre 75,000 à 225,000 par année. Aucun autre hôpital en dehors de Montréal n'enregistre plus que 20,000 consultations externes annuellement. Puis-je ajouter, monsieur le ministre, que le coût de revient de chaque consultation se chiffre, à Montréal, à 0.61¢, comprenant R.X., laboratoires, etc., attendu qu'il nous faut, pour répondre à ces besoins, un personnel plus nombreux, un espace plus considérable, que dans les centres moins importants. Ces consultations nous rapportent entre 0.3 1/8¢ à 0.6¢ par consultation, variant dans les différents hôpitaux. Il est à remarquer que pour cette médecine préventive qui épargne des sommes considérables à la province et aux municipalités, nous ne recevons aucun octroi pour nous aider à maintenir ces différentes cliniques.¹⁵⁵

Indeed, in 1945 the Montreal General, which recorded 151,523 consultations and treatments in its clinics, also recorded a deficit of \$415,000 in the clinics alone.¹⁵⁶ And this was after cutting the number of clinics and despite efforts by the hospital to control clinic use by investigating the financial status of patients and sending those

¹⁵⁴ ANQ, E8/3, J. H. Roy, President of the Montreal Hospital Council Inc. to Henri Groulx, Minister of Health, August 6, 1940. This sentiment was reiterated in the Report of the General Superintendent of the Montreal General in the AR, 1940.

¹⁵⁵ ANQ, E8/3, Roy to Groulx, *op. cit.*

¹⁵⁶ MA, MGH, Statistics, and Report of the General Superintendent, AR, 1945.

able to pay physician's fees to a private doctor.¹⁵⁷ Acceptance by the government of some financial responsibility for out-patient clinics would have had a significant effect in lowering the hospitals' annual deficits. Yet nothing was done, despite persistent requests from the hospitals and the Montreal Hospital Council that the government take the question in hand.

Similarly, repeated requests for increases in PCA rates (not changed since 1929) and Workmen's Compensation resulted in one increase of each in 1942-43 (The PCA rate moved from \$2.00 to \$3.00). Even collecting the inadequate existing amounts was not always guaranteed, however. As Roy noted, again to Health Minister Groulx in a letter in 1941,

... depuis l'institution du Service du Bien Être Social de la Cité de Montréal, 50 à 60% des cas que nous soumettons à ce département sont refusés pour des raisons que nous ne trouvons pas valables. De plus, il s'écoule souvent trois, quatre et souvent même cinq mois avant que nous soyions avisés par ce département que ces cas sont refusées.¹⁵⁸

The hospitals hoped that the Lessard Commission would vindicate their claims and suggest an increase in the PCA rate. The Commission certainly showed that funding was inadequate, and the PCA rate was increased, but even the Lessard Commission seemed capable of causing more headaches. Part of its mandate was to examine working conditions in the hospitals. In this regard, it proposed an increase in the

¹⁵⁷ MA, MGH, General Superintendent's Report, AR, 1942.

¹⁵⁸ ANQ, E8/3, J. H. Roy, President of the Montreal Hospital Council Inc. to Henri Groulx, Minister of Health, March 18, 1942.

allowance paid to nurses for external living costs. Where the Commission proposed \$17.50 a month, St-Luc paid only \$7.50. In order to avoid the added expense, the Board of Management decided to renovate one of their buildings as a nurses' residence.¹⁵⁹

Some positive initiatives did come from government, however. The Dominion government did eventually listen to the CHC's pleas on various questions, unemployment insurance and problems with the NSS, for example. And other actions, not necessarily aimed specifically at aiding hospitals, also helped. One of the best examples was the 1942 changes in the income tax law allowing husbands to maintain their wives' full married status exemption if they returned to work, regardless of the wife's salary.¹⁶⁰ This helped hospitals particularly in that it prompted married nurses to return to the work force. In 1943, the Montreal General's Director of Nursing noted that, "Some of our older married nurses have come forward to help in this crisis and we find them among the general duty group, private duty, and even in the special departments of the hospital."¹⁶¹

¹⁵⁹ HSL, Procès-verbal, Conseil d'Administration, le 1 mars 1943.

¹⁶⁰ "One accommodation, in the way of an economic incentive to married women, was the July 1942 amendment to the Income War Tax Act with respect to the income of married couples. Under the tax law in force up to July 1942, a married woman, whose husband also received an income, could earn up to but not more than \$750 without her husband's losing the right to claim the full married status exemption. The 1942 revision of the tax law as it affected married couples granted the husband whose wife was working the full married status exemption 'regardless of how large his wife's earned income might be.' The 'special concession' was regarded as a 'wartime provision.' This amendment to the Income Tax Act was designed 'to keep married women from quitting employment' and to 'encourage the entry of married women into gainful employment.' Up through 1946, the husband paid no tax on any income up to \$1,200, regardless of his wife's earnings. The wife paid tax on income exceeding \$660." Pierson, *op. cit.*, pp. 153-154.

¹⁶¹ MA, MGH, Report of the School for Nurses, AR, 1943.

As hospital administrations followed the developments leading towards a national health insurance plan, they had, on the basis of their own experience, reason for mixed feelings about further state intervention. While their relationship with the state was, on the whole, good, and the special circumstances of the war explained much of the strain between hospitals and the different levels of government, nonetheless, the long history of underfunding, coupled with the general resistance in voluntary hospitals to state action, did not encourage total enthusiasm for further state intervention in the hospital sector.

Conclusion

The war years witnessed the articulation and debate, inside government and in society in general, of competing visions of post-war Canada. The core of the debate was the opposition of a government-funded and -directed welfare state, including health insurance, to a market-based model free of any major state intervention.

While the population as a whole seemed to strongly support state-funded health insurance, this was not the case for several groups inside and outside of government. Inside government, at both federal and provincial levels, there were groups that supported the vision of greater state activity: the federal Minister of Pensions and National Health, with his department, worked to develop a national insurance plan; in the Godbout government, the Minister of Health appointed the Lessard Commission and then, following on its recommendations, the Garneau

Commission to examine a provincial health insurance plan. Outside of government, no group was overtly opposed to a state programme, but several groups did express reservations. There was also opposition inside Cabinet in Ottawa, and in the Department of Finance in particular. And Mackenzie King himself wavered considerably over the question. In Quebec, the Union Nationale, on its return to power, was not interested in instituting a provincial plan.

The reservations expressed, in government, by business groups, by the Canadian Medical Association, and by the Canadian Hospital Council, implied concern about moving away from a market-based system. Hospitals' anxieties about their role in the post-war government-funded insurance plans, and especially about the loss of the liberal voluntary spirit or of their autonomy, were reflections of these concerns. Their organizations watched the process closely and participated in the deliberations over government plans, making sure their viewpoint was taken into consideration. At the same time provincial hospital associations began to fashion market-based alternatives to the government plans, that is the non-profit group hospitalization plans under the umbrella of the Blue Cross system.

While these debates were being carried on, the prosecution of the war had major immediate implications for the health-care delivery system. Hospitals certainly did not escape the effects in their daily activity. The war attenuated some aspects of hospitals' financial crisis, but introduced other major problems to the already over-extended hospital system. Thus, in what could be considered a positive financial situation, with a significantly larger proportion of paying patients, the fundamental

weakness of the financial structure of hospital care did not change. While deficits were reduced in the case of St-Luc and did not grow substantially in the case of the Montreal General, for example, they still were a fact of life.

As they confronted the new challenges of the war period, both hospitals enunciated solutions for their financial troubles. Not afraid of government intervention when it came to indigents, an echo of the liberal voluntary tradition, they made repeated demands that the government pick up the tab for indigent clinic visits, and that government increase payment for hospitalized indigents. Not wanting to see too much extension of government control, they hoped the new non-governmental group insurance plans would grow, providing hospital insurance for a larger segment of the population.

Clearly the two hospitals' reaction towards the growth of state intervention, paralleling hospitals in Canada as a whole, was mixed. Their vision had been transformed during the war years from one that wanted only higher rates for indigents to a hesitant acceptance of a national plan in some form or other, as witnessed by the CHC's brief to the federal Heagerty Committee. Yet, because of an ongoing discomfort with extensive government wartime intervention, they must have felt some relief when it became clear that the federal plan would not go ahead. Real problems of financing would clearly persist. Yet there was almost certainly relief as well, as the voluntary hospitals, the predominant sector in Canada, would see the continuation of their cherished autonomy. Hospitals and their

organizations, ambivalent in any case about more government involvement, once again looked elsewhere for a solution to their financial problems.

Chapter IV

THE POST-WAR ERA: RETREAT TO INCREMENTALISM

Hopes for universal health insurance faded with the conclusion of the Dominion-Provincial conference on May 3, 1946, victim, specifically, of unwillingness on the part of the Quebec and Ontario Premiers to agree to the tax-sharing proposal that the Dominion government considered a necessary pre-condition for a universal health care plan, but, more generally, of a rapidly fading commitment on the part of the Liberal Cabinet to any extension of the welfare state.¹ As a result, with no expectations of a major federal incursion into health insurance but with continued hope that government would improve its contribution to the indigent care, the hospital sector was free to test its conviction that, for the most part, the market held the solution to hospital financing problems. In many ways, the situation appeared ideal: the booming economy promised a paying clientele, and the federal government's withdrawal from the field of health insurance left it open to the private sector. Surely this combination of factors would lead to the growth of private insurance membership.

¹ See David Jay Bercuson, *True Patriot: The Life of Brooke Claxton 1898-1960* (Toronto: University of Toronto Press, 1993), pp. 140-145; Malcolm G. Taylor, *Health Insurance and Canadian Public Policy*, Second Edition (Kingston: McGill-Queen's University Press, 1987), pp. 48-68; Antonia Maioni, "Explaining Differences in Welfare State Development: A Comparative Study of Health Insurance in Canada and the United States" (Ph.D. diss., Northwestern University, Evanston, Illinois, 1992), pp. 160-161; Donald Swartz, "The politics of reform: conflict and accommodation in Canadian health policy," in Leo Panitch, ed., *The Canadian State: Political Economy and Political Power* (Toronto: University of Toronto Press, 1977), pp. 321-322; Doug Owsram, *The Government Generation: Canadian intellectuals and the state 1900-1945* (Toronto: University of Toronto Press, 1986) pp. 321-23.

Speaking to the Canadian Public Health Association a few days later, Health Minister Brooke Claxton, champion of the health insurance plan, noted: "Failure to reach agreement at the conference has meant that we cannot begin to implement these proposals in the immediate future and consideration will have to be given to the whole situation."² Indeed, the whole situation was reviewed, but not in haste. In the meantime, as Claxton pointed out in the same address, provinces were taking measures to expand and improve health care: among the provinces putting in place measures in anticipation of a national programme Claxton noted Saskatchewan, Manitoba, and Alberta.³

Paul Martin replaced Brooke Claxton as Minister of Health and Welfare in December 1946. Martin, who saw himself as a "small-l liberal," saw no contradiction between this position and a belief in state intervention for the common good.

Ideologically, I believed strongly that the power of government could be brought to bear on most health and social welfare questions. Etienne Gilson's speech to the young Liberals in Hamilton [September 1947] very much expressed my own philosophy. A liberal does not stand for political liberty in everything, he told the gathering; political liberty is not an end in itself, but a means to ensure other liberties... Government intervention was necessary, he said, to safeguard individual freedom and so ensure the common good. The state should give people the supplementary legal and technical means necessary to allow for full individual development.

² Brooke Claxton, "More Health for Canada," *CJPH*, vol. 37 (June 1946), p. 235.

³ *Ibid.*

To accomplish what Gilson had prescribed, we had to forge a broad program of social services through a carefully devised social insurance plan.⁴

Committed to expanding the role of the state in health matters, Martin faced a Cabinet where, in his words, “right-wingers were ruling the roost.”⁵ Nevertheless, through various manoeuvres over the next few years, and in particular by appealing to the aging Mackenzie King’s desire to be remembered for putting into action the values of social reform he had espoused in *Industry and Humanity*, Martin managed to put in place measures which would move the country in the direction of health insurance.⁶ By 1948 he had managed to build up enough momentum to convince Cabinet to agree to a series of measures to improve health care services in Canada.

Some aspects of the political context favoured Martin’s approach: the Saskatchewan government had decided to institute its own hospitalization insurance

⁴ Paul Martin, *A Very Public Life*, vol. II, *So Many Worlds* (Toronto: Deneau, 1985), pp. 28-29. Martin’s interpretation of liberalism fits into a long line of liberal thought reaching back to John Stuart Mill and beyond, and including, to name a few, Gladstone, Hobhouse, Hobson, Keynes and Beveridge. This stream of thought, unlike its *laissez-faire* cousin, saw no problem in the state actively promoting the collective well-being of the nation. For a discussion of this branch of liberalism and its evolution from the classical (*laissez-faire*) liberal position, see L. T. Hobhouse, *Liberalism* (London: Oxford University Press, 1964); Alan Bullock and Maurice Shock, eds., *The Liberal Tradition From Fox to Keynes* (London: Oxford University Press, 1956), particularly the Introduction; John Gray, *Liberalism* (Minneapolis: University of Minnesota Press, 1986).

⁵ *Ibid.*, p. 37. Martin, like Ian Mackenzie, came from a riding (Windsor, Ontario) where organized labour and the CCF were strong, and thus was also very conscious of their strength in promoting social issues like health insurance. See Maioni, *op. cit.*, p. 144.

⁶ Among methods used by Martin were giving support, but no funding because of Cabinet resistance, to the development of a national campaign against cancer in 1947, and winning a \$50,000 emergency grant — but not a sustaining grant — from Cabinet for Wilder Penfield’s Montreal Neurological Institute in 1948. Martin considered this second incident as precedent for further grants. See Martin, *op. cit.*, pp. 36-42.

programme, effective January 1, 1947⁷; all provinces except Quebec and Ontario had signed tax agreements with Ottawa; and the end of King's career in public life and concerns about winning the upcoming federal elections made King and the Party more open to Martin's proposals, since government-funded health insurance had strong support among the voters.⁸

Martin was determined not to let go of the health insurance question despite meagre support in Cabinet for the measure. In his department he surrounded himself with individuals dedicated to health insurance, and had his staff working on an approach to the question. Some interesting notions were evident in a discussion paper on hospital insurance produced in January 1947. Several insights into the thinking of the day are provided by this document. The political implications of Saskatchewan's new hospitalization programme seemed pre-eminent in the minds of the authors:

... It is proposed that the Federal Government should proceed with the development of a National Hospital Act to provide hospitalization and diagnostic service benefits at the earliest date possible. This would provide a substantial sum of money to those provinces which would be willing to sign agreements. It would give the Cabinet an opportunity to meet the provinces again with fresh proposals to meet the current crisis. It would further prove to be a bold and sound piece of legislation aimed at an expansion of the Government's already excellent social security programme. To date, probably the only field left in the social security advance lies in the realm of health advancement for

⁷ According to Maioni, *op. cit.*, the Saskatchewan government, in its step-by-step approach to the institution of universal health insurance, chose to start with hospitalization insurance because it suited the province's rural settlement pattern and did not interfere with the private practice of medicine, thus avoiding antagonizing the well-organized medical lobby. See pp. 197-198.

⁸ Martin, *op. cit.*, pp. 45-46; Martin comments: "but Ottawa still resolutely refused to act on its health and social welfare blueprint until every provincial government had come on board," p. 33. See also, Maioni, *op. cit.*, pp. 161-162; Malcolm G. Taylor, *op. cit.*, p. 162. The tax agreements were not now linked to health and social security reform, as they had been in the Green Book proposals of 1945.

Canada. The Saskatchewan Government, under the Honourable Mr. Douglas, who is giving a large portion of his time to making health a dominant factor in the province, is spending a large share of its budget to prepare the way for a successful appeal to the electorate not only in Saskatchewan but in all Canada....

... This sum of \$37,961,140.00 [amount required for national hospitalization insurance] would provide an extremely reasonable means of proving that the Federal Government is well in the van in providing health security as well as other social security measures.

... If this step were made at the present moment, it would provide the Federal Government with the prestige of having initiated a national scheme and at the same time it would open the way within the next three years, before a further appeal is made to the electorate, for designing and developing more concrete proposals for a wider health programme in some such measure as has been laid out in previous proposals as drafted by the Department of National Health and Welfare.⁹

The paper summarized advantages of immediate implementation of National Hospitalization: it was badly needed legislation; the costs were significantly less than any previously proposed general plan; it did not include general practitioner services, potentially very expensive and strongly opposed by the medical profession; it would be acceptable to municipal hospital boards and church hospital orders in that it would simplify their accounting and relieve the very considerable financial pressure they experienced; it would be beneficial to private corporations by relieving them of their share of the cost of private hospitalization insurance plans; it would provide labour and farm groups with hospital accommodation much cheaper than they could secure through Blue Cross or commercial insurance companies; and it would permit the Saskatchewan Government to gain sufficient finances to proceed with their further

⁹ NAC, RG 29, Department of National Health and Welfare, vol. 1063, file 502-1-1, pt. 11, untitled, Jan. 8, 1947.

plans, while allowing the Federal Government to learn valuable lessons from its observation of Saskatchewan's errors. Finally, it "would also nullify the prestige of the CCF Party's present advance by making similar opportunities open to other provinces on a national scale."¹⁰

The document also proposed creating a low-interest-rate fund for hospital expansion so that provinces could meet expected increased demand for elective (non-emergency) hospital procedures once the hospitalization plan was implemented.¹¹ Given the serious shortage of beds in Canada,¹² this was the key to avoiding chaos once a hospitalization insurance plan was put into effect. It also seems to have been the element immediately focused on. In fact, a few days later, in another document, J. L. Little, Assistant Director of Health Insurance Studies, proposed providing immediate planning and organization grants to the provinces to determine their needs, a necessary first step for developing any plan with federal involvement.¹³ Little also insisted that the Dominion government pass enabling legislation for a Dominion-sponsored, provincially administered hospitalization insurance plan. In this way, he reasoned, with the planning grant each province would move to implement the plan when the public

¹⁰ *Ibid.*

¹¹ *Ibid.*

¹² In 1945, while the Heagerty Plan was still under consideration, the CHC calculated that approximately 42,000 more acute care beds would be needed immediately, with an addition of about 20,000 in the ten years following implementation. See, Harvey Agnew, "If Health Insurance Comes: What Hospital Facilities Will be Needed?" *TCH*, vol. 22, no. 9 (September 1945), p. 30.

¹³ NAC, RG no. Interim 150, Department of National Health and Welfare, file 615-3-15, pt. 1, J. L. Little, Asst. Director of Health Insurance Studies, "Confidential: An Advance in Health Security," Jan. 16, 1947.

pressure was there and when it felt it had sufficient bed capacity to accommodate the public (funding for acute-care beds would be the responsibility of the province and municipality). "In other words, the Dominion would be passing enabling legislation whereby progressive provinces could secure assistance in meeting modern conditions."¹⁴ It would appear that Little too was preoccupied with the advantages this would give the Liberals in the next federal election:

No broad Dominion plan can be formulated until sufficient factual data on provincial levels can be ascertained. More than likely an appeal will be made to the electorate in or before 1950. To be prepared for an appeal to the country by that date, it is essential that the planning commissions be set up and factual data be compiled from every source available.¹⁵

This preoccupation with future elections was apparently well warranted. The question of health insurance was in the public eye. Commenting on a new privately operated prepaid medical care plan in Ontario, in September 1947 *The Ottawa Citizen* noted the pertinence of a government plan.

Founding of another privately-operated prepaid medical care plan in Ontario only emphasizes the need for a comprehensive national health insurance program. Even in these prosperous times few people can stand the financial strain of ill-health....

The project just announced, like all privately-operated plans, is restrictive in that its benefits are available only to its members. It also lacks one of the most important features of national health insurance in that it makes no provision for the expansion of hospital facilities, or for providing these in areas now without them.

Although declared to be a non-profit enterprise, the financial aspects of the new privately-owned scheme should be kept under close public supervision. In the case of one large prepaid hospital care plan, such a huge surplus has been accumulated that it was criticized by the

¹⁴ *Ibid.*

¹⁵ *Ibid.*

Ontario Minister of Health. The schedule of medical fees as well as the amount of membership dues, should also be subject to review by the authorities of the province of Ontario which granted the charters.¹⁶

Several polls were taken over these years to gauge the public's feelings towards a government health insurance plan. In an internal document, a summary of an informal discussion held with Dr. Fred Jackson, the department official responsible for the grant programme, it was noted that, according to one such poll taken in 1949, approximately 83 per cent were in favour of health insurance.¹⁷ This support seems to have been consistent in the 1940s. Malcolm Taylor cites two Gallup polls, one in 1944 and the other in 1949, both giving 80 per cent support for "a National Health Plan whereby you would pay a flat rate each month and be assured of complete medical and hospital care by the Dominion Government."¹⁸ The proposed grants would most certainly be favourably viewed by the electorate.

In 1948, Martin moved into action. His 1948 proposals, though much more restrictive than the 1945 Green Book proposals, were an important basis for creating an infrastructure that could support a later national health insurance programme. First, on the judgement that the federal government had to keep the initiative and not wait to be out-manoeuvred by Ontario and Quebec, Martin suggested that proposed federal health care measures apply to all provinces, regardless of whether they had signed tax

¹⁶ "National Health Insurance," *The Ottawa Citizen*, September 12, 1947, in NAC, RG 29, vol. 1063, file 502-1-1, pt. 11.

¹⁷ NAC, RG 29, vol. 1063, file 5021-1-1, pt. 11, "Health Insurance — An Informal Discussion," September 7, 1949.

¹⁸ Taylor, *op. cit.*, p. 166.

agreements with Ottawa. The first stage would be the survey grants, so that provinces could evaluate and plan their health care needs. Next would come general grants for public health programmes (tuberculosis, cancer, venereal disease, mental health, childhood diseases and professional training); and hospital construction grants, by which the federal government would pay one-third of the cost of new hospital beds if matched by the provincial government, in order to bring the number of beds up to the level needed before hospitalization insurance was introduced. With King's support the measures passed Cabinet. King presented this in the Commons as a step towards the development of a national health programme, "leading up to, and ultimately including, health insurance."¹⁹ It is worth noting the actual scope of these grants, however. Despite the fact that the new grants programme represented a thirty per cent increase in the total expenditure on health by all governments in Canada, the actual amount allocated for hospital beds still came nowhere near the estimated cost of construction.²⁰

The plan was announced on May 14, 1948. A few days later Paul Martin addressed the annual meeting of the Canadian Public Health Association in Vancouver. His topic was "A National Health Program for Canada." In his speech he noted that "When the present program is well under way, it will then be possible to proceed with

¹⁹ Martin, *op. cit.*, pp. 46-53. King quoted on p. 52.

²⁰ The federal government was offering a grant of \$1,000 per bed to be matched by a grant of the same amount from the provincial government. In 1947, the Superintendent of the Montreal General estimated that the cost of hospital construction was equivalent to \$12,000 per bed. MA, RG 96, MGH, Report of the General Superintendent, AR, 1947.

the implementation of a national plan for hospital and medical care insurance."²¹ To deal with the serious shortage of hospital beds, Martin announced: "To get the results desired, the Dominion Government will now make matching grants to the Provinces, totalling up to \$13,000,000 a year, for a period of at least five years, at which time the needs of the succeeding five-year period will be examined and the grants adjusted accordingly." The aim was to provide 40,000 new hospital beds, a figure very close to what the CHC had calculated as necessary.²²

In order to qualify, the first step for each province was to make a survey of its hospital/medical needs.

The information about each provincial plan that will be collected under the Health Survey Grants will provide a clear picture of provincial hospital needs. By carefully planning the type and location of new hospitals in relation to regional requirements, it will be possible to correct the present maldistribution of hospitals and of medical services — especially as between rural and urban areas. At the present time, the greatest shortages are of hospitals for mental care and chronic and convalescent cases. There are also urgent shortages of hospitals for tuberculosis care and active treatment.²³

Martin, undoubtedly in keeping with feelings inside Cabinet, did note that a full-fledged health insurance programme was not around the corner:

The great three-point National Health Program of the Federal Government that I have outlined does not indicate the immediate beginning of a national hospital and medical care insurance plan, but it does clear the way for the great eventuality....

There must be vastly increased hospital accommodation, the entire public health structure must be strengthened and extended, and there

²¹ Paul Martin, "A National Health Program for Canada," *CJPH*, vol. 39, no. 6 (June 1948), p. 220.

²² *Ibid.*, p. 223.

²³ *Ibid.*, pp. 223-224.

must be greatly increased numbers of public health personnel. But everyone who is interested in the advancement of the health levels of our citizens and in clearing the way for a national health insurance plan can now be encouraged by the large-scale and bold health program that the Federal Government is putting into effect. The eventual implementation of health insurance will depend to a great extent on our success in wisely and effectively expending the very considerable Federal moneys that now become available.²⁴

The Canadian Hospital was quick to comment on the government plans. In an article in June the editor, noting that health insurance was being approached by stages, wrote that this was "preferable to a precipitate all-inclusive measure."²⁵ In general, the comments were favourable, with, however, some reservations. The article agreed, for example, that the surveys were an essential first step, noting that similar surveys had been made in most American states in the two previous years as a pre-requisite for government aid. The grants for hospital construction, a positive step "if matched by the provinces and supplemented by local support, should go a long way toward overcoming the bed shortage." "However," the article went on to say, "there will still be a heavy share of the cost to be borne by the community and hospital supporters. Nor is there assurance that all provincial governments will match the federal offer."²⁶ Finally, on the question of the nursing shortage, the editor noted with approval the \$500,000

²⁴ *Ibid.*, p. 224. Martin, in his autobiography notes that King, himself, considered this sufficient action, with no need to go further. See Martin, *op. cit.*, p. 52.

²⁵ "Health Insurance Program Announced by Federal Government: Large Grants for Hospital Construction," *TCH*, vol. 25, no. 6 (June 1948), p. 27.

²⁶ *Ibid.*

available annually for training public health professionals, which would also be available for training hospital personnel.²⁷

Funds for construction of student nurse accommodation were not included in the programme, however, an unfortunate exclusion considering the severe shortage of nurses across the country. In November of the same year, at a meeting of voluntary and professional health care organizations with provincial and federal government officials to discuss the advances made in the National Health Program, the CHC proposed that such accommodation be included in the grants programme. As the Canadian Nursing Association noted at the same meeting, "81 per cent of the 172 nursing schools could accommodate 4,283 more students *if residence accommodation were available*."²⁸

Despite some criticisms, however, the grants were overwhelmingly welcomed and used. By March 1949, grant applications had been made for the construction of 13,000 beds, of which 6,400 had been approved.²⁹ The programme was definitely well underway, and seemed to justify Martin's conviction that it would be necessary to complete this stage before moving forward on a comprehensive health insurance plan.

²⁷ *Ibid.*, p. 28. Later clarification indicated that half of the yearly sum was to be appropriated for training of hospital professionals. See "Further Details Available Respecting Federal Health Grants," *TCH*, vol. 25, no. 9 (September 1948), p. 46.

²⁸ Quoted in "Survey Program Clarified at Ottawa Conference," *TCH*, vol. 26, no. 1 (January 1949), p. 34. (Italics in original text.)

²⁹ "Notes on Federal Grants," *TCH*, vol. 26, no. 3 (March 1949), p. 50.

The notion that Saskatchewan should be watched to see how it handled hospitalization insurance also proved to be useful, particularly to the proponents of a broader system.

- **Lessons from the Saskatchewan Experience**

By 1950, the advantages of the Saskatchewan Hospital Services Plan could be seen by all who cared to look. The benefits were clearly enumerated in an article written by Frederick Mott, Acting Deputy Minister of the Saskatchewan Department of Public Health. The plan was financed by a combination of annual designated taxes, ranging from \$10 for an adult to a family maximum of \$30, and from general tax funds.³⁰ The plan provided virtually complete in-patient hospital care on a public ward basis, with no limit on length of stay in hospital and no restrictions such as the exclusion of pre-existing conditions.³¹ The plan also allowed for the building of hospitals where they were needed, particularly in remote areas.³²

Hospital administrators could also see value in the plan. As Mott noted:

Hospital administrators will tell you that they have no desire to forego today's stable hospital financing and to return to the good old days when one of the basic if questionable freedoms enjoyed by each patient was the freedom *not* to pay his hospital bill.³³

Mott noted that indigents and pensioners were fully covered, that the plan had allowed for a significant building programme, and that, though costs were going up because of

³⁰ Frederick D. Mott, "Prepaid Medical Care under Government Auspices in Saskatchewan," *CJPH*, vol. 41, no. 10 (October 1950), p. 407.

³¹ *Ibid.*, p. 404.

³² *Ibid.*, p. 408.

³³ *Ibid.*, p. 404. (Italics in original text.)

increased use as well as increased costs (which was true across Canada), the plan was still more cost efficient even than the non-profit plans, with overhead costs amounting to five per cent of total expenditure in 1949, against a Blue Cross average of nine per cent.³⁴ Finally, in the most telling argument that could be made to win over hospital administrators:

This matter of stabilizing of hospital financing stands out as the chief contribution which the Hospital Services Plan has made when one considers its effect on the hospitals themselves. The method of paying hospitals practically assures the meeting of their costs of operation, provided they are managed well and maintain satisfactory occupation. Serious operating deficits, reported constantly in the press elsewhere, are now almost unknown in Saskatchewan... Observers agree that our hospitals as a group are in better shape today than ever before, with much new equipment, improved diagnostic facilities, and general maintenance right up to par. With financial worries minimized, hospital administrators are better able to concentrate on raising the standards of hospital care.³⁵

Provincial governments could be attracted by the financial efficiency of the system, and by the way in which it enabled the planned development of health care resources. In fact, two provinces did follow Saskatchewan in introducing state-directed hospitalization insurance: British Columbia in 1949, and Alberta in 1950.³⁶

³⁴ *Ibid.*, p. 407.

³⁵ *Ibid.*, p. 408.

³⁶ Taylor, *op. cit.*, pp. 167-180. According to Taylor, neither the B.C. nor the Alberta systems were as comprehensive or as effective as that of Saskatchewan. In 1954, for example, government payments to hospitals in Saskatchewan equaled 85.7 per cent of hospital revenues; in British Columbia, payments then totalled 73 per cent, while in Alberta they totalled only 38.6 per cent. Newfoundland entered Confederation in 1949 with its already-established Cottage Hospital system for outport regions, where it provided services through provincially-owned hospitals and salaried physicians. Thus, by 1950, four provinces had some form of state-run hospitalization system for the non-indigent public. See Taylor, *op. cit.*, p. 170.

Meanwhile, although Paul Martin envisioned moving rapidly from the granting programme to a hospitalization insurance programme, Prime Minister Louis St. Laurent was not interested. In 1950, in preparation for a federal/provincial premiers' meeting, St. Laurent asked Martin to prepare a statement emphasizing the fact that "our efforts had not provided sufficient hospital accommodation or qualified personnel to implement a national health insurance scheme 'at this time.'"³⁷ On the opening day of the conference, St. Laurent marshalled the Secretary of State for External Affairs, the Minister of National Defence and the Minister of Finance, all to argue that the potential costs of involvement in the Korean crisis made it impossible to commit any increased funding to a hospitalization insurance programme. Of the provinces, only Saskatchewan insisted that the federal government move ahead nonetheless.³⁸ For the time-being, a more market-oriented vision was ascendant. As a result, Martin would have to content himself with continuing to administer the 1948 funding programme, using it as a public platform to promote a broader programme, and wait for a more opportune time to push forward.

In Quebec, Duplessis Takes the Plunge

When the federal hospital grants were announced in 1948, there was some question in the Department of National Health and Welfare as to whether Quebec Premier Duplessis would accept the new health grants. It was feared that his anti-

³⁷ Martin, *op. cit.*, p. 219.

³⁸ Taylor, *op. cit.*, pp. 183-185.

federalist stance, combined with Church concerns about any programme that might menace the existence of Church-run hospitals in the province, would stand in the way of his acceptance. After Duplessis' Union Nationale won re-election in August 1948, Martin arranged to see him in order to convince him that the grants programme had no strings attached. Duplessis and his Cabinet accepted the programme in September 1948.³⁹

Why Duplessis accepted this programme, while rejecting other federal programmes, such as the one for post-secondary education, is an open question.⁴⁰ Martin implies in his autobiography that one of the reasons may have been the desire to use hospital construction as a patronage tool.⁴¹ Vaillancourt, on the other hand, points out that Duplessis made hospital construction a centre-piece in his government's discourse and activity in health care, making it a constant theme, for example, in the annual budget speeches.⁴² Robert Rumilly, Quebec historian and propagandist for Duplessis, certainly underlines the advances made in hospital construction in the Duplessis era in his biography of the Union Nationale leader. In

³⁹ See Martin, *op. cit.*, pp. 58-59.

⁴⁰ The Quebec government did in fact accept federal funding for post-secondary education in 1951, but then reversed its position the following year. Why this happened is unclear. See René Durocher, Michèle Jean, "Duplessis et la Commission royale d'Enquête sur les problèmes constitutionnels, 1953-1956," *Revue d'Histoire de l'Amérique française*, vol. 24, no. 3 (December 1971), p. 338.

⁴¹ *Ibid.*, p. 61.

⁴² Yves Vaillancourt, *L'Évolution des politiques sociales au Québec 1940-1960* (Montreal: Les Presses de l'Université de Montréal, 1988), p. 186.

his tribute to Dr. Albiny Paquette, Minister of Health under Duplessis, who retired in 1958, Rumilly noted that

Le ministre a dépensé, depuis 1944, plus de 155 millions pour construire 60 hôpitaux généraux, 6 sanatoriums, 4 hôpitaux pour malades mentaux, 6 hospices et orphelinats, 11 hôpitaux spéciaux. Il a mis 29,000 nouveaux lits à la disposition des malades.⁴³

In fact, there was little political risk in accepting the federal grants.

Undoubtedly, Quebec sorely needed more hospital beds: the ratio of beds to population was significantly below the minimum required. Though the federal funding was far from adequate to cover the real cost of construction, it was nonetheless a significant contribution, not to be rejected. The fact that no commitment to a national health insurance plan at a later date was required made acceptance politically risk-free. In addition, since there would be no infringement of the autonomy of the institutions involved, a particular concern of the Catholic institutions, there was little resistance on their part. Considering the crisis situation in hospitals in the post-war era, it might actually have been politically risky not to participate in the programme.

As a first step, in 1948, the Quebec provincial government accepted federal funds to commission a survey on the state of health care services in Quebec. The report, the *Enquête sur les Services de Santé*, was presented in 1950, by which time the

⁴³ Robert Rumilly, *Maurice Duplessis et son temps*, Tome II (1944-1959) (Montreal: Fidès, 1978), p. 659. This volume lists innumerable government grants for hospital extensions or new construction. See, for example, pp. 497-8. No mention is made, however, of the federal contribution to these expenditures. See also, Robert Rumilly, *Quinze Années de Réalisations: Les faits en parlent* (Montreal, 1956), pp. 109-110. Rumilly apparently lumps together all sorts of beds, for acute care, tuberculosis, psychiatric patients, etc.

Provincial government was already taking full advantage of the Dominion/Provincial grant programme for hospitals.⁴⁴

The report noted the increase in hospital beds in the two years since 1948: in 1948, there had been 14,269 active beds (for acute care, convalescence, pregnancy and contagious diseases); in 1950, there were 17,121 active beds. The ratio of beds to population improved from 3.74/1000 population to 4.39/1000 population.⁴⁵ Despite the impressive overall increase, Quebec's ratio of beds/population was still below both the national average and the estimated needs posed by rapid growth of the population. The report underlined the need for still more hospital beds, and for new hospitals in peripheral regions which lacked adequate services.⁴⁶ It also touched on several aspects of particular interest to university-linked city hospitals like St-Luc and the Montreal General. In terms of funding formulas, the report noted:

Le coût d'administration d'un hôpital augmente proportionnellement avec la qualité des services qu'on y donne. C'est pourquoi il serait juste que chaque institution hospitalière soit classée et que le taux d'assistance publique soit en rapport avec ce classement.⁴⁷

Noting the problem of chronically-ill patients tying up acute-care beds, the report also suggested the creation of community-based institutions for chronic patients to free up

⁴⁴ *Enquête sur les Services de Santé* (Province de Québec, 1948).

⁴⁵ *Op. cit.*, vol. V, *L'Hospitalisation*, p. 287. As a point of comparison, according to TCH estimates, an adequate ratio of beds was somewhere in the vicinity of 5 to 7 beds/1,000 population. (See Harvey, Agnew, "What Hospital Facilities will be Needed?", *TCH*, vol. 22, no. 9 (September 1945), p. 31. Quebec, therefore, still had some distance to go.

⁴⁶ *Enquête sur les Services de Santé*, vol. I, *Présentation et Synthèse du Rapport*, p. 33.

⁴⁷ *Ibid.*, p. 34. (Hospitals were classified generally as full-service, or other.)

beds in general hospitals, and the opening of hospital clinics for cancer, tuberculosis and prenatal care for those who could not pay for doctors. No suggestions were made about financing these clinics.⁴⁸ It is not clear to what extent Quebec followed up on any of these suggestions outside of the funds available through the Dominion/Provincial programmes. In 1951 the provincial government did pass a law that would have rendered quality care more accessible. This was the Act for the Establishment of Provincial Medical Diagnostic Centres, which permitted the government to assume the cost of organizing, building and developing medical diagnostic centres that would have been free for persons of low income. The law was never put into effect, however.⁴⁹ Regarding other recommendations, the government seems to have undertaken a policy of decentralization of hospitals, promoting the building of small hospitals in the hinterland. However, by the end of 1951 the rural regions still faced a serious bed shortage. In addition, the shortage of beds for chronic care and incurable patients was still unresolved, obliging acute care hospitals to continue to lodge these patients. The overall result was an overly long average length of hospital stay.⁵⁰

⁴⁸ *Ibid.* pp. 34-35.

⁴⁹ "History of Health Services," *Report of the Commission of Inquiry on Health and Social Welfare* (Castonguay-Nepveu Report) (Quebec, 1970), Part Two, vol. IV, *Health*, Tome I, *The Present Situation*, p. 29.

⁵⁰ *Rapport de la Commission royale d'enquête sur les problèmes constitutionnels*, vol. III, Tome I, Cinquième partie: *Analyse des Besoins et Recommandations* (Quebec: 1956), pp. 92-93.

Once Quebec had embarked on the Dominion/Provincial plan, however, it took full advantage of it. In June 1950, *The Canadian Hospital* published a summary of the first two years of the programme. Of the \$23 million in health grants, Quebec obtained over \$7.5 million, the highest of any province (Ontario obtained \$5.4 million). Of the 19,800 beds added, Quebec's portion was 6,551 (Ontario added 5,339).⁵¹ The provincial government also allowed hospitals to take advantage of other Dominion/Provincial grants for cancer treatment, tuberculosis treatment, or other services. On the whole, however, the only other means used by the Quebec government to improve the quality and accessibility of hospital care in the province was through the PCA. The rest was left to the market. This was problematic, however, since Quebec did not have a high rate of adherence to private or group health insurance plans. By way of example, Blue Cross plans covered 16 per cent of Quebec's population in 1951, compared to 34.8 per cent of Ontario's population in the same year.⁵²

⁵¹ "Two Years of Progress: A Brief Survey of Federal Grants," *TCH*, vol. 27, no. 6 (June 1950), p. 70. It is worth noting, as a point of comparison, that according to statistics published by Quebec's Royal Commission on Constitutional Problems, in 1952 Quebec had a ratio of public hospital beds/1000 population of 4.17, while Ontario's ratio was 4.67 (This was based on a total of 17,412 beds in Quebec, 22,251 in Ontario.) The Canadian average was 4.72. In 1954, Malcolm Taylor, using DBS Hospital Statistics pegged the ratios at 3.6 for Quebec (15,720 beds) and 4.4 (22,260 beds) in Ontario, and 4.5 in Canada. The discrepancies could be due to variations on reporting, and in particular to what was considered at public general hospital bed. See *Rapport de la Commission Royale sur les Problèmes Constitutionnelles*, vol. IV, Documentation, Section 3, "Santé et Hospitalisation," Table 94, p. 221; Malcolm G. Taylor, *Financial Aspects of Health Insurance* (Canadian Tax Papers, no. 12, December 1957), p. 12.

⁵² "A Brief Review of Canadian Blue Cross Plans in 1951," *TCH*, vol. 29, no. 4 (April 1952), p. 64.

The programme of building new hospital accommodation was certainly necessary, and if the improvement in terms of bed ratios was minimal, at least it prevented Quebec from falling behind. Certainly hospitals, after years of making do with overcrowded facilities, were open to participation in the Federal programmes. As well, with the prospect of a state hospitalization plan receding, they were aiming especially to expand accommodation for private and semi-private patients. The fact that only a small percentage of the Quebec population was covered by private insurance did not seem to deter the hospitals. Undoubtedly they believed that the situation could only improve.

The Montreal General and St-Luc Deal with the Present and Plan for the Future

In the prosperous post-war era hospitals hoped to find solutions to their financial difficulties in an improved and more stable mix of private and public funding. In the immediate post-war period, however, the legacy of the war — labour shortages, growing costs, problems with physical plant, and deficits — lingered, and hospitals had to deal with them on an ongoing basis.

- **Labour**

Labour was the most acute problem in the immediate post-war period. General labour, while more expensive, was nonetheless easier to find, in part because of higher wages. But shortages did still exist, particularly in the first few years after the war. By 1948, departments like Dietary at the Montreal General acknowledged that the situation

had eased somewhat.⁵³ However, as the dietician-in-charge at the Western Division noted in 1950, while workers were available, they were hard to keep because of the difficult working conditions. A major shift in policy was the institution of the eight-hour day, as part of the ongoing attempt to resolve the problem of maintaining a more permanent force of general workers.

It is becoming increasingly evident that a straight eight-hour working day for our employees is essential. With living-in accommodation restricted to eight beds [at the Western Division], and no rest-rooms available for their use during mid-afternoon off-duty hours, both men and women alike are finding the twelve-hour schedule exhausting. Although wages have been advanced, high salaries elsewhere make it impossible to obtain and retain reliable help.⁵⁴

It was in 1952 that the eight-hour day was finally instituted, leading to what the Director called "some improvement."⁵⁵

Much more problematic was the question of nurses. A combination of several factors rendered these workers a rare commodity right across the country. There was fierce competition for nurses as demand expanded in government agencies, industry and the expanding hospital sector.⁵⁶ Industry and government had the advantage over

⁵³ MA, MGH, Report of the Dietary Department (Central Division), AR, 1948.

⁵⁴ MA, MGH, Report of the Dietary Department (Western Division), AR, 1950. The eight-hour day signified a major shift from the long-standing policy of maintaining living quarters for general staff. The abandonment of this policy would necessarily result in higher wages, since room and board were no longer supplied.

⁵⁵ MA, MGH, Report of the Dietary Department (Central Division), AR, 1952. The Director went on to say that since there was still a shortage of full-time trained staff, the department was obliged to depend on part-time women workers.

⁵⁶ "The Shortage of Nurses," *CJPH*, vol. 39, no. 11 (November 1947), pp. 548-549. The author, citing an analysis of the shortage, pointed out other factors in the creation of this problem: "drastic reduction in domestic help, the employment of women in industry with the consequent inability of the home to provide for the sick; but perhaps the most important has been the increased ability of the public to pay

hospitals since they could provide regular hours with no night shifts. In addition, married nurses, who had stepped into the breach in the war years, left active service as their husbands lost the benefit of dependent exemption from income tax for working spouses, a benefit extended by the federal government to entice married women into the work force during the war.⁵⁷ As a result, if married nurses did work, they tended to limit their working time so as to not affect their husband's spousal deduction.⁵⁸ The Canadian Hospital Council lobbied the federal government to extend the income tax exemption, but to no avail.⁵⁹ In addition, in Quebec the Catholic hospitals began to demand more lay nurses as the numbers of sisters available for nursing declined, adding even more pressure to the shortage.⁶⁰ In sum, the nursing shortage was one of the major problems faced by the hospitals in the post-war period.

Naturally this shortage had repercussions on hospital finances, as hospitals tried to improve conditions and salaries in order to entice nurses into employment. In the Montreal General's 1946 *Annual Report*, Honorary Treasurer W. S. M. MacTier noted

for nursing services." p. 548. See also, Jessie Fraser, "Canadian Hospital Council Considers Topics of Timely Concern," *TCH*, vol. 26, no. 6 (June 1949), pp. 40-41.

⁵⁷ Ruth Pierson, "Women's Emancipation and the Recruitment of Women into the Canadian Labour Force in World War II," Canadian Historical Association, *Historical Papers* 1976, p. 154; "Tax Revision for Married Women Crippling Blow to Hospitals," *TCH*, vol. 23, no. 12 (December 1946), p. 41.

⁵⁸ MA, MGH, Report of the Department of Nursing, *AR*, 1948.

⁵⁹ "That Tax on Married Women's Incomes," *TCH*, vol. 25, no. 1 (January 1948), p. 48.

⁶⁰ Johanne Daigle, "L'Émergence et l'Évolution de l'Alliance des Infirmières de Montréal" (M.A., UQAM, Montreal, 1983), notes that lay nurses became the majority in Quebec hospitals in 1941. See pp. 73-74.

that, in a nine-month period, salaries and wages had increased by over \$52,000.⁶¹ He explained:

Effective September 1st last your Board decided to increase the scale of nurses' salaries and thus bring them more in line with prevailing rates. I feel sure you will approve this decision although it is estimated that it will cost an additional \$50,000 per annum.⁶²

In a sense the decision was a recognition of the new position of strength nurses now found themselves in, thanks to their scarcity. In fact, in the same *Annual Report*, Mary Mathewson, Director of Nursing noted:

the shortage of nurses has been as acute as at any time during the war. At the same time the bed occupancy has been at a high level with a rapid turnover which has meant a steady flow of acutely ill patients without the normal proportion of those less acutely ill or convalescent.⁶³

Mathewson went on to point out that nurses were also obliged to spend hours on non-nursing tasks because of vacancies and changes in non-nursing staff. She noted that essential services were maintained thanks to part-time married nurses, and the longer hours of work often required of student nurses. In closing, she expressed hopes that increased accommodations and improved salaries for nurses would help remedy the situation.

The nursing shortage continued to be a problem, however, to the point where in early 1947, the hospital's bed capacity was temporarily reduced. The Medical Board

⁶¹ Figures in the text are in current dollars. Figures in tables are in constant and current dollars as indicated.

⁶² MA, MGH, Honorary Treasurer's Report, AR, 1946.

⁶³ MA, MGH, Report of the Department of Nursing, AR, 1946. This point was also noted in "The Shortage of Nurses," *CJPH*, *op. cit.*, p. 548.

decided to appoint a committee to investigate and to propose solutions.⁶⁴ In June the committee reported that the nursing shortage was a Canada-wide problem. To the causes already noted above, the report added the shortage of nursing aides, orderlies and domestic staff (which obliged nurses to spend time on non-nursing duties), the low salaries; and what the committee referred to as:

the employment of married and part-time nurses and of drifting graduates, who profess no allegiance to the Hospital and who come and go, depending upon their whim of the moment. This factor is mainly responsible for the seasonal shortage — e.g. Christmas, Easter, summer vacation time. An adequate supply of M.G.H. graduate nurses, having a spirit of loyalty to the Institution, would, in the opinion of the Director of Nursing, overcome this difficulty. This implies an increase in the enrolment in the School of Nursing.⁶⁵

The committee proposed an expansion of housing facilities for nursing students to allow for this increase in enrollment, and an adequate supply of non-professional support staff to help ease the nursing load.⁶⁶

It is unclear that the recommendations were acted on. What is clear is that the problem was far from resolved by the time the *Annual Report* was published in late 1947. Despite increased expenditures on salaries and wages on the order of \$136,000,

⁶⁴ MA, MGH, Minutes of Medical Board meeting, March 5, 1947.

⁶⁵ MA, MGH, Committee re Shortage of Nurses, Minutes of Medical Board meeting, June 11, 1947. As a point of comparison, in 1948, the Montreal General, with 660 beds, had 29 teaching staff or nursing supervisors, 75 graduate nurses, 187 students and 26 auxiliary workers; St-Luc, with 451 beds had 13 teaching staff or supervisors, 71 graduate nurses, 50 student nurses and 158 auxiliary workers. "Relation entre le personnel hospitalier et le nombre de lits dans les hôpitaux publics de la province de Québec au 31 décembre 1948; Hôpitaux généraux — Section Montréal," *Enquête sur les Services de Santé*, Tome V, *l'Hospitalisation* (Québec, 1948).

⁶⁶ *Ibid.*

nursing was still in crisis.⁶⁷ One result was the closing of floors in the Private Patients' Pavilion during the summer, and the inability of the Nursing Department to cut down on the hours worked by students; as well, the shortage of living space for new students remained.⁶⁸ One element affected another, as staff faced increased pressure to deal with more patients in a shorter time in order to keep the waiting lists manageable. The end result was more stress on the staff, and more paperwork and other tasks related to faster patient turnover. As for the hospital, it always faced a loss of potential revenue when beds had to be closed because of staff shortages.

As General Superintendent Burnett S. Johnston pointed out in his report, the situation at the hospital was well in keeping with problems faced by institutions across the country: across Canada there was an estimated shortage of 9,000 graduate nurses.⁶⁹ There was also a glimmer of hope, however, thanks to a proposed joint plan for the training of nursing aides for Montreal's English hospitals.⁷⁰ These trained workers could at least take over the more routine tasks from registered nurses.

In 1948, the hospital still faced nursing shortages, particularly at the Western Division, where only graduate nurses were employed (a tradition when treating private

⁶⁷ MA, MGH, Honorary Treasurer's Report, Report of the Department of Nursing, AR, 1947.

⁶⁸ MA, MGH, Report of the Western Division, Report of the Department of Nursing, AR, 1947. Nursing head Mathewson drew out the interconnectedness of different aspects of the problem in her Report: "I regret to report that the working hours of the students have not been shortened to any marked degree during the year... The hours of duty for night nurses must be shortened but this adjustment depends upon a larger student body which is contingent upon the provision of more residence accommodation."

⁶⁹ MA, MGH, Report of the General Superintendent, AR, 1947.

⁷⁰ MA, MGH, Report of the Department of Nursing, AR, 1947.

patients). Nonetheless Mathewson expressed confidence that the situation would improve by the following year because of the opening of the school for nursing aides.⁷¹ Indeed, six graduate nursing aides did join the staff in 1949, to the relief of the nursing staff, but new challenges were constantly arising:

The nursing time involved in the administration of Penicillin was greatly reduced in the later months of the year by the institution of the daily rather than three-hourly dosage. However, the larger number of patients whose blood pressure must be taken and recorded at fifteen minute intervals, and the increase in the number of tests and treatments requiring nursing service, have more than absorbed any time thus saved. Wherever possible nurses have been relieved of non-nursing duties, but still more remains to be done along this line. Each day brings new demands upon the nursing service, and eternal vigilance is necessary to see, in the constantly changing picture of modern medical and surgical practice in a teaching hospital such as this, that non-nursing duties are not taken on by the already hard-pressed nursing services.⁷²

By 1950, though the shortage of nurses remained, particularly during the summer months and holidays, Mary Mathewson was at least able to report that student nurses could finally be given one whole day off each week. She also had hopes in at least one other area, as the Women's Auxiliary, organized in 1949, was organizing volunteer services, another potential method of assisting the nursing staff in non-nursing tasks.⁷³

At St-Luc, the situation seemed little different, although the manner in which problems manifested themselves may have varied, as did some of the solutions

⁷¹ MA, MGH, Report of the Department of Nursing, AR, 1948.

⁷² MA, MGH, Report of the Department of Nursing, AR, 1949. Penicillin became available for civilian use in 1944. See "Distribution of Penicillin for Civilian Use in Canada," *CJPH*, vol. 35, no. 11 (October 1944), p. 407.

⁷³ MA, MGH, Report of the Department of Nursing, AR, 1950.

attempted. The director of nursing did not make a separate report at the annual members' meeting and, in fact, the question of nurses was seldom mentioned in the President's reports. Still, a careful reading of the Minutes of the Executive Committee and Board of Management meetings reveals similar problems and stresses related to a shortage of nurses.

Since student nurses provided a significant part of the actual work done in the hospital, a logical response to the personnel shortage would be to increase the number of students at the hospital.⁷⁴ One proposal to this effect was tried in 1946. The Association of Nurses of the Province of Quebec insisted that student nurses complete their eleventh year of schooling before entering nursing training.⁷⁵ The hospital adopted a plan, already being tried at Ste-Justine Hospital, by which girls who had successfully completed their tenth grade could be admitted to a special programme at the hospital to study for eleventh grade exams, while at the same time working as nurses' aides. They would be given a stipend of \$35.00 per month plus room and board, and would have to pay instructors \$7.00 per month. After passing their exams,

⁷⁴ For an examination of the role of student nurses in the hospital work force, see, Johanne Daigle, "Devenir infirmière: Le système d'apprentissage et la formation professionnelle à l'Hôtel-Dieu de Montréal, 1920-1970," (Ph.D. diss., UQAM, Montreal, 1990); André Petitat, *Les infirmières: De la vocation à la profession* (Montreal: Boréal, 1989); and, for Canada as a whole, Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford University Press, 1966), particularly pp. 26-73.

⁷⁵ The Registered Nurses' Association of the Province of Quebec, an organization of voluntary membership incorporated in 1920, was transformed in 1946 to the Association of Nurses of the Province of Quebec, a closed corporation with mandatory membership for all practicing nurses in the province. The Association was responsible for maintaining standards in the province's nursing schools. See, Edouard Desjardins, Eileen C. Flanagan and Suzanne Giroux, *Heritage: History of the Nursing Profession in the Province of Quebec* ((Montreal: ANPQ, 1971).

they would be admitted to the nursing school, where they would be given a stipend of \$5.00 per month plus room and board. Of course, the idea was considered potentially very advantageous to the hospital, especially in terms of the work these students would do,⁷⁶ and the plan did in fact benefit the hospital. Benefits for the students were less clear, however. In 1949, a report on the results of this programme was made to the Board of Management by Miss Tremblay, Director of Nursing:

Rapport est fait que les cours de la 11e année, l'an dernier, a été un fiasco. Les élèves devaient aider les gardes-malades le jour et étudier le soir seulement, ce qui était insuffisant. L'on voudrait cette année que les élèves consacrent tout leur temps aux études jusqu'à la date des examens en février prochain.⁷⁷

The recommendation was accepted.

Other attempts to entice nurses to stay at the hospital included instituting the eight-hour day, as proposed by the new head of nursing in 1946⁷⁸, and making a comparison of salaries and working conditions at other hospitals, in order to bring St-Luc into line with other institutions.⁷⁹

Finally, unionization became a factor — the first attempts to unionize nurses in Canada began in Montreal in 1946 — giving nurses a collective voice with which to

⁷⁶ HSL, Procès-verbal de la réunion du Conseil exécutif, le 17 mai 1946.

⁷⁷ HSL, Procès-verbal de la réunion du Conseil d'Administration, le 30 août 1949.

⁷⁸ HSL, Procès-verbal de la réunion du Conseil exécutif, le 4 septembre 1946. This proposal was made just two months after the superintendent reported that a union was being formed at the Verdun General Hospital, and that the union submitted a contract demanding the 8-hour day. See HSL, Procès-verbal de la réunion du Conseil d'Administration le 24 juillet 1946.

⁷⁹ HSL, Procès-verbal de la réunion du Conseil exécutif, le 24 juillet 1947.

negotiate for better conditions and better wages.⁸⁰ This was a reality that St-Luc had to face in short order, one avoided until considerably later by the MGH.⁸¹ The Alliance des Infirmières de Montréal (AIM) organized nurses at St-Luc in 1948, two years after its first successes in unionizing nurses in Montreal.⁸² Thereafter, the hospital would have to negotiate salaries and working conditions with the union.

In the post-war period unionization of the Quebec hospital sector grew rapidly, particularly following the 1944 changes in the Labour Code (under the Godbout government) which obliged employers to negotiate in good faith with their unionized employees and which, though denying hospital workers the right to strike, did create a structure for mandatory conciliation and arbitration.⁸³ These gains have to be put into context, however. While the AIM was organizing nurses in a somewhat more favourable legal framework, it was facing a political environment that was hostile to unions. Daigle — along with many other authors — characterizes the years from 1948 to 1954 as the most difficult for unionization. And hospitals, with little financial flexibility, tended to try to be tough negotiators.⁸⁴

⁸⁰ See Daigle, "L'Émergence." For unionization of nurses in Canada as a whole, see McPherson, *op. cit.*, chapter 6.

⁸¹ In fact, it was only in the late 1960s that nurses in the English-language hospitals felt the necessity to organize into unions, after the provincial government announced a policy of province-wide collective negotiations. See Edouard Desjardins, Eileen C. Flanagan and Suzanne Giroux, *op. cit.* p. 94.

⁸² Daigle, "L'Émergence," p. 107. The AIM was affiliated to the CTCC, the Catholic union federation.

⁸³ Daigle, "L'Émergence," p. 83.

⁸⁴ *Ibid.*, pp. 109-110.

Nonetheless, nurses did make gains over these years. In 1949, St-Luc nurses won, through arbitration, a contract retroactive to June 1, 1948 increasing their wages, giving them 15 days annual paid vacation, and the same in sick leave. This improvement in working conditions and salaries for general-duty nurses then necessitated a similar adjustment in the salaries of head and assistant head nurses as well as of other nurses not in the bargaining unit.⁸⁵ All of which increased personnel costs for the hospital.⁸⁶ The base salary for general nurses, established in September of 1947 after comparison with other hospitals, but before unionization of St-Luc, was pegged at \$130.00 per month.⁸⁷ In 1950, the negotiated agreement raised the base rate to \$145.00 and then to \$160.00 after 18 months of service.⁸⁸ Since salaries were the largest item in hospital budgets, these changes inevitably had a significant impact on hospital finances, as noted by the honorary treasurer on a regular basis.⁸⁹ Yet even these measures were occasionally insufficient to assure adequate staffing levels. In the summer of 1953, the

⁸⁵ HSL, Procès-verbal de la réunion du Conseil exécutif, le 10 février 1949. The fact of winning an arbitration, the most frequent form of resolution of worker/management conflicts at this point for AIM, did not ensure immediate application. Daigle points out several cases of management dragging their feet. See Daigle, "L'Émergence," p. 111.

⁸⁶ The following was noted in the meeting of the Board of Management in April, 1952: "Le Surintendant traitant de la question du salaire des gardes-malades fait part que la situation devient difficile à cause des salaires que l'hôpital est tenu de payer en vertu des contrats collectifs." HSL, Procès-verbal de la réunion du Conseil d'Administration, le 29 avril 1952.

⁸⁷ HSL, Procès-verbal de la réunion du Conseil exécutif, le 4 septembre 1947. According to McPherson, a general-duty graduate nurse at Brandon General Hospital in 1947 earned \$100.00 per month. This was less than a nurse at St-Luc. See McPherson, *op. cit.*, pg. 226.

⁸⁸ HSL, Procès-verbal de la réunion du Conseil d'Administration, le 27 juillet 1950. Approximately 77 registered nurses were working in the hospital at this time. *Ibid.*

⁸⁹ HSL, Procès-verbaux des réunions des membres à vie, le 30 avril, 1953, le 19 mai 1954.

hospital decided to pay nurses a \$1.00 per hour supplement for overtime because of the impending staff shortage during vacations.⁹⁰

Nurses were not alone in unionizing. Attempts had been made to organize hospital workers, particularly those in the Catholic hospitals, since the 1930s, with some limited success.⁹¹ In the post-war period, in particular following the Labour Code changes, hospitals had to become reconciled to the fact that their once-docile work force was in the process of joining unions and becoming part of a more formalized negotiation process, and making gains in wages as a result. An article in *La Presse* in May of 1946 noted that several hospital workers' unions affiliated with the Confédération des Travailleurs Catholiques du Canada (CTCC), the Catholic workers' union, had gained salary increases of up to 30 per cent along with significant improvements in working conditions.⁹² Neither St-Luc nor the Montreal General escaped this trend, which had serious consequences for budgets, since wages and salaries made up approximately 50 to 60 per cent of expenditures.

Both the Montreal General and St-Luc kept a keen eye on developments on the labour front, and both were affected by these changes. In June 1946, the Policy Committee of the Board of Management of the Montreal General discussed the

⁹⁰ HSL, Procès-verbal de la réunion du Conseil d'Administration, le 29 mai 1953.

⁹¹ For a discussion of the growth of unionization in the hospital sector, see Luc Desrochers, *L'Époque de la Patience: Histoire de la Fédération des Affaires Sociales (CSN)*, (forthcoming).

⁹² "Décision favorable aux employés d'hôpitaux," *La Presse*, May 29, 1946, p. 29.

attitude to take regarding labour organizing at the hospital. The committee, apparently exploring the advantages of setting up their own "company" union, sought advice from Mr. James Wilson of the Industrial Relations department of Shawinigan Water and Power

... who advised against our taking any action in this matter at the present time and had also mentioned that in their opinion the formation of our own employees' association would not help the situation, an opinion endorsed by Mr. P. F. Sise after discussing the matter with his Industrial Relations Department [of the Northern Electric Co.]. It was, therefore, proposed to leave the whole matter in abeyance for the time being; which was approved.⁹³

In September of that same year, after a near-miss – when the Provincial Labour Relations Board rejected a certification bid by the Building Service Employee's International Union (Local 298), affiliated with the American Federation of Labour – management at the Montreal General decided on a course of action. Since unionization seemed likely to happen, and 11 hospitals in Montreal were already represented by the Association des Employés d'Hôpitaux de Montréal, Inc. (AEHM, affiliated to the CTCC), a group with which the Montreal Hospital Council seemed willing to negotiate, the Policy Committee proposed that the Montreal Hospital Council be informed that the Montreal General

would be prepared to accept the Association des Employées d'Hôpitaux de Montréal, Inc. as the bargaining agent for our employees; and to suggest that this be brought about by a decree of the Lieutenant-

⁹³ MA, MGH, Minutes of the Policy Committee of the Board of Management, June 24, 1946.

Governor in Council in accordance with the provisions of Sect. 2 of the Collective Agreement Act.⁹⁴

About the same time St-Luc also became acutely aware of the movement to organize. A report in June 1946 mentioned that the "Syndicats Nationaux", likely the AEHM, were attempting to organize St-Luc workers.⁹⁵ In July, the Board of Management noted that a union had been formed by nurses, nursing aides and technicians at a Verdun hospital, and that nine hospitals had authorized the Montreal Hospital Council to sign a contract with non-nursing employees in their name. St-Luc's Board of Management decided that the executive would study the proposed contract to see if the hospital should join the others.⁹⁶ The idea of uniformity of conditions in several hospitals seemed to be attractive, and in September the Executive decided to ratify this agreement.⁹⁷ Not long after, the hospital installed time clocks and set up a grievance committee.⁹⁸ This was not the end of the saga, however. While the AEHM may have been the union of choice of the administration, St-Luc's workers seemed to have had other ideas and, within one year, they voted to join Local 298 of the American Federation of Labor's Building Service Employees' International Union.⁹⁹

⁹⁴ MA, MGH, Minutes of the Policy Committee of the Board of Management, September 5, 1946. Section 2 of the Collective Agreement Act reads: "The Lieutenant-Governor in Council may order that a collective agreement respecting any trade, industry, commerce or occupation shall also bind all the employees and employers in the Province or in a stated region of the Province within the scope determined in such decree." Quoted in Minutes, *ibid*.

⁹⁵ HSL, Procès-verbal de la réunion du Conseil exécutif, le 12 juin 1946.

⁹⁶ HSL, Procès-verbal de la réunion du Conseil d'Administration, le 24 juillet 1946.

⁹⁷ HSL, Procès-verbal de la réunion spéciale du Conseil exécutif, le 16 septembre 1946.

⁹⁸ HSL, Procès-verbal de la réunion du Conseil exécutif, le 8 novembre 1946.

⁹⁹ HSL, Procès-verbal de la réunion du Conseil exécutif, le 1 octobre 1947.

This did regularize to a certain extent relations between management and workers. As of 1949, for example, the union was to present demands for wage increases on November 1 of each year.¹⁰⁰ The unions attempted, often with success, to make regular salary gains.¹⁰¹ The annual increase in salaries was clearly laid out each year in the annual report, and frequently imputed directly to a new collective agreement with the hospital workers' unions. It varied between \$55,000 and \$97,000, the latter figure in 1954, when the total deficit was \$98,083.¹⁰²

- **New Technologies and New Prospects, Old Buildings and Ongoing Problems:
Higher Costs**

Other costs were also on the rise after the end of the war; some occurred simply because of the release of pent-up demand and the elimination of price controls, but others were linked to changes in how hospital care was being delivered

The end of the war meant the end of price and wage controls. It also led to an unexpected economic boom and significant increases in the cost of living in the first few post-war years. The annual change in the consumer price index, at 0.5 per cent in 1945 (when war-time wage and price controls were still in effect), rose to 3.4 per cent in

¹⁰⁰ HSL, Procès-verbal de la réunion du Conseil exécutif, le 4 avril 1949.

¹⁰¹ In 1950, for example, the union asked for shorter hours and higher wages. The hospital was willing to give them higher wages. See HSL, Procès-verbal de la réunion du Conseil exécutif, le 30 novembre 1950. In 1951, arbitration resulted in wage increases for hospital workers totalling \$34,746. See HSL, Procès-verbal de la réunion du Conseil exécutif, le 21 septembre 1951. And in 1953, the monthly increase for wages for 301 workers totalled \$2,806. See HSL, Procès-verbal de la réunion du Conseil d'Administration, le 29 mai 1953.

¹⁰² HSL, Procès-verbaux des Réunions des membres à vie, 1946-1954.

1946, 9.3 per cent in 1947, and 14.4 per cent in 1948, before it settled back to 3 per cent in 1949.¹⁰³ Items as varied as surgical instruments, X-ray apparatus, glassware, carbon paper, and tuna fish were released from controls very shortly after the war, resulting in significant cost increases for hospitals across the country.¹⁰⁴ At the Montreal General, one department where the cost increases were in evidence was the Dietary Department, where the changes were documented yearly. In 1945, the cost of preparing a meal was 19.9 cents; of that, provisions cost 14.2 cents. In 1948, it stood at 27.4 cents, with provisions accounting for 19.5 cents. In 1953, a meal cost 36.9 cents, with provisions accounting for 25.7 cents.¹⁰⁵ St-Luc saw the global cost of provisions go from \$121,585.25 in 1945 to \$293,766.29 in 1951.¹⁰⁶

While these increases were significant, especially when added to the growth in wages, the increase in the cost of medication was even more spectacular. In this case, the key was the growth in the number and kind of drugs available for use. Two simultaneous processes were affecting the cost of medication for hospitals: new drugs, particularly antibiotics, were being developed at an unprecedented rate (90% of drugs prescribed in 1966 did not exist before 1945); secondly, these drugs were being

¹⁰³ Dennis Guest, *The Emergence of Social Security in Canada* (Vancouver: University of British Columbia Press, 1980), p. 207.

¹⁰⁴ "Price Ceiling Lifted on Many Articles," *TCH*, vol. 23, no. 5 (May 1946), p. 58.

¹⁰⁵ MA, MGH, Reports of the Dietary Department, ARs, 1945, 1948, 1953. In 1950, at the Montreal General Hospital, raw food accounted for 16 per cent of expenditures, salaries and wages, 56 per cent, drugs and surgical supplies, 13 per cent and other expenses (mainly heavy maintenance costs), 15 per cent. See Report of the Executive Director, AR, 1950.

¹⁰⁶ HSL, Procès-verbal de la réunion du Conseil exécutif, le 2 octobre 1952.

produced in pharmaceutical factories, not in hospital or commercial pharmacies (where the majority of drugs were prepared in pharmacies at the beginning of the Second World War, 90% were produced industrially by 1960).¹⁰⁷

The increase in use of medication was stunning. The number of prescriptions dispensed for in- and out-patients by the Montreal General pharmacy grew from 94,958 in 1945 to 185,410 in 1953.¹⁰⁸ St-Luc saw its expenditure on pharmaceutical products go from \$36,556 in 1945 to \$161,607 in 1951.¹⁰⁹ While the cost of medication might be paid by semi-private and private patients, it was often not paid for by ward or dispensary patients, thus creating another source of financial strain for the hospitals.

A case in point was a change noted in 1953 by the head of the Department of Anaesthesia at the Montreal General.

The number of anaesthetics given was less than in previous years but more time was spent in their actual administration because of the greater number of major operations performed. Modern anaesthetic techniques, the greater availability of blood for transfusion because of the Red Cross Blood Bank, and the use of plasma volume expanders, made it possible to accept patients for anaesthesia who, a few years ago, would have been considered as not suitable for operation. There were so many details requiring attention in the care of these patients that frequently two Anaesthetists had to be assigned to each case.

At one time the cost of drugs required in the administration of a major anaesthetic was under two dollars. During this year the cost varied from five to twenty-five dollars without any evidence of extravagance.

¹⁰⁷ Johanne Collin, *Changement d'Ordonnance* (Montreal: Boréal, 1995), p. 55.

¹⁰⁸ MA, MGH, Statistics, ARs, 1945, 1953. As a point of comparison, in 1945 the MGH recorded 199,355 in-patient days and 151,523 dispensary visits; in 1953, it recorded 194,105 in-patient days and 165,031 dispensary visits. The increase in number of prescriptions was clearly not a result of an increase of patients.

¹⁰⁹ HSL, Procès-verbal de la réunion du Conseil exécutif, le 2 octobre 1952.

Several drug firms were kind enough to supply us with expensive drugs for clinical trial without charge.¹¹⁰

This statement, while underscoring the many, very positive effects of the introduction of a host of new drugs, diagnostic tools, therapies and procedures during these years, emphasized the growing cost of these new tools and raised the problem of finding new ways of obtaining them.

Often the hospitals were faced with replacing equipment that was no longer serviceable. In 1948, the administration at St-Luc approved about \$71,000 worth of purchases to replace radiology equipment that was now considered dangerous.¹¹¹ In the same year, they agreed to purchase new equipment and open a new operating room for one of the surgical services. This implied transforming one of the anaesthetists' rooms into an operating room, as no new space was available.¹¹² The Radiology Department at the Montreal General also purchased new radiation therapy equipment in 1951, under a Dominion/Provincial Grant.¹¹³ This followed several years of difficulty in accomplishing the work required.

Medical, surgical and investigative techniques were developing rapidly, leading to new, often more complex and time-consuming procedures that hospitals felt obliged to provide. In 1947, for example, the heads of both Radiology, and Pathology and Bacteriology at the Montreal General talked of new, time-consuming techniques which

¹¹⁰ MA, MGH, Report of the Department of Anaesthesia, *AR*, 1953.

¹¹¹ HSL, Procès-verbal de la réunion du Conseil d'Administration, le 2 avril 1948.

¹¹² HSL, Procès-verbal de la réunion du Conseil exécutif, le 8 juillet 1948.

¹¹³ MA, MGH, Report of the Department of Radiology, *AR*, 1951.

were taxing the capacities and facilities of their departments. In both cases there had been increase in routine work as well requiring an increase of staff or new equipment. The Director of the Department of Metabolism and Toxicology had a similar message to the hospital. In 1948, he noted:

with advances in medical knowledge, laboratory procedures have tended to become more complex. Increases in work from this cause are not reflected in the total numbers of tests. For example, this is the first year in which biological assays have been done in this Department; such assays involve much more work than do many of the other laboratory procedures.¹¹⁴

The opening of new departments also reflected scientific progress. In 1950 several new services were inaugurated at the Montreal General: a radioactive isotope laboratory; a cardio-respiratory laboratory to carry out new procedures for making exact diagnoses of heart and lung disorders (funded in part by Herbert W. Molson); and a sub-department of vascular surgery.¹¹⁵ Usually, what was involved in these changes was the reorganizing of other departments and the hiving off of some space for the new facilities.

New technologies and increased demand for hospital accommodation aggravated the old problems of lack of space and obsolescent equipment that had resulted from purchasing and building freezes during the war. In 1946 the head of Radiology at the Montreal General underlined the steady increase in "multiple and increasingly complicated examinations. This has all been carried out in the same space,

¹¹⁴ MA, MGH, Report of the Department of Metabolism and Toxicology, AR, 1948.

¹¹⁵ MA, MGH, Secretary's Report, AR, 1950.

but this has developed a very difficult and almost impossible situation, as so frequently we get so far behind our work that naturally we are criticized."¹¹⁶ Similar problems were raised by the head of the Department of Metabolism and Toxicology in 1947.¹¹⁷

These problems also were evident in non-medical facilities, witness the report of the head of Dietetics in 1946:

The lack of adequate storage space for canned foods, frozen foods, root vegetables, staples and china does not permit the purchasing of foods in season or in adequate quantities when available. This situation prevents more efficient and economical purchasing, and I cannot stress to a too marked degree the urgent necessity for additional accommodation not only in connection with the storage mentioned above, but in connection with the dining rooms, serving pantries and kitchens.¹¹⁸

The extent of these space problems was eloquently laid out by General Superintendent Burnett S. Johnston in his 1949 report: the Operating Room suite, built in 1887, was obsolete; the Anaesthetic Department was located in a closed-off corridor; the Department of Allergy occupied a former bathroom; sun galleries were converted into public wards to meet the growing demand for hospital beds; and the butcher shop was housed in an untilled entrance vestibule.¹¹⁹

St-Luc probably had less of a space problem for laboratory and research work, as these aspects were significantly less developed than at the Montreal General. Perhaps the most crying problem at St-Luc was the ongoing lack of adequate semi-private and

¹¹⁶ MA, MGH, Report of the Department of Radiology, *AR*, 1946.

¹¹⁷ MA, MGH, Report of the Department of Metabolism and Toxicology, *AR*, 1947.

¹¹⁸ MA, MGH, Report of the Dietary Department (Central Division), *AR*, 1946.

¹¹⁹ MA, MGH, Report of the General Superintendent, *AR*, 1949.

private accommodation, which denied the hospital potential revenues, a state of affairs noted in almost every Annual Report.¹²⁰ Nonetheless, St-Luc was also in dire need of expansion in many of its departments. In his 1953 address to the annual general meeting, Board Chairman Edouard Asselin outlined the need for expansion, particularly in the context of the imminent move of the Montreal General:

Nos salles d'opération sont devenues insuffisantes; il faudrait doubler notre service de Rayons X, agrandir nos laboratoires, créer des "salles de réveil", trouver de l'espace supplémentaire pour loger nos infirmières et étudiantes, dont un grand nombre doivent habiter à l'extérieur de l'institution, ce qui comporte pour l'hôpital comme pour elles-mêmes de sérieux inconvénients.¹²¹

These inadequacies in physical plant had definite economic consequences. The General Superintendent of the General put a cash value on the cost in 1946:

The cost in maintenance of these old buildings is extremely high and during the past year a sum in excess of \$113,000.00 was expended on renovations, repairs, and the replacement of worn and obsolete equipment. There were no structural alterations effected except ones of a very minor nature, as improvisation in the present physical plant is no longer practicable.¹²²

The Montreal General, as a leading research and teaching hospital, was in part responding to external imperatives, trying to maintain its leading position in Canada and to attract and retain leading medical doctors and researchers. Obsolete equipment

¹²⁰ See for example, HSL, Procès-verbal de la réunion des Membres à vie, le 25 mai. 1948.

¹²¹ HSL, Le Rapport du Président, Procès-verbal de la réunion des Membres à vie, le 30 avril 1953.

¹²² MA, MGH, Report of the General Superintendent, AR, 1946. The net deficit for this year was \$45,000. See Honorary Treasurer's Report, *ibid*.

and lack of space threatened to scare away potential recruits.¹²³ Continuing under these conditions was judged impossible. Very soon after the war, the Montreal General started planning for a completely new edifice on Pine Avenue, far away from its original site, where fewer English-speaking Montrealers now lived. St-Luc, meanwhile, equally hard-pressed for space, more modestly opted for a new wing with 300 additional beds.¹²⁴ Both plans necessitated substantial fund-raising. The MGH joined with other Montreal English hospitals to launch a campaign under the Joint Hospital Fund, eventually raising over \$18 million from the general public and the private sector, another indication of the tradition of support of English institutions by wealthy English Montrealers. Of the total, the General's share was \$11 million.¹²⁵

Imperatives did differ in the two hospitals. While the Montreal General was worried about maintaining its leading status, St-Luc was often obliged to meet externally imposed requirements simply to maintain the level required for certification. In 1949, for example, St-Luc was obliged to hire a professional medical archivist for its medical records department in order to avoid being decertified by the American College of Surgeons.¹²⁶ That same year, it was suggested that the Cancer Clinic be supplied with a nurse, again to satisfy criteria of the American College of Surgeons, and

¹²³ MA, MGH, Report of the Secretary, AR, 1949; "Preliminary and Tentative Report on the Joint Hospital Fund Campaign Survey," February 25, 1949, Policy Committee Minute Book I, 1946-1949.

¹²⁴ MA, MGH, Report of the Board of Management, AR, 1946. HSL, Procès-verbal de la réunion du Conseil d'Administration, le 24 janvier 1952.

¹²⁵ Report of the Board of Management, The Montreal General Hospital AR, 1950.

¹²⁶ HSL, Procès-verbal de la réunion du Conseil d'Administration, le 8 avril 1949.

that a qualified dietician be hired to satisfy the criteria of Suzanne Giroux, nursing school inspector of the Association of Nurses of the Province of Quebec.¹²⁷ Finally, in 1950, the hospital faced problems in obtaining recognition from the Royal College of Physicians and Surgeons of Canada as a training hospital for medical specialities.¹²⁸ Throughout this period St-Luc, like the General, was also faced with the growing complexity of diagnostic tools and medical procedures, and the need to put in place the structures for delivering these services. In 1952, for example, Dr. Paul Martin, head of laboratory services, noting that "non seulement les analyses de routine ont considérablement augmenté en nombre, mais de plus en plus fréquentes sont les demandes pour analyses nouvelles spéciales," requested the hiring of a haematologist and two new technicians.¹²⁹

All of these changes had a direct negative impact on hospital budgets, since labour, materials, food, drugs and more complex technologies and procedures all required substantial increases in hospital revenues. This was a problem of national magnitude. M. G. Taylor, in his work on *Financial Aspects of Health Insurance*, noted a significant increase of costs in Canadian hospitals, one that was higher than the general increase in the cost of living. Taking 1945 as the base year (=100), he

¹²⁷ HSL, Procès-verbal de la réunion du Conseil exécutif, le 9 mai 1949; Procès-verbal de la réunion du Conseil d'Administration, le 19 septembre 1949. Part of the mandate of the ANPQ was the inspection of all nursing schools to maintain standards of education.

¹²⁸ HSL, Conseil Médical, Procès-verbal de l'Assemblée spéciale tenue le 16 février 1950 à 11.30 a.m. Re.: Au sujet d'une lettre du Collège Royal. The College introduced certification for specialists in 1946. See G. Harvey Agnew, *Canadian Hospitals 1920-70: A Dramatic Half Century* (Toronto: University of Toronto Press, 1974), p. 109.

¹²⁹ HSL, Procès-verbal de la réunion du Conseil d'Administration, le 18 mars 1952.

determined that by 1953 the cost of hospital wages per patient day had increased to 293, significantly higher than general industrial wages which had increased to 179. The cost per patient day, excluding wages, was 186, while the general wholesale price index had risen to 167.¹³⁰

Both hospitals clearly needed substantially increased revenues to deal with these multiple sources of growing costs. The ultimate solution appeared to be the building of new facilities that could take advantage of what the hospitals hoped was a growing market for private and semi-private accommodation. However, in the immediate, they also required short-term solutions, and for these they looked to several sources. They constantly lobbied government for increased subsidies, for indigents in particular but for other government-subsidized patients as well, they increased room rates for the rooms they already had, and they made various attempts at cost containment, particularly in the area of service to indigent patients.

• **Quest for Revenues**

While costs increased significantly in the post-war period, revenues also grew, in part through increases from traditional sources, and in part from new sources. Substantial as these increases might be, however, they were often not enough to keep up with growing costs.

¹³⁰ Malcolm G. Taylor, *Financial Aspects*, p. 16. Taylor's statistics come from the Dominion Bureau of Statistics.

The Public Charities Act rate reached \$7.50 by 1953 (up from \$4.00 in 1947).

This rate, in fact, almost covered the two-thirds share of hospitalization costs that government was supposed to pay under the Public Charities Act, according to costs calculated by the Montreal General (cost per ward patient in 1953 was \$12.94; St Luc charged \$7.00 for a ward bed in the same year, charging supplementary costs for all services). Of course, hospitals still had to cover the other third for PCA patients.¹³¹ And, as a member of the medical staff at St-Luc pointed out, a significant number of public cases, in this instance 40 per cent, were rejected by the PCA, generally leaving the hospital to absorb the entire cost of caring for the patient.¹³²

The major means used in the attempt to cover the shortfall remained the charges billed to patients. Room rates were revised annually, and sometimes twice a year; this usually added \$1.00 to the rate for private and semi-private rooms, and 50 cents to ward beds. St-Luc charged \$4.00 per day for a ward bed in 1947, but by in 1953 the cheapest ward bed (with five or more beds in a room) was \$7.00. Private rooms, costing \$6.00 and up in 1947, ranged from \$10.50 to \$11.00 in 1953.¹³³ The Montreal General

¹³¹ MA, MGH, Statistics, AR, 1953; HSL, Procès-verbal de la réunion du Conseil d'Administration, le 7 décembre 1953. According to Taylor, the average national cost per patient day in 1953 was \$12.79. See Taylor, *Financial Aspects*, p.15.

¹³² HSL, Procès-verbal de la réunion du Conseil Médical, le 9 décembre 1948.

¹³³ HSL, Procès-verbal de la réunion du Conseil exécutif, le 25 juin 1947; Procès-verbal de la réunion du Conseil d'Administration, le 17 décembre 1952. This situation was not unlike that in hospitals across Canada, as affirmed by a 1947 article in *TCH*, "Hospitals Being Forced to Increase Rates Again," *op. cit.*, vol. 25, no. 4 (April 1948), pp. 40-41. As a partial indication of the population's ability to pay for hospitalization, a clerical worker at St-Luc had a salary of between \$15.00 and \$25.00 per week in 1948. The starting salary for a nurse was about \$32.00 per week in 1947. Clearly, with the rates of ward beds starting at \$4.00 per day in 1947, hospitalization was still out of reach for many. See HSL, Procès-verbaux des réunions du Conseil exécutif, le 16 décembre 1948, le 24 juillet 1947.

also increased its room rates frequently, usually by one dollar for private rooms and fifty cents to one dollar for semi-private and ward beds.¹³⁴ Of course, all other services, operating room costs and X-rays, for example, were charged separately and also increased in cost.

Rates paid to the hospitals from other sources went up as well, often after negotiations by the Montreal Hospital Council: at different times, the Department of Veterans Affairs, the Quebec Workmen's Compensation Commission, and the Department of Indian Affairs raised the amounts they paid for in-patients under their authority.¹³⁵ Blue Cross, with about 16 per cent of the population of Quebec enrolled by 1951 (compared to almost 35 per cent in Ontario), also regularly raised rates paid during this period.¹³⁶ In July of 1946, rates for a semi-private bed were raised to \$4.50 from \$4.00.¹³⁷ In 1951, daily rates varied between \$6.00 and \$9.00, depending on whether the patient requested a ward, private or semi-private bed.¹³⁸ However, in 1951 the average cost per patient day at the Montreal General varied from \$10.38 for ward patients to \$15.09 for private patients, leaving a significant gap that the patient was

¹³⁴ See, for example, MA, MGH, Report of the Board of Management, AR, 1947; Honorary Treasurer's Report, *ibid.*, 1950.

¹³⁵ HSL, Procès-verbaux des réunions du Conseil d'Administration, le 26 juin 1946; le 22 octobre 1951; le 21 août 1953. The Workmen's Compensation Commission also paid for out-patient services, as did the Department of Indian Affairs.

¹³⁶ "A Brief Review of Canadian Blue Cross Plans in 1951," *The Canadian Hospital*, vol. 28, no. 4 (April 1952), p. 64.

¹³⁷ HSL, Procès-verbal de la réunion du Conseil d'Administration, le 24 juillet 1947.

¹³⁸ HSL, Procès-verbal de la réunion du Conseil exécutif, le 1 août 1951.

supposed to cover.¹³⁹ Overall, while the hospitals were able to increase their revenues, these increases were not keeping pace with the growth of expenditures (see Tables 5 and 6).

- **Funding: Public and Private**

Perhaps the most significant element in this period was the increasing role of government funding in the hospital sector as the institutions expanded, taking advantage of the new programmes of Dominion/Provincial grants. While grants were available for new beds, they could also be obtained for new hospital services. Both St-Luc and the Montreal General proposed projects under this umbrella. St-Luc gained ongoing annual funding for a psychiatric out-patient clinic, for a cancer control clinic (close to \$100,000 *per annum*), and for tuberculosis detection.¹⁴⁰ The General gained funding for cancer control (over \$100,000 *per annum*), for a glaucoma clinic and for the Department of Psychiatry.¹⁴¹ These new funds could be used for equipment or salaries, and to pay for patient treatment. In fact this was one way that the hospitals

¹³⁹ MA, MGH, Statistics, *AR*, 1951. As a point of comparison, in 1948, the average per diem cost at the Toronto General Hospital, an equivalent hospital in Toronto ranged from \$8.45 for a ward bed to \$12.88 for private and semi-private beds. See "Hospital Costs Analysed," *TCH*, vol. 27, no. 4 (April 1950), pp. 38-39.

¹⁴⁰ HSL, Procès-verbal de la réunion du Conseil exécutif, le 25 janvier 1949; HSL, Procès-verbal de la réunion du Conseil d'Administration, le 21 octobre 1950.

¹⁴¹ MA, MGH, Report of the Board of Management, *AR*, 1951; Grants & Donations for Special Purposes, *AR*, 1950.

could buy expensive new equipment, and both hospitals took advantage of it, particularly for the purchase of radiology equipment for the cancer treatment.¹⁴²

Both hospitals also planned to take advantage of the funding available for expansion. In fact, the General did obtain funding from the Dominion/Provincial programme for its new complex starting in 1953. In all, it would receive over \$1.2 million from Ottawa over several years.¹⁴³

At the same time, the Montreal General Hospital was also exploring other sources of funding, and doing so quite successfully. Above and beyond the gifts and legacies the hospital received, it started obtaining substantial amounts from the private sector in various forms of research partnerships or for services rendered. An Institute for Special Research and Cell Metabolism was set up in the late 1940s, with funding maintained separately from the hospital's general funds.¹⁴⁴ While a substantial amount of the funding came from the National Cancer Institute, other sources were Sun Life Assurance Co. of Canada and the Sugar Research Foundation, Inc., which was specifically funding diabetes research.¹⁴⁵ Some relationships with the private sector did not seem to involve direct cash contributions. In one such case, the hospital formed a "liaison" with the Canadian Car and Foundry Company to organize a rehabilitation

¹⁴² HSL, Procès-verbal de la réunion du Conseil exécutif, le 16 avril 1953; MA, MGH, Report of the Department of Radiology, AR, 1951.

¹⁴³ NAC, RG 29, vol. 356, file 615-34. pt. 1, National Health Grants Administration, June 26, 1953; April 27, 1954, December 2, 1954, May 9, 1955.

¹⁴⁴ MA, MGH, Report of the Board of Management, AR, 1949.

¹⁴⁵ MA, MGH, Grants & Donations for Special Purposes, AR, 1950; Medical board, Minutes, November 6, 1946.

centre.¹⁴⁶ Others did financially benefit the hospital. Pharmaceutical manufacturers

Ayerst, McKenna & Harrison also made a proposal to the hospital:

asking the cooperation of the Hospital in its various Departments in carrying out preliminary trial of new therapeutic agents for the purpose of assessing therapeutic effectiveness, and patient, physician and hospital acceptability. The Hospital's cooperation in batch testing of certain products, mainly injectables, was also asked; the understanding being that Messrs. Ayerst, Harrison would not expect the Hospital to undertake the administration of any drugs which the Chief of the Service did not feel free in conscience to carry out. In return for this cooperation on the part of the Hospital, Messrs. Ayerst, Harrison have offered to donate immediately \$5000 to the Joint Hospital Fund in addition to an annual grant to the Montreal General Hospital of \$5000.¹⁴⁷

The proposal was accepted and the pharmaceutical company became a contributor to special projects for the hospital.

These funds from private sources did not surpass the government contribution to hospital care and research. In 1950, for example, government funding for specific programmes at the General totalled close to \$177,000, while private funding reached close to \$75,600. Nonetheless, this was a significant amount that the hospital would have been hard-pressed to do without.¹⁴⁸

• Cost Containment

The final means of dealing with the growing deficit was the attempt to lower costs. While other areas were undoubtedly scrutinized for means of trimming costs, the

¹⁴⁶ MA, MGH, Medical Board, Minutes, June 7, 1950.

¹⁴⁷ MA, MGH, Medical Board, Minutes, September 6, 1950.

¹⁴⁸ MA, MGH, Grants & Donations for Special Purposes, AR, 1950.

focus seemed to be on areas where free treatment was given — in the out-patient clinics and on the wards. The clinics were still a virtual sink-hole for money, still not covered in any way by government funding. In 1946, for example, the General Superintendent of the Montreal General noted that the net deficit resulting from the operation of the Out-patient Department amounted to \$166,000.¹⁴⁹ Three years later, he noted that average revenue in the same department was only 32 per cent of costs.¹⁵⁰ St-Luc experienced the same problems with large numbers of non-paying patients in the out-patient clinics.¹⁵¹ It was logical, therefore, that this would be a focus for cost-cutting.

More scrutiny was exercised in both hospitals to weed out patients who would once have been called “phoney indigents,” and to limit the number of free cases in the clinics.¹⁵² At St-Luc, in 1953, the hospital instituted a system of “filtrage social et pathologique” to stop patients who could pay from using the free services.¹⁵³ In general these efforts did not bring the wanted results. At the Montreal General, for example, clinic attendance in 1953 was higher than it had been in 1946, and the Treasurer noted a “substantial loss” in the out-patient clinics for the year.¹⁵⁴ The number of patients treated in the out-patient clinics also grew at St-Luc.¹⁵⁵ Attempts

¹⁴⁹ MA, MGH, Report of the General Superintendent, AR, 1946.

¹⁵⁰ MA, MGH, Report of the General Superintendent, AR, 1949.

¹⁵¹ See, for example, Rapport du Président, Assemblée annuelle des Membres à vie, le 30 mai 1947.

¹⁵² MA, MGH, Medical Board, Minutes, May 3, 1950. HSL, Procès-verbal de la réunion du Conseil d'Administration, le 24 juillet 1946.

¹⁵³ HSL, Procès-verbal de la réunion du Conseil médical, le 18 septembre 1952.

¹⁵⁴ MA, MGH, Statistics, ARs, 1946, 1953, Report of the Honorary Treasurer, *op. cit.* 1953.

¹⁵⁵ HSL, Procès verbaux, Assemblées annuelles des Membres à vie, le 25 mai 1948, le 19 mai 1954.

were also made in both hospitals to control diagnostic services and medications prescribed for indigents, both in the clinics and on the wards, usually by restricting the right to prescribe medications or tests to upper levels of the medical staff.¹⁵⁶

While these attempts were ongoing — the problem of the costs of out-patient clinics was mentioned on a regular basis by both hospitals — certain reflections appeared in the Montreal General's annual reports as to who should really be responsible for these indigents. In 1946, the Montreal General's General Superintendent, discussing the high occupancy rates, particularly in the wards, went on to reiterate the standard sentiments about the hospital's concerns for the sick poor:

It is felt, however, that when the sick poor apply for admission, their claim for assistance entitles them to all possible consideration and these continued and increasing demands compel us to strain our inadequate facilities to the utmost limit.¹⁵⁷

Within a short time, however, the attitude seemed to be shifting. In the following year's *Annual Report*, the General Superintendent returned to the problem of the clinics.

After reporting the loss of more than \$252,000 in the out-patient departments, he went on to warn:

This heavy financial burden incurred in providing care for one class of patient is important in that it is indicative of the service which your Hospital rendered to the Community during the past year. What is more important, however, is that this heavy financial burden points to the fact that unless a policy of financial assistance to hospitals towards the cost of treating indigent outpatients is recognized in the immediate future by the Provincial and Municipal Governments, then it may well be necessary for

¹⁵⁶ HSL, Procès-verbal de la réunion du Conseil Médical, le 12 février 1948; MA, MGH, Medical Board, Minutes, April 1, 1953.

¹⁵⁷ MA, MGH, Report of the General Superintendent, AR, 1946.

this Hospital to curtail drastically, this phase of its activities — a step, which I am sure your Board would be most reluctant to take.¹⁵⁸

This was not an isolated threat. In 1949 *The Canadian Hospital* reprinted comments made by the CHC President during the annual meeting underlining that the problem of indigents was a major one for hospitals across the country, and noting, as did the Montreal General's Superintendent, that they should not be the responsibility of the hospitals:

We are gratified to note the increasing interest of governmental bodies in the health of our people and to note that certain provincial governments have, in the past year or so, increased the grants to hospitals to assist them in providing care for indigent or partially indigent patients. The responsibility for the payment for the care of these people must be removed entirely from the shoulders of those public-spirited citizens who act as trustees and governors on our hospital boards. It is sufficient for them to furnish large sums to help build the hospitals and equip them and, by their direction, to assist in the management. They should not have to find money to help pay for the maintenance of indigent or partially indigent patients who are entirely the responsibility of the state and not of any small groups of individuals.¹⁵⁹

Whether by coincidence or not, the President's Address was followed by a report on Alberta's Health Survey, where it was noted that: "In many cases hospitals have found it necessary to curtail free services because of reduced income from endowments and benevolent contributions."¹⁶⁰

¹⁵⁸ MA, MGH, Report of the General Superintendent, AR, 1947.

¹⁵⁹ Andrew J. Swanson, "Presidential Address to the Canadian Hospital Council," *TCH*, vol. 26, no. 7 (July 1949), p. 29.

¹⁶⁰ A. Somerville, Director, Alberta Health Survey, "Present and Future Trends in Hospital and Medical Services: Noticeable Demand for Government Participation," *TCH*, vol. 26, no. 7 (July 1949), p. 31.

To what extent, if any, cost-containment measures aimed at indigent patients — either by excluding people who really could not afford to pay or by skimping on treatments or medication — compromised hospital care of the indigent is impossible to know. What can be seen clearly here, however, is slippage in the original and long-standing commitment on the part of the hospitals to serve the poor. More and more, the hospitals were attempting to remove responsibility for indigents from their shoulders — not without justification — and to turn that responsibility over to the state exclusively. The state, however — in this case the provincial state — seemed to be willing to carry some of the burden, but not all.

When all was said and done, the end result for both hospitals of all attempts at increasing revenues and containing costs was an ever-present and often growing deficit (see Tables 5 and 6). Revenues almost doubled over the years, thanks to increases in insurance payments and in most government programmes, but expenditures, covering more costly equipment, drugs, labour and supplies in general, grew on a par with revenues at St-Luc, leaving it with almost double the deficit it had faced in 1946. At the General, the deficit in 1953 was more than twice as large as it had been in 1946.

Table 5
Montreal General Hospital: Revenue, Expenditures and Deficits
1946-1953
(in 1940 dollars)

	Revenue	Expend-iture	Gross Deficit*	Net Deficit**	Net Deficit (in current dollars)
1946	945,000	1,097,000	152,000	39,000	46,000
1947	1,266,000	1,537,000	271,000	110,000	142,000
1948	1,299,000	1,557,000	259,000	76,000	112,000
1949	1,326,000	1,651,000	324,000	139,000	211,000
1950	1,408,000	1,753,000	345,000	174,000	271,000
1951	1,530,000	1,833,000	303,000	150,000	238,000
1952	1,685,000	1,965,000	280,000	116,000	188,000
1953	1,727,000	2,035,000	307,000	118,000	194,000

Source: Montreal General Hospital, Statement of Revenue and Expenditure, Annual Reports, 1946-1953.

* Includes other expenditures: Interest and Bank Charges, Custodian's Fees, Appropriation to Bad Debts Reserve, Appropriation to Employees' Benefit Reserve.

** After deduction of fees, donations, endowments, grants, other revenues.

Table 6
St-Luc Hospital: Revenue, Expenditures and Deficits
1946-1953
(in 1940 dollars)

	Revenue	Expenditure	Deficit	Deficit (in current dollars)
1946	778,000	805,000	27,000	32,000
1947	897,000	963,000	66,000	85,000
1948	876,000	936,000	60,000	88,000
1949	918,000	988,000	71,000	108,000
1950	924,000	1,002,000	78,000	122,000
1951	1,003,000	1,087,000	84,000	134,000
1952	1,142,000	1,193,000	51,000	83,000
1953	1,213,000	1,266,000	49,000	81,000

Source: Hôpital St-Luc, Procès-verbaux des réunions des membres à vie, 1946-1953.

Nonetheless, despite proof that market solutions, principally groups or private insurance, were unable to resolve the problem, the hospitals were reluctant to allow more government control over their institutions. While they were content to receive grants for specific projects, and consistently demanded more funding for indigents, they still firmly believed in a kind of mixed economy of hospital financing. In 1947, in a telling discussion of a report of the U.S. Commission on Hospital Care, the Montreal General's Burnett S. Johnston laid out the principles guiding the Board of the General, and hospitals in Canada in general:

It is certain that the voluntary hospital system as we know it in Canada today is in jeopardy. A national stabilized economy would do much to solve our difficulties. However, in the minds of many the only solution

to all our problems is a National Health Insurance Scheme, with which must be accepted its corollary of bureaucracy, confusion, and costliness. Such a scheme too, in the final analysis, might well be detrimental to the best interests of patients, the medical profession and the voluntary hospitals which, except in certain cases, would lose their autonomy.

In the country of our neighbours to the south, the Commission on Hospital Care, an independent non-governmental committee, composed of outstanding leaders from many fields, very recently published a report titled "Hospital Care in the United States", which is as timely as it is interesting. In it were embodied recommendations which suggest a feasible alternative to a National Health Insurance Scheme....

Briefly, the pattern for the complete overhauling of the United States hospital system outlined by the Committee is contained in the following recommendations: —

- (1) That a very wide expansion of the practice whereby city, country, and state funds as well as federal funds, be used to buy at actual cost hospitalization for those who cannot afford to pay...
- (3) That new hospitals be built where they are needed. To finance them, all local methods of raising money should be utilised — charity drives, building campaigns, and such like — this sum to be supplemented by all that local and state governments can afford to appropriate. In the event that this should prove to be insufficient money, then federal funds for hospital construction should be made available.
- (4) That during this period of building expansion every method should be used to persuade people to join voluntarily one of the existing hospital insurance plans, industrial group insurance, commercial insurance, or one of the non-profit organizations like Blue Cross.
- (5) That when new building has finally caught up with the demand for hospital accommodation, State or Federal laws should be passed compelling every individual to belong to some insurance plan. But he should always be permitted to join a plan or organization of his own choosing.

The difficulties confronting the hospitals of the United States and Canada are very similar. It would appear, therefore, that the recommendations of the Commission mentioned might well receive serious consideration in this country with a view to solving the problems presently facing Canada's voluntary hospitals.¹⁶¹

¹⁶¹ MA, MGH, Report of the General Superintendent, AR, 1947.

The usual themes of individual responsibility, and the primacy of private sector initiatives and solutions over state solutions and control, were very much present in this document. In the same year, an article in *The Canadian Hospital* discussing the founding of the Health Insurance Plan of Greater New York, a non-profit insurance fund for medical care, echoed the sentiment expressed by Johnston (and in fact by Louis St-Laurent):

Being contributory and self-supporting, it should be of value in teaching the public to work out their own solution rather than turn everything over to the State.¹⁶²

These sentiments, expressed in 1947, did not change significantly by 1953. In 1949 the CHC passed a resolution on Contributory Health Insurance at its annual conference, which reiterated many of the sentiments expressed in the statements quoted above: individual responsibility; wariness about state control of hospitals; and the necessity of a contributory basis for any plan.

WHEREAS, in the opinion of the Canadian Hospital Council, the individual should be encouraged to regard the costs of illness and hospitalization as a personal responsibility to the degree possible; and

WHEREAS, in the opinion of the Canadian Hospital Council, the principle of compulsory taxation for hospitalization and state control of hospitals is not in the best interests of either patients or hospitals;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council urge strongly that in the event the Federal Government deems it advisable to institute a plan for health insurance, that such plan be established on a contributory basis.¹⁶³

¹⁶² "HIP; The Medical Insurance Plan of Greater New York," *TCH*, vol. 24, no. 5 (May 1947), p. 62.

¹⁶³ NAC, RG 29, vol. 857, file 20-C-27, Canadian Hospital Association 1949 Annual Conference, Quebec City, Resolution, "Contributory Health Insurance."

This position — promoting individual responsibility, a diminished role for the state, and the pre-eminence of the market — was reaffirmed annually at the CHC conferences.

In the intervening years, the federal government, through its granting policies, did begin to implement a step-by-step programme of health insurance. The Quebec government, while claiming vigilance against any attempts to infringe provincial autonomy, participated fully, allowing for significant growth both in numbers of beds and in other health care services. The hospitals benefited from these programmes. They also benefited from the growth of private and group insurance. Yet deficits did not disappear— in fact they grew: the cost of caring for indigents grew, and so did the costs for other patients.

After the interventionist years of the war, the state stepped back in the post-war period, hoping that the private sector would move into the breach. As St. Laurent had said, it would be better if the private sector could see to the need for health insurance, and in general the hospital sector agreed wholeheartedly with this sentiment. Not that the state was totally absent: the federal granting programmes helped the hospital sector significantly in building up needed infrastructure, and the province played a role here too. Quebec's multiple increases in PCA rates over these years also aided the deficit-ridden hospitals.

Yet the private sector, expand as it did both Blue Cross and private insurance coverage, did not seem quite up to the task. The majority of the population was still without coverage. The end result was growing revenues for hospitals, but also more rapidly growing expenditures and, therefore, greater deficits.

The result seemed to be a hardening of positions towards indigents. Hospitals wanted to relieve themselves of all financial responsibility for them, but this was a responsibility government was not ready to take on fully. At the same time, the hospitals were still convinced that, with time and the proper circumstances, that is, with expanded private and semi-private accommodation, the private sector solution was still the key to the future.

Chapter V

HOSPITALIZATION INSURANCE: CANADA, 1957, QUEBEC, 1961

As the 1950s progressed, and the institution of hospitalization insurance seemed unlikely in the near future, hospitals focused on developing private market solutions to their financial problems. Key was the two-fold process of extending private hospital insurance to uninsured sectors of the population and expanding the stock of semi-private and private beds in hospitals. The knotty and persistent problem of indigents remained, however, with hospital boards demanding more state intervention at least on this question. At the federal level, however, despite the apparent lack of interest in Cabinet for further extension of health care initiatives, Paul Martin, aware of the strong public support for such measures, continued to push for health insurance. In Quebec, the Public Charities Act remained the mainstay of government hospital policy.

Pushed From Behind, Ottawa Takes The Lead

In 1953 the first five-year plan for expansion of health care facilities came to an end, and federal Minister of National Health and Welfare Paul Martin inaugurated another plan. By this time, some 46,000 new hospital beds had been made available or were under construction, bringing the bed complement in most provinces close to the accepted level.¹ As Martin emphasized in an address to the Canadian Hospital Association in May of 1953, where he summed up the benefits of the first plan and

¹ "The New Health Grants," *CJPH*, vol. 44, no. 6 (June 1953), pp. 224-226.

laid out the contours of its successor, the increase in beds amounted to "one-third as many new hospital beds as we had managed to accumulate in all the years before 1948."²

The new plan would continue grants for construction, but the total funding available was reduced. New grants targeted child and maternal health, medical rehabilitation, and the setting up of laboratory and radiological services (these services were seen as a means of reducing unnecessary hospitalization for diagnostic purposes); all of these grants could be applied to hospitals.³

Martin, in his speech to the Hospital Association, made no link between these programmes and the implementation of universal health insurance, something he had done consistently during the implementation of the first programme. However, according to his autobiography, he never wavered in his determination to bring in a universal health insurance plan: the problem lay in the lack of support in Cabinet, particularly from the Prime Minister. Archival documentation certainly supports Martin's contention that he and his men in National Health and Welfare never stopped their work of formulating a full programme of health insurance and determining strategies for the best means to implement the programme, and what parts

² "Five Years of Health Progress," *TCH*, vol. 30, no. 7 (July 1953), p. 35.

³ *Ibid.*, pp. 33-35.

of the programme to implement first.⁴ They would carry on this work until a bill was passed in Parliament, four years later.

1953 was also an election year. In his autobiography, Martin accuses Prime Minister Louis St. Laurent of “backsliding” on the Liberal party’s programme on health insurance during the campaign.⁵ St. Laurent continued to prefer a market solution to health care problems, as can be seen in his remarks to the Commons in 1951, where he congratulated the medical profession for organizing a national non-profit medical plan, and concluded with these words:

... I am sure that all levels of government – and that includes this government as well as others – will be most anxious to do everything they can to make it possible for the medical profession to carry out this undertaking under their autonomous powers. I think that it would be a most happy solution if the medical profession would assume the administration of, and the responsibility for, a scheme that would provide prepaid medical attendance to any Canadian who needed it.⁶

However, government-financed health insurance had been part of the Liberal Party platform since 1919, as the CCF’s Stanley Knowles pointed out later that day in the Commons. To strengthen his case, Knowles quoted the Liberal Party platform from 1948:

⁴ See for example: NAC, RG 29, Department of National Health and Welfare, vol. 1063, file 502-1-1, pt. 11, “Health Insurance – An Informal Discussion,” September 1949; vol. 1061, file 500-3-4, pt. 2, “Informal Discussion Concerning Health Insurance,” August 25, 1955; vol. 1372, file 1-5, “The Case for National Health Program,” 1955.

⁵ Paul Martin, *A Very Public Life*, vol. II, *So Many Worlds* (Toronto: Deneau, 1985), p. 225.

⁶ Canada, House of Commons *Debates* June 29, 1951, p. 4349.

The Liberal party stands for a national program of social security in collaboration with federal and provincial governments with the following objectives: useful employment for all who are willing to work, standards of nutrition and housing adequate to ensure the health of the whole population; social insurance against privation resulting from unemployment from disability, from ill health and from old age.

The program will include a steady extension of insurance on a contributory basis to protect all citizens from a temporary loss of income and to provide for their old age; health insurance covering medical, dental, surgical and hospital health services on a contributory basis; more equal care and opportunity for all children through family allowances; and pensions for the blind.⁷

Knowles, insisting that the platform supported a government-administered health insurance programme, not a privately-administered plan, would appear to have been in agreement with Martin about St. Laurent's backsliding.

During one of St. Laurent's national broadcasts on CBC radio (after the announcement of federal elections in 1953), his decidedly cautious stance on health insurance was again apparent. In a speech where he vaunted the Liberal government's careful financial management, including debt reduction and tax cuts, and promised to continue on these fronts, St. Laurent's comments on health insurance indicated that the federal government was not ready to act. After insisting first that this field be left to provincial administrations, he quashed any suggestion that the federal government aid those provinces that had already undertaken or were ready to undertake health insurance measures, stating:

But I do not think it would be fair to the taxpayers of Canada in all the Provinces to make Federal contributions to Provincial schemes in only

⁷ Resolution no. 11 of Liberal Party Program quoted by Stanley Knowles in *House of Commons Debates*, June 20, 1951, p. 4387.

one or two Provinces. Federal contributions should be regarded as a supplement and an even-er-out when most of the provinces are prepared to undertake satisfactory schemes.

And it is Liberal policy to go on improving Federal health grants which have done so much to place all the Provinces in a better position to discharge their primary responsibility in this important field.⁸

• Results of Public and Private Plans

By this time, four provinces— Saskatchewan, British Columbia, Alberta and Newfoundland — had moved on their own in implementing various hospitalization insurance plans, and the results were beginning to be felt, both in terms of costs and in terms of coverage. At the same time, statistics on the growth and effectiveness of voluntary commercial and non-profit hospitalization plans were also revealing interesting trends. All this was, of course, being monitored by Martin's Department of National Health and Welfare, giving it ammunition in its bid to move the country as a whole towards comprehensive health insurance. It should be remembered, too, that the population as a whole supported a universal health insurance plan. It was special interest groups: the hospitals, the medical profession, the insurance industry, and some government leaders, among others, who needed convincing.

Newfoundland had its state-subsidized cottage hospital system, dating from 1935, whereby outport residents were covered for hospital services on payment of a

⁸ NAC, MG 32, B 12, Paul Martin Papers, vol. 30, Rt. Hon. Louis St. Laurent, "Second National Broadcast — 1953."

small premium. Almost one-half of the population was covered by this plan.⁹ Alberta, in 1950, had implemented a partial hospitalization plan, based on the voluntary adherence of municipalities to the scheme. Financed in part by a municipal property tax and patient co-payment (the patient paid a daily fee for hospitalization), the plan allowed for a provincial subsidy of 50 per cent of the cost of standard ward care for eligible individuals.¹⁰ By 1954, about 40 per cent of Alberta's population was covered by this plan. (According to Malcolm Taylor, there was some resistance on the part of municipalities because the Act obliged hospitals to shoulder responsibility for deficits, which were almost guaranteed by the low level of funding. The Alberta government used an element of coercion to force adherence, by refusing access to provincial construction grants and, by extension, to federal grants, if hospitals were not in the plan.)¹¹ When the provincial-municipal plan was combined with other separate plans – the maternity plan, poliomyelitis plan, and social service recipient plan – about 71 per cent of the population was covered.¹²

The British Columbia and Saskatchewan plans were more comprehensive, covering most of the population in these provinces. Both provinces instituted premiums and/or taxes to be paid by the public for coverage. In both cases costs in

⁹ Royal Commission on Health Services (Hall Commission) *Report*, vol. I, 1964, p. 410; Malcolm G. Taylor, *Health Insurance and Canadian Public Policy*, Second Edition (Kingston: McGill-Queen's University Press, 1987), p. 170.

¹⁰ M. G. McCallum, M.D., "Alberta's Provincial-Municipal Hospitalization Plan," *CJPH*, vol. 47, no. 4 (April 1956), pp. 142-143.

¹¹ Taylor, *Health Insurance*, p. 170.

¹² McCallum, *op. cit.*, p. 147.

the first few years grew rapidly, because they were inaugurated in the post-war period, with its rising labour and material costs (the Saskatchewan plan was inaugurated in 1947, the B.C. plan in 1949), and because of sudden increased use of services as they became accessible to the entire population.¹³ However, by 1953, use had stabilized in Saskatchewan, and costs, though still rising, seemed to be under control.¹⁴ The British Columbia plan actually registered a growing surplus in its Hospital Insurance Fund as of 1950.¹⁵ Finally, administrative costs of the plans were low. In British Columbia, the administrative costs were projected to be six per cent of total budget in 1953.¹⁶

Concerned hospital administrations in other provinces could perhaps take solace in the insistence by Saskatchewan's Deputy Minister of Public Health, F. B. Roth, that "there has been no interference by the government with the autonomy of hospitals. In fact there has been a constant insistence on the part of the Department of Public Health and Plan officials that hospitals must be responsible for their own operation."¹⁷

Thus, though there were significant problems to overcome initially, both the B.C. and Saskatchewan plans seemed to be working more smoothly by 1953, and had

¹³ On costs, see, "Drastic Increase in Costs Causing Alarm in Saskatchewan," *TCH*, vol. 24, no. 11 (November 1947), p. 46; "Hospitalization Tax Raised in Saskatchewan," *TCH*, vol. 25, no. 10 (October 1948), p. 42; "A Symposium — Recent Trends in Financing Hospital Care; In British Columbia — B.C.H.I.S.," by L. F. Detwiller, *TCH*, vol. 30, no. 9 (September 1953), pp. 39-41. See also, Malcolm G. Taylor, *Financial Aspects of Health Insurance, Canadian Tax Papers*, no. 12 (December 1957), pp. 63-64.

¹⁴ Taylor, *Financial Aspects*, pp. 60-61.

¹⁵ Detwiller, *op. cit.*, p. 39.

¹⁶ *Ibid.*, p. 40.

¹⁷ "A Symposium — Recent Trends in Financing Hospital Care: Government Plan in Saskatchewan," by F. B. Roth, M.D., *TCH*, vol. 30, no. 9 (September 1953), p. 38.

the support of the population. As Roth wrote in a Canadian Hospital Association Symposium on hospital financing:

...it should be stated that, in meeting the needs and conditions prevailing in Saskatchewan, the Plan has been generally successful. It has been accepted by the people, by the hospitals, and I think it can be safely said that few hospitals in Saskatchewan would wish to return to the pre-Plan days. This is not to say there has been no criticism either by the hospitals or by the public. But, in general the idea of the Plan has been widely accepted as both suitable in principle and workable in detail.¹⁸

In 1957, after eight years of operation, a hospital administrator noted the positive effects of the BC plan on hospitals:

...the operation of the scheme has been of real assistance to the financing of hospitals and the problems of the governing boards... our collection worries and working capital requirements have been minimized.¹⁹

Universal plans did not offer a solution to all problems for hospitals, but, by including all residents in the plans and thus eliminating the category of indigents, they did offer a solution to the major financial problems of assuring sufficient income for day-to-day operations. Hospital administrators working under provincial plans seemed to be content to operate under their auspices.

A certain number of trends were also becoming clear regarding commercial and non-profit health insurance plans. In 1955 Bruce Power of the Canadian Life Insurance Officers Association made available to the Department of National Health and Welfare

¹⁸ *Ibid.*, pp. 37-38.

¹⁹ L. F. C. Kirby, Director, Royal Columbian Hospital, New Westminster, B.C., "Focus on Hospital Insurance: Viewpoint of a Hospital Administrator," *TCH* vol. 34, no. 2 (February 1957), p. 72.

confidential information on commercial sickness insurance operations.²⁰ This document outlined trends in the growth and coverage of private sector for-profit and non-profit health insurance. In 1953, commercial companies had 2.9 million persons covered under hospital contracts, while non-profit companies had enrolled 2.5 million. Since 1950, commercial enrollment had been expanding much more rapidly than Blue Cross coverage, by one million in the first case as opposed to 500,000 for Blue Cross. However, in both cases the annual rate of growth had been declining: going from 22 per cent in 1950 to 8 per cent in 1953 for commercial contracts, and from 8 per cent to 6 per cent for Blue Cross.²¹ Just under 20 per cent of Canada's total population was covered under commercial contracts and 23 per cent were enrolled under Blue Cross in 1953.²² While commercial enrollment was growing more rapidly, these plans provided significantly lower benefits than non-profit plans. In 1953, while non-profit plans spent \$11.80 *per capita* in benefits, commercial insurance companies spent only \$8.16.²³ (The Department's Joseph H. Willard, in his memo on this subject, suggested that the commercial plans, despite their inferior product, could maintain competitive superiority by offering to employers cheaper health insurance with limited benefits as

²⁰ NAC, MG 32 B 12, vol. 28, Memo, To the Minister, From D. J. W. Willard, Director, Research Division, Department of National Health and Welfare, "Developments in Voluntary Health Care in Canada 1953," February 3, 1955.

²¹ NAC, MG 32 B 12, vol. 28, Department of National Health and Welfare Memorandum, Joseph A. Willard, "A Comparison of Enrollment and Expenditures on Health Care Benefits under Commercial Insurance Companies and Non-Profit Plans," February 1955, p. 1.

²² *Ibid.*, p. 2.

²³ *Ibid.*, p. 4.

part of attractive insurance "packages", and by using sales staff working on commission.²⁴

The Department's Memorandum on commercial and non-profit plans, based on information supplied by the industry, concluded with an evaluation of the comparative worth of the programmes:

The obvious conclusion to be drawn from these statistics is that mere size of enrollment, number of members covered, indicates little or nothing about the extent of protection against the costs of health care that is held by the people of Canada. The kind of protection, the nature of the benefits available, the per capita payments on behalf of members, and the proportion of the patient's total bill met by his insurance, are much more relevant statistics for estimating the effectiveness of one type of insurance coverage as compared with another.²⁵

Yet, even Blue Cross was less than adequate. Plans did not necessarily pay the total hospital bill, and they often limited the number of days payable, thus cutting off benefits for patients with chronic illnesses requiring long hospitalization. Not everyone had access to Blue Cross plans either; group plans, which were less expensive, were not easily obtained in rural areas, for example.²⁶

In another memo a few months later, Willard noted that Blue Cross payments to Canadian hospitals in 1951 amounted to \$7.86 per patient day while expenditures of public general hospitals in the eight provinces where Blue Cross operated amounted to

²⁴ Willard, "Developments in Voluntary...", p. 2.

²⁵ Willard, "A Comparison of Enrollment and Expenditures...", p. 5.

²⁶ NAC, RG 29, vol. 1372, file 1-5, "The Case for a National Health Program Now," March 1955. See also, Antonia Maioni, "Explaining the Differences in Welfare State Development: A Comparative Study of Health Insurance in Canada and the United States" (Ph.D. diss., Northwestern University, Evanston, Illinois, 1992), pp. 196-197; C. David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance 1911-1966* (Kingston: McGill-Queen's University Press, 1986), p. 163.

\$9.03 per patient day, leaving a shortfall to be absorbed either by the patient or the hospital.²⁷ Though Blue Cross plans were promoted by provincial hospital associations and were advantageous because they guaranteed a certain level of income, the fact that these plans did not cover real costs was definitely disadvantageous to both hospitals and patients.

Finally, there was a clear class bias in terms of access to these plans. As showed by the 1950-51 national sickness survey (a random sampling of about 40,000 Canadian households), the poorest, who were also the most often in need of medical attention, were often excluded by cost from buying insurance, and even many of the middle class did not buy comprehensive protection.²⁸ These, of course, were the potential indigent patients that caused hospitals so much financial grief.

Voluntary insurance, though still growing in terms of clientele, was in many ways inadequate, for the policy-holders, for hospitals, and for governments, which were left with the responsibility of covering costs of indigents and other uninsurables, often the bad risks that insurance companies would not take on. Provincial government plans, which spread the risks and the benefits across the entire population, seemed to be more equitable and more cost-efficient for all concerned. Finally, also from the government point of view, voluntary plans concentrated solely on curative medicine,

²⁷ NAC, RG 29, vol. 1372, file 1-5, Memo from Dr. J. W. Willard to Dr. Cameron, "Comparison of Blue Cross Enrollment in Canada and the United States," May 5, 1955.

²⁸ C. Lloyd Francis, "Expenditure Patterns from the Canadian Sickness Survey 1950-1951," *CJPH*, vol. 47, no. 8 (August 1956), p. 330. See also, M. G. Taylor, *Health Insurance*, pp. 173-177.

whereas there was room in compulsory insurance for preventive work.²⁹ For all these reasons, Martin and his department were convinced that a state-financed universal system was the only viable solution.

- **Opposition and Resolution**

Despite the mounting evidence in favour of government-funded health insurance, the various interest groups involved in health care provision, however, took different stances. The Canadian Medical Association, as of 1949, reversed its qualified support for government health insurance, now promoting private initiatives supplemented by government support.³⁰ The CHA, and the Blue Cross plans, as noted in the previous chapter, had moved in the same direction, stressing individual responsibility, and remarking that state control of hospitals was not in the best interests of either patients or hospitals.³¹ Commercial insurance companies, represented by the Canadian Life Insurance Officers Association (CLIOA), with a large potential market, insisted that private insurance was the best solution. Despite statistics which showed the superiority of provincial government plans, the CLIOA insisted that:

... it is not desirable in the public interest to establish a compulsory government hospital insurance plan and to ignore the demonstrated ability and willingness of most of our people to insure themselves voluntarily with private health insurance agencies. Seventy per cent of the people of this province [Ontario] have done this at no cost to

²⁹ NAC, MG 32, B 12, vol. 29-1, Department of National Health and Welfare, Research Division, "The Need for Health Insurance," February 20, 1952, pp. 5-6.

³⁰ Taylor, *Health Insurance*, pp. 189-190.

³¹ CHA Resolution on hospitalization insurance from 1951, quoted in NAC MG 32, B 12, vol. 30, file 4, Untitled document, 1951.

governments. Voluntary insurance is in many respects better than the proposed government plan. If government action is needed, it should supplement, not supplant private insurance.³²

It was logical for the insurance companies to promote market solutions, which would benefit their own financial health. Hospitals, which had at best given guarded support to the idea of state-financed health insurance and which had a long history of difficulty with the various state-funded programmes, were hoping now that the generally good economic situation in the country would help maintain the growth of plans like Blue Cross. Yet there had been problems with Blue Cross and private insurance funding as well. Despite this, the hospitals preferred this source to the government. Underlying this choice of the market over the state was the general preference of those involved in voluntary hospital boards, members of the private sector whose belief in private-sector solutions was evidently very strong.

The preferences of various interest groups were clear, but this time, unlike the process in the early 1940s where hearings were held, there was no single forum where the various parties concerned – the medical profession, hospital organizations, labour, or farm groups, for example – could present their positions. In fact, at this time there was no official intent on the part of the government to bring forward a health

³² Quoted in NAC, MG 32, B 12, Vol 30, G. F. Davidson, "Summary of C.L.I.O.A. Memorandum," January 21, 1957. See also, Taylor, *Health Insurance*, pp. 194-195, for similar positions expressed in 1954. Paul Martin notes the irony that one of the industry spokesmen was Brooke Claxton, Martin's predecessor as minister of health. See Martin, *op. cit.*, p. 243.

insurance plan, despite Martin's convictions. Martin's major problem was lack of support in Cabinet coupled with a seeming lack of adequate provincial support for a national plan, despite constant popular support for the initiative. Here Ontario, as one of the two most populous provinces, was key, since Quebec's lack of interest was clear and seemingly unshakeable. At the 1950 Dominion/Provincial meeting, in a kind of pre-emptive strike, Prime Minister St. Laurent had emphasized that increased defence spending resulting from the Korean War would preclude any new programme like health insurance. Only Saskatchewan attempted to focus on the need for national health insurance regardless of the international situation.³³

By 1955, however, when tax rental agreements were to be re-negotiated at a Dominion/Provincial Conference, the situation had changed. Though St. Laurent was still not interested in bringing in a national programme, he left the conference agenda open to the provincial premiers as a means of improving relations with the provinces. He was taken by surprise when, at the organizing conference in April 1955, Ontario's Premier Frost listed health insurance as one of the points he wished to discuss. He informed the Prime Minister that he would bring a proposition to the fall conference.³⁴ Though Frost, like St. Laurent, was more pre-disposed to market solutions than government intervention, he was aware of certain elements that could weaken his bid for re-election in an election year. He was facing a strong labour movement, in the

³³ Taylor, *Health Insurance*, p. 184.

³⁴ *Ibid.*, pp. 207-209.

most industrialized province, that was pushing for national universal health insurance. To make the situation more acute for Frost, the two major Canadian labour federations were in the process of uniting into one organization. Frost was also well aware of the growing deficits of Ontario hospitals, and the increasing cost of hospital insurance. Ontario Blue Cross had raised its rates by about 26 per cent in 1954 because of increasing hospital costs and utilization.³⁵ As a result, Frost felt the need to resolve hospital funding problems but was unwilling to envisage them solely within a provincial context.³⁶ The other premiers agreed, and the question of hospitalization insurance at least was on the table. Martin was ready, but the Cabinet was not necessarily convinced.

In his autobiography, Martin emphasizes repeatedly that, except for a few individuals like Jean Lesage, Minister of Northern Affairs and Natural Resources, the Cabinet was generally unsympathetic to his plans for universal health insurance.³⁷ In fact, it was most often Stanley Knowles who aided Martin by keeping the question before the public eye through his constant questions and reminders in the Commons.³⁸ One of the most resistant to the idea of health insurance was Finance

³⁵ "The Common Denominator" (Editorial), *TCH*, vol. 31, no. 2 (February 1954), p. 31.

³⁶ See Donald Swartz, "The Politics of Reform: conflict and accommodation in Canadian health policy," in Leo Panitch, ed., *The Canadian State: Political Economy and Political Power* (Toronto: University of Toronto Press, 1977), p. 323. See also, Taylor, *Health Insurance*, pp. 110-118; Maioni, *op. cit.*, pp. 198-200.

³⁷ Martin, *op. cit.*, p. 241. Other supporters, open or tacit, were Milton Gregg, Mike Pearson, Jimmy Sinclair, Jim McCann and Stuart Garson. See p. 226. Jean Lesage later left the federal Liberal Party to take over the leadership of the Quebec Liberal Party.

³⁸ Martin, *op. cit.*, p. 224; Maioni, *op. cit.*, pp. 204-207; Taylor, *Health Insurance*, pp. 188-189.

Minister Walter Harris.³⁹ It was for Harris's benefit that Paul Martin marshalled arguments collected over the years by the Department of National Health and Welfare in a memo in September 1955. The memo discussed an article in the August 23rd issue of the *Toronto Telegram* on the nature of Frost's plan for health insurance for Ontario.

This despatch supports the indications given in Frost's recent conversation with the Prime Minister that he will come to the conference in October prepared to support a program of action in the health insurance field...

I think you will agree that these indications that Frost is seriously prepared to take some initiative in the health insurance field make it all the more important that we should be prepared for the October meeting with a program which will ensure that the Liberal Party retains the initiative in this important area of public policy. It is already clear that the CCF, represented by the Saskatchewan Government, and the Social Credit Party, represented by the British Columbia government, and possibly the Alberta Government, will be pressing at the October meeting for federal action in respect of health insurance; and if to this combination is added the Conservative Government of Ontario, it will place the Liberal Party in the position where, if we hold back on health insurance, we will appear to be the only political party in the country which is unwilling to take a forward step in this field. In view of all that has been said in the name of the Liberal Party during the last thirty-six years on the subject of health insurance, you will, I know, agree with me that we cannot allow ourselves to be caught in that position in the October meeting.

... In point of fact, Canada and the United States of America are the only two modern, industrial, democratic countries which do not have health insurance legislation already on their statute books. The reason for this is partly because of the high income levels enjoyed by our people, which make it possible for them to bear with less difficulty the additional costs of illness. But this advantage is in itself more than offset by the fact that the costs of hospitalization and of medical care and of

³⁹ Martin, *op. cit.*, p. 226, pp. 237-240.

all the services that relate to illness are very much greater in this country and in the United States than they are in any other part of the world.⁴⁰

Hospital insurance was on the agenda at the October Dominion/Provincial Conference, and after debate and accommodation with provincial governments the federal government agreed to proceed to formulate a bill, to be presented to a meeting of provincial health ministers on January 23, 1956. The battle was not yet won. Martin obtained Cabinet approval for a plan only on January 20, and only with the provision that six provinces had to be in agreement before the plan would proceed. It was obvious that the holdbacks hoped that six provinces would not come on-side. Nonetheless, on January 26, St. Laurent rose in the Commons to present the plan for hospitalization insurance at the same time that Martin was offering the federal plan to the provincial health ministers.⁴¹ The plan was still not guaranteed. After the Ontario electorate returned Frost to power he became resistant to the plan, which left little place for voluntary insurance. This put the process in jeopardy, since Ontario was a key province.⁴² St. Laurent was willing to consider any obstacle as a reason to slow down the process. Finally, the upcoming federal elections in 1957 forced St. Laurent's hand. Public opinion strongly supported health insurance, the unions and the CCF were pushing the issue, and this was reflected in the media.⁴³ The Act, Bill 320, was presented on April 10, 1957. The general public support for this Bill can be seen in the fact that

⁴⁰ NAC, MG 32, B 12, vol. 28, file 1, Paul Martin to Walter Harris, Minister of Finance, Sept. 1, 1955.

⁴¹ Martin, *op. cit.*, pp. 235-242.

⁴² Maioni, *op. cit.*, p. 218-219; Taylor, *op. cit.*, pp. 221-225.

⁴³ Taylor, *op. cit.*, p. 225.

the House of Commons unanimously passed the Hospital and Diagnostic Services Act the same day. Two days later, after the Act was passed unanimously by the Senate, Parliament was dissolved.

The plan agreed upon would cover diagnostic services and hospitalization. The addition of out-patient diagnostic services, it was hoped, would reduce unnecessary hospitalizations. However, in the final compromise with the provinces, out-patient diagnostic and laboratory services could be included at the discretion of the provinces.⁴⁴ The federal government would pay half of the national cost of the programme, the contribution covering normal operating and maintenance costs of hospital care at the standard ward level, but would not include capital costs, depreciation, or payment of interest on capital debts. It would not cover mental hospitals or tuberculosis sanatoria, chronic care facilities or home care programmes. Uniform standards for provincial participation were established, making the plan a national one, though administered provincially. St. Laurent insisted that six provinces agree to participate before the programme could start up, a condition that worried Martin.⁴⁵

The Liberals lost the elections, and hospitalization insurance was in fact inaugurated by John Diefenbaker's Conservative minority government after the six-

⁴⁴ In fact the inclusion of diagnostic services, left to the discretion of the provinces, was not implemented in many cases because the medical profession resisted seeing medical diagnosticians, principally radiologists and pathologists, become salaried employees obliged to negotiate with the provincial government. See Taylor, *Health Insurance*, p. 235; Naylor, *op. cit.*, pp. 165-166.

⁴⁵ Taylor, *Ibid.*, pp. 217-218, p. 234-235.

province minimum was dropped. The programme finally began on July 1, 1958, at which time five provinces, Newfoundland, Manitoba, Saskatchewan, Alberta and British Columbia had programmes in operation. Newfoundland, Saskatchewan, Alberta and British Columbia had of course already inaugurated their own provincial plans, and the Manitoba government had in 1956 moved to cover the full cost of indigent in-patient and out-patient care in its hospitals.⁴⁶ These provinces would seek to enter the programme as quickly as possible to gain relief for expenditures they were already making. However, the other provinces were not long in following. Nova Scotia, New Brunswick and Ontario joined on January 1, 1959, Prince Edward Island on October 1, 1959.⁴⁷ Only Quebec remained outside the programme.

The Canadian Hospital Association did not mount a campaign against the bill. Despite all their hesitations, they were undoubtedly conscious of the level of support for the plan in the population, and somewhat reassured by the fact that provinces with plans allowed a level of autonomy to the hospitals. They did not become state hospitals. The Hospitalization Act was, of course, far from perfect in the eyes of those running hospitals, even though they were in fact glad of the guaranteed funding. Some of the most important problems were discussed at a CHA special meeting organized in

⁴⁶ G. L. Pickering, "Manitoba Hospitals Accorded Full Cost of Indigent Care," *TCH*, vol. 33, no. 2 (February 1956), p. 42.

⁴⁷ Taylor, *Health Insurance*, p. 233-234.

May 1958 to review the progress of the programme.⁴⁸ Major concerns related to what was funded and what was not, particularly the exclusion of capital costs, depreciation or payment of interest on capital debts. Almost all hospitals were in debt; the lack of coverage for depreciation made replacement and renovation difficult; the cost of building was enormous. The provinces were given latitude by the law to cover any part of these costs, and in fact some did include depreciation and interest in their calculations of funding; others did not. Federal grants were available for capital construction, and often provinces also contributed, as did municipalities, although this was not universal.⁴⁹ In fact in many cases, particularly for construction, the onus would be on the hospitals, in the future as in the past, to campaign for at least part of the funds for renewal or expansion. This could be seen as maintenance of an element of autonomy from the state, particularly if the hospital was situated in a strongly supportive community; however it could also be seen as a burden that could perpetuate inequality. Hospitals with a wealthy community to support them would continue to be more easily able to raise funds to expand than hospitals which had few resources outside government support.

Nonetheless, despite its shortcomings, the Hospitalization Act was a major step forward in the creation of a universal health care system for Canadians. It guaranteed

⁴⁸ NAC, RG 29, vol. 857, file 20-C-27, "Report, Assembly Meeting," Canadian Hospital Association, May 8-9, 1958.

⁴⁹ "Recently the Council of Metropolitan Toronto announced that in the future they would not give any construction grants to hospitals in the Toronto area." Report of the President, "Report, Assembly Meeting," *op. cit.*, p. 6.

the population of those participating provinces the right to hospitalization, with no concern for the cost. For all intents and purposes it eliminated the stigma of pauperization that was attached to indigent status. Hospitals benefited through stability of financing, and particularly thanks to the alleviation of the burden of covering much of the cost of treating the poor.

Quebec

The provinces had differed significantly in terms of the kind of plan they were willing to embark upon. The Maritime provinces, for example, had expressed interest in a programme, but were loath to initiate it themselves because of the cost.⁵⁰ Ontario would have preferred a mixed public/private system, but definitely one that involved the participation of the federal government.⁵¹ Quebec was a different case. The Duplessis government was not interested in a nationally funded programme, which was a direct incursion in provincial affairs. Paul Martin and his department assiduously avoided giving Duplessis any chance to construe federal actions as an intrusion in Quebec affairs, adopting a kid-glove approach in any correspondence with the

⁵⁰ See, for example, NAC, RG 29, vol. 1132, file 504-5-6, pt. 1, Memo from G. D. W. Cameron to the Minister, "Regarding Meetings of the Preparatory Committee for the Federal-Provincial Conference, held at Halifax on Sept. 11-12," September 16, 1955.

⁵¹ NAC, RG 29, vol. 1372, file 1-1, G. F. Davidson, "Health Insurance and Ontario," August 5, 1955.

Duplessis government regarding health care matters.⁵² Duplessis did however claim that he was not averse to a provincial scheme, just against federal intrusion.⁵³ This is a point of contention among Quebec historians. Linteau, Durocher, Robert and Ricard support the Quebec government response to Ottawa's post-war social programme expansions: "For Quebec nationalists, a system of this sort [with national standards] was hard to accept, as it prevented Quebec from developing its own distinct policies that would meet the needs and objectives of its population."⁵⁴ While the analysis of Quebec's concerns about Ottawa's centralizing tendencies is valid, what Linteau *et al.* do not do is clarify what if anything Duplessis proposed in its place, thus leaving the analysis incomplete. François Guérard, taking a more neutral tone, notes, however, that there was a general tendency under Duplessis to avoid increased government intervention in social policy, as well as resistance to federal intrusion:

Au Québec, Maurice Duplessis, à la tête du gouvernement provincial de 1936 à 1939 et de 1945 à 1960, s'oppose à une intervention plus marquée de l'État dans les affaires sociales. Les tentatives du gouvernement fédéral de s'immiscer dans ce domaine de compétence exclusivement provinciale lui apparaissent de surcroît comme autant de menaces à l'autonomie du Québec.⁵⁵

⁵² These comments for example come from an internal memo in 1955: "In the light of many discussions which have taken place regarding the introduction of hospital insurance and laboratory and radiological diagnostic services we have refrained from establishing any contact with the province of Quebec for fear that our interest might be interpreted as trying to bring about participation on the part of the government of that province." See NAC, RG 29, vol. 1072, file 502-3-4, pt. 2, Memo to Dr. F. W. Jackson, from Dr. C. A. Roberts, Principal Medical Officer, Mental Health, April 19, 1956.

⁵³ Martin, *op. cit.*, p. 236.

⁵⁴ Paul-André Linteau, René Durocher, Jean-Claude Robert, François Ricard, *Quebec Since 1930* (Toronto: James Lorimer & Co., 1991), p. 279.

⁵⁵ François Guérard, *Histoire de la santé au Québec* (Montreal: Boréal, 1996), p. 73.

However, as Denis Monière has pointed out, Duplessis used different arguments at different times against expanding social programmes,⁵⁶ and, despite his insistence that Quebec would look at instituting a provincial hospital insurance programme, did nothing to inaugurate such a plan in Quebec. This was despite growing calls inside the province for a resolution of health care problems and apparent public support for more government intervention.

The Quebec government continued to participate in the Dominion/Provincial granting programme, now in its second phase, thus continuing to support the expansion of hospital facilities. Its sole other contribution to the hospital sector for most of this period was a series of increases in the PCA rates, apparently in recognition of the escalating financial problems the hospitals faced. The rate, which stood at \$5.50 per patient per day in 1951 was increased to \$7.50 in April 1953, and again to \$10.50 in April 1957.⁵⁷ These rates, while an improvement, were not adequate to resolve the growing problems of hospital financing and the population's access to hospital services.

The Royal Commission of Inquiry on Constitutional Problems (the Tremblay Commission), convened in 1953, became a choice venue for the hospitals and those

⁵⁶ Denis Monière, *Le développement des idéologies au Québec des origines à nos jours* (Montreal: Québec/Amérique, 1977), pp. 306-308.

⁵⁷ Figures in the text are in current dollars. Figures in tables are in constant and current dollars as indicated.

interested in the health care sector to lay out in great detail the problems faced by the sector, as well as their preferred solutions.

• **The Tremblay Commission**

The Tremblay Commission sat from 1953 to 1956. While focusing on a range of problems in federal-provincial relations, it was an ideal forum for a thorough exposition of the many problems in the health care sector. Assembled in the period when the federal government was, in the eyes of many Quebecers, attempting to centralize fiscal power in Ottawa and weaken provincial autonomy in constitutionally provincial fields, the Commission's role was to examine the problems of federal and provincial jurisdictions. More specifically, its mandate was to examine the division of tax revenues among the different levels of government; what it considered the intrusion of the federal government into the fields of direct taxation, constitutionally assigned to the provinces; the consequences of these federal encroachments on provincial jurisdictions; and other legislative and fiscal constitutional problems.⁵⁸ Duplessis set up the Commission in response to pressures from the Chamber of Commerce. His intent was apparently to set up a commission of short duration which would superficially examine the contentious areas, and would appear to respond to pressures coming from Quebec nationalists. Durocher and Jean paint Duplessis as a somewhat ambivalent opponent of federal encroachment, in fact initially accepting federal grants to universities and

⁵⁸ René Durocher and Michèle Jean, "Duplessis et la Commission Royal d'Enquête sur les Problèmes Constitutionnels, 1953-1956," *Revue d'Histoire de l'Amérique française*, vol. 25, no. 3 (December 1971), pp. 343-344.

rejecting proposals by the Montreal Chamber of Commerce that he take advantage of fiscal tax agreements that would allow the province to impose a five per cent tax on its citizens.⁵⁹ This supports Richard Desrosier's contention that Duplessis was an autonomist (promoting provincial autonomy) more because he was a determined opponent of Keynesian economics and welfare state policies like those emanating from the federal government (as feeble as these measure might be), than because of serious nationalist sentiments on his part.⁶⁰

Despite Duplessis' modest ambitions for it, the Commission blossomed into a far-ranging, thorough examination of the various aspects of the problem.⁶¹ Over 200 submissions touched on a broad range of subjects related to the maintenance of cultural and fiscal autonomy in areas where the federal government appeared to be intruding, including education, social services, municipal finances, and many others. Health care, which represented the intersection of many aspects under study — provincial rights, municipal fiscality, provincial fiscality, and culture — came under close scrutiny.

Several briefs touched on the question of health care. They came from a variety of sources: unions, nurses, the nationalist Société St-Jean Baptiste, the Services de Santé de Québec (SSQ, the non-profit medical care insurance group), and from hospital

⁵⁹ *Ibid.*, p. 338.

⁶⁰ "Entrevue avec Richard Desrosiers," Gilles Gougeon, *Histoire du nationalisme québécois: Entrevues avec sept spécialistes*, (Montreal: VLB Éditeur, 1993), pp. 114-118.

⁶¹ Durocher and Jean, *op. cit.*, pp. 344-345.

management. One of the key briefs came from the Committee on Hospital Problems, a coalition of the Montreal Hospital Council and the Catholic hospitals. This document clearly enunciated the position of Quebec hospital management and became a major source for the Tremblay Commission's ultimate position on hospital financing. Among Committee members were Dr. Gilbert Turner, Executive Director of the Royal Victoria Hospital, St-Luc's superintendent, J. H. Roy (also president of the Montreal Hospital Council), members from Ste-Justine Children's Hospital, from St-Joseph de Rosemont Tuberculosis Sanatorium, the accountant for the Sisters of Providence (proprietors of 13 hospitals in Quebec), Dr. Raphael Boutin, Medical Director of Notre-Dame Hospital, and Father Hector-L. Bertrand S. J., head of the Catholic Hospital Council of Canada.⁶² In other words, the members were representatives of the major elements in the Quebec hospital sector, covering English/French, lay/Catholic general hospitals and specialized services such as sanatoria and children's hospitals. The document was a tribute to the ideological constancy of hospital administrations in the face of ever-worsening budget deficits.

In the analysis of the financial health of its institutions the Committee noted the weight of the total deficit of all Public Charity institutions.⁶³ In 1950-51, for

⁶² Commission royale d'enquête sur les problèmes constitutionnels (Tremblay Commission), Séance tenue à Montréal, le 26 février 1954, vol. XIX, pp. 1633-1635.

⁶³ These institutions included more than acute-care hospitals. Psychiatric hospitals, tuberculosis sanatoria, chronic care institutions, orphanages and other institutions all fit under this umbrella.

example, the deficit totalled \$21,700,000. In addition, the institutions themselves contributed close to \$20 million to the care of indigents, while municipalities were proving unable to assume their portion of these costs. (Rural municipalities were already responsible for only 15 per cent of the cost as opposed to the one-third they had originally been obliged to cover.)⁶⁴ The Committee also noted that procedures prescribed by law for certifying indigents led to all sorts of abuses and complications. Some municipalities refused to sign any demand for hospital admission as a Public Charity patient, while others certified anyone, provided that that individual promised to reimburse the share paid by the municipality. This, of course left hospitals with more indigents for whom they had to find the hospital's one-third share of funding as well as responsibility for the total cost of those rejected by the municipalities.⁶⁵ In addition, the Committee reaffirmed the necessity of aid from all levels of government for out-patient services, with the reminder that financially accessible service in out-patient clinics could reduce unnecessary hospitalization, and thus reduce costs.⁶⁶

However, despite the overwhelming proof that a private system had serious shortcomings, the core of the brief was the reaffirmation of the necessity of keeping hospitals within the private sector and maintaining the state in a secondary, supportive role. Father Bertrand asserted:

Monsieur le Président, messieurs les commissaires, j'ai entendu le Dr Turner exposer un principe qui nous est bien cher et qui vous est bien

⁶⁴ Commission royale, *op. cit.*, p. 1709.

⁶⁵ *Ibid.*, pp. 1647-1649.

⁶⁶ *Ibid.*, p. 1656.

cher, à savoir que nous devons conserver nos institutions telles qu'elles le sont en les améliorant, que nous devons protéger nos institutions contre l'intervention intempestive de l'État. Nous avons absolument besoin de l'État mais nous ne voulons pas que l'État nous supprime complètement. Son rôle comme dans bien d'autres domaines est un rôle supplétif, et nous croyons difficilement que notre province qui a beaucoup fait pour nos institutions doit faire davantage à une condition: c'est qu'on lui donne les moyens financiers d'accomplir sa tâche.⁶⁷

As an element of solution to the problems, the Committee proposed that the levels of government constitutionally responsible for health care, that is the province and the municipality, have the taxation powers necessary to fulfil these commitments.⁶⁸ The Committee correctly pointed out that, in fact, the federal government spent significantly less on health care than did the provinces. It also insisted that the federal justification for maintaining control over spending — to equalize revenues of the provinces so as to aid the poorer ones — was equivalent to setting up a communist system to equalize income among citizens.⁶⁹ For the hospitals directly, the Committee requested an immediate increase of PCA rates from \$5.50 to \$8.50 for "A" class hospitals (more than 100 beds), with proportional increases for other classes of institutions.

In the longer term, the Committee proposed "un plan d'assurance-hospitalisation non-gouvernemental, contributoire, et dans l'esprit de notre

⁶⁷ *Ibid.*, pp. 1660-1661.

⁶⁸ *Ibid.*, p. 1685.

⁶⁹ *Ibid.*, pp. 1685-1686.

commission, si nécessaire, allant jusqu'à la rendre obligatoire."⁷⁰ In explaining its position, the Committee noted that it was opposed to a federal plan, and looked to the province for an alternative.

Et alors, nous recommandons une mesure éminemment sociale et chrétienne, à savoir: un plan d'assurance maladie contributoire non gouvernementale et obligatoire si jugé nécessaire, après une étude sérieuse...

Nous désirons sauvegarder le caractère privé et charitable de nos institutions et nous prions votre Commission d'intervenir auprès des autorités afin que nous puissions en agir ainsi pour ainsi dire éternellement.⁷¹

The vision of the hospital system presented in this brief and the solutions proposed to resolve its acute financing problems was little altered from the position taken by hospitals in the 1940s. Central was the desire to remain autonomous from the state, to oblige individuals who were able to see to their own needs to procure insurance (commercial or co-operative), and to have the state supply funds for those who were unable to assume the costs. The *laissez-faire* liberal division between state responsibility for indigents and the market provision for the needs of the rest remained at the core of the proposal.

These concerns were taken seriously by Dr. Ernest Sylvestre in his synthesis of health care problems for the Tremblay Commission. Combining the viewpoint of the hospitals with that presented in the brief of the Services de Santé du Québec (SSQ), which, as a non-profit medical insurance group set up by Quebec doctors, represented

⁷⁰ *Ibid.*, p. 1699.

⁷¹ *Ibid.*, pp. 1700-1701.

the viewpoint of at least part of the medical profession, Sylvestre proposed that a system be developed that would remain essentially private with the state playing a secondary role. The plan would be in the hands of private enterprise, but would be non-profit; it would provide complete services, but would maintain ceilings on payments to doctors and hospitals; it would be extended to the majority of the population in order to spread the risk (the insurance principle); and would be decentralized in order to respond to the different needs of the different regions.⁷²

The role assigned to the state was to be secondary. It would activate the legislation already passed in 1951 for the creation of diagnostic centres in order to reduce unnecessary hospitalization for testing. And, most important – and this is where Sylvestre's report is a departure from that of the Committee on Hospital Problems and more in line with the position that the CHC was refining – it would pay the insurance premium of indigents and "semi-indigents" (those families with an income of less than \$3,000 yearly would have assistance in paying insurance premiums), thus reducing the role of the Public Charities Act to the care of psychiatric and tuberculosis patients.⁷³ The implications of this were significant both for indigents and the working poor, and for hospitals: those who were unable to pay for hospital care would no longer be in a separate category from the rest of the population, as their premiums, paid by the government, would be paid nonetheless like everyone else's, thus avoiding means

⁷² ANQ, E114/2, Tremblay Commission, Dr. J. Ernest Sylvestre, "Synthèse des problèmes de la Santé," Report prepared for the Tremblay Commission, pp. 74-75.

⁷³ *Ibid.*, pp. 73-77.

testing at the hospital door. Hospitals would no longer be forced to take chances on not being paid for services to indigents and the working poor, and would be assured a more stable income from the insurance plans, rather than from the government. These proposals were more egalitarian (for the patients) and more of a break with the status quo than those proposed by the hospitals.

Not surprisingly, two of the major union federations supported a government-run health insurance system. The Fédération provinciale du travail du Québec, a union federation affiliated to the AFL, continued its support for a government plan.⁷⁴ The Catholic union federation, the Confédération des Travailleurs Catholiques du Canada, moved away from a guarded stance on government involvement in health insurance and proposed a universal and egalitarian plan, whereby employees, employers and government would all contribute.⁷⁵ While concerned about maintaining provincial autonomy, the CTCC brief stated, in direct contrast to Duplessis' stand:

Nous ne voulons pas croire que les intérêts de l'autonomie concordent avec un retard systématique en matière social...
Le sens de l'autonomie doit s'accompagner d'un souci authentique d'assumer le plus tôt possible à notre population les services sociaux les plus adéquats, les mesures de sécurité sociale les plus complètes et les plus efficaces. À cette seule condition les Travailleurs pourront apprécier les mérites d'une politique autonomiste.⁷⁶

⁷⁴ Yves Vaillancourt, *L'Évolution des politiques sociales au Québec 1940-1969* (Montreal: Les Presses de l'Université de Montréal, 1988), pp. 191-192.

⁷⁵ ANQ, E114, Tremblay Commission, "La CTCC réclame l'enseignement secondaire gratuit pour 4 ans," *Le Devoir*, April 2, 1954. See Jean-Louis Roy, *La Marche des Québécois: le temps des ruptures (1945-1960)* (Ottawa: Leméac, 1976), pp. 114-118 for a discussion of the evolution of the position of the CTCC on health insurance.

⁷⁶ *Mémoire* (no 180) of the CTCC, 1954, quoted in Vaillancourt, *op. cit.*, pp. 195.

The unions were isolated, however, as most other interveners proposed remaining with a predominantly private sector solution. The final *Report* focused on the more traditional proposals.

The section on health care of the final *Report* of the Tremblay Commission began with a discussion of government finances relating to health care, and explicitly to the PCA, to show the strength of the provincial contribution to health costs and the significantly lower level of federal contribution. According to the *Report*, the provincial government had spent \$42,521,382 on hospital construction between 1944 and 1953; during the same period, the federal government had contributed \$5,989,610. This was a confirmation of the general orientation of the *Commission Report*, supporting more provincial autonomy in fields constitutionally attributed to the provinces by indicating the high level of activity already sustained by the province as compared to the federal government.

The *Report* also noted, however, that the end result of the spending was an insignificant change in the ratio of beds per population because of the rapid growth of population during the same period. Whereas the ratio of beds per thousand population had been 4.62 in 1933, it stood at 4.65 in 1951. In addition, only Montreal and Quebec City had higher-than-minimum ratios, leaving the rural areas underserved.⁷⁷

⁷⁷ *Rapport de la Commission Royale d'Enquête sur les Problèmes Constitutionnels*, vol. III, Tome I, Cinquième Partie: *Analyse des Besoins et Recommendations* (Quebec, 1956), pp. 88-92.

The *Report* pointed out other weaknesses in the financial support structures for hospitals. It noted the difference in growth of hospital revenues between Quebec, Ontario and Canada as a whole. While revenues per patient-day were approximately equal for Ontario, Quebec and Canada in 1942, by 1951, these revenues in Quebec equalled only 79.9 per cent of revenues of Ontario hospitals and 89.2 per cent of Canadian hospitals overall.⁷⁸ In terms of the PCA, between 1937 and 1951, PCA funds, which constituted a significant part of the funding of the Ministry of Health and virtually the sole source of government support for hospitals, grew by 155 per cent, from \$4,772,767 to \$12,165,310. PCA expenditures over the same period, however, grew by 379 per cent, leaving a deficit in the fund – to be covered from the government's consolidated funds – that grew from \$2,302,255 to \$21,693,297 in the same period (see Chart 1).⁷⁹

It is difficult to trace the exact breakdown of funding, but as a point of comparison, in 1957-58, of the 98.9 million dollars gross expenses for the PCA, 68.7 million, or approximately two-thirds, were allocated to the health care sector.⁸⁰

(Government revenues for PCA funding came from amusement, restaurant, and theatre

⁷⁸ *Ibid.*, p. 97. Comparisons between provinces can be done in a number of ways. Malcolm G. Taylor, in *Financial Aspects of Health Insurance*, compares *per capita* expenditures on health care by province. In 1954, according to Taylor, Quebec spent \$23.57 *per capita* on hospitals, while Ontario spent \$29.19, and the Canadian average was \$29.18. See, Table 27, p. 39. However, Taylor also compares spending on health care services (that is all services) as a proportion of total personal income for each province. In this comparison, Quebec's expenditures equal 3.9 per cent of total personal income, while Ontario's equals 4.0 per cent and Canada's 4.4 per cent. In these terms the difference is less significant. The fact that Quebec's *per capita* income is lower is significant. See Table 26, p. 36.

⁷⁹ *Ibid.*, p. 89.

⁸⁰ *Annuaire de Québec*, "Public Health - Charitable Institutions," 1960, p. 142.

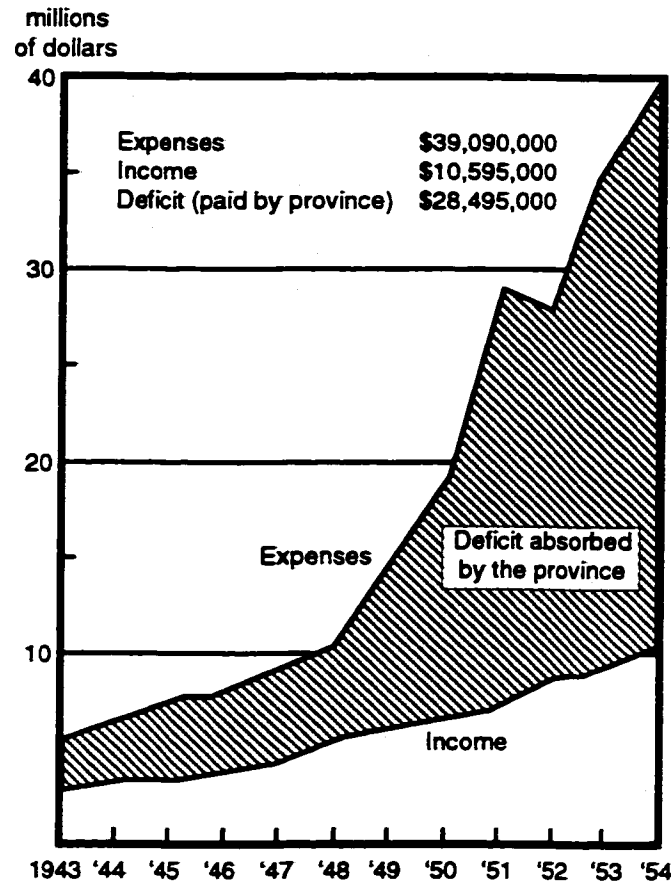
taxes, as well as from liquor sales and race track licences and taxes. The services that came under the PCA umbrella included various classes of hospitals, hospices, sanatoria, infant homes, nurseries, services for crippled children, and other non-hospitalizing institutions and charitable organizations.) Individual hospital deficits also grew. As the document pointed out, in 1951, PCA patients accounted for 24.5 per cent of hospital days, while *per diem* revenues from the provincial and municipal governments for these patients amounted to only 12 per cent of net operating revenue. As a result, according to the *Report*, hospitals gave \$4 million of free service to indigent patients in 1951, and an equal amount to those who could not pay but did not qualify under the PCA. The *Report* also noted that Quebec hospitals on average received \$2.03 less per patient/day than did hospitals in Ontario. Finally, while revenues not directly applicable to operating expenditures (donations and some grants) rose by 693 per cent in Ontario between 1942 and 1951, they rose by only 108 per cent in Quebec.⁸¹ When these elements (along with the growth of expenditures) were translated into the deficit, the results were an increase in the deficit in hospitals from \$0.95 per patient/day in 1942 to \$1.48 in 1951.⁸² Clearly a problem was at hand.

⁸¹ *Ibid.*, p. 98. The total of these donations and subventions rose from \$1,545,700 to \$12,285,363 in Ontario and from \$2,963,294 to \$5,961,603 in Quebec.

⁸² *Ibid.*, p. 99. The *Report* notes that the deficit rose from \$0.45 to \$0.76 in Ontario, and from \$0.51 to \$0.88 in Canada.

Chart 1

Income and Expenses of the Government of the Province of Quebec for Public Charities, 1943-1954



Source: Rapport de la Commission royal sur les problèmes constitutionnels, vol. IV, Documentation, p. 215.

By way of solution, the *Report* essentially proposed a slightly modified status quo, reiterating the proposals made in the brief of the Committee on Hospital Problems. Noting a recent improvement of Public Charities provisions, the *Report* stated that the ultimate solution for hospitals "... porte non seulement sur le financement de l'hospitalisation des indigents, mais aussi sur le financement des soins hospitaliers pour toutes les classes de la société." For the middle class it proposed the

solution that the hospitals favoured, encouraging hospitalization insurance through the private sector (whether profit or non-profit). This was "la solution qui semble la moins lourde," and also fit the culture of the province:

Il s'agirait donc de protéger surtout la population disposant de revenus moyens contre les risques de la maladie et des frais d'hospitalisation tout en sauvegardant la liberté individuelle, et en conservant aux institutions leur caractère charitable et bénévole.⁸³

Finally, the *Report* noted that the Committee on Hospital Problems, the College of Physicians and Surgeons, and other groups had recommended that the provincial government move towards a generalized system of health insurance administered by private groups with the aid of the state.⁸⁴

Even these very limited proposals — which side-stepped the SSQ's proposal that indigents be covered by private non-profit insurance with the state footing the bill — were not implemented, as Duplessis, apparently uneasy with the rather radical proposals for provincial control of taxation powers and responsibility for social welfare, shelved the Tremblay Commission *Report* as quickly as he could.⁸⁵

Yves Vaillancourt characterizes the Commission *Report* as a document "épousant nettement les vues du courant petit-bourgeois traditionnel clérical," and as legitimizing Duplessis' health-care policies, that is, his policies of inaction.⁸⁶ There is no

⁸³ *Ibid.*, p. 100.

⁸⁴ *Ibid.*, p. 101.

⁸⁵ For a description of Duplessis' attempts to avoid dealing with the *Report*, see Durocher and Jean, *op. cit.*, pp. 358-362.

⁸⁶ Vaillancourt, *op. cit.*, pp. 195-196.

question that the path proposed by the Commission was a totally inadequate response to the growing problems of the provincial PCA deficit, escalating hospital deficits, and growing difficulty of access for the population to health care, particularly hospital, services. The government was not unaware of these problems. Deputy Minister of Health Dr. Jean Grégoire, speaking at a conference of Quebec's Catholic hospitals in 1955, emphasized that 80 per cent of patients in Quebec were unable to pay their hospital bills.⁸⁷

However, when the overlay of Catholic and nationalist discourse are removed from the recommendations of the Commission, the essential points of the proposals — leaving the majority of the population to find hospital coverage through the market, while the state took care of the indigent — do not differ significantly from the preferred approach of Leslie Frost, Louis St. Laurent, the insurance companies, the Canadian Hospital Association, and the Canadian Medical Association, among others. In fact, while the Tremblay Commission was wrapping up, and while the provinces and Ottawa were attempting to come to an agreement on hospitalization insurance, Herbert H. Lank, president of Du Pont of Canada and president of the Montreal Joint Hospital fund-raising campaign (the Montreal General being among the hospitals represented), advocated the same liberal voluntary system of health insurance, leaving

⁸⁷ NAC, MG 32, B 12, vol. 29, "L'hôpital est fermé à 80% de la population," *La Presse*, June 27, 1955. The title is sensationalistic, because those who could not pay, at least those who were seriously ill, were not turned away. Martin kept an extensive file of newspaper clippings relating to health care issues.

citizens free to purchase the kind of insurance best suited to their needs.⁸⁸ Finally, there is some irony in the fact that Quebec's Catholic hospitals, while still advocating a private system, now accepted the idea of a state-operated scheme if the first option was unworkable. Father Bertrand of the Catholic Hospital Council was quoted in *The Gazette* as saying that health insurance "operated by the state would be 'less evil' than the unfavourable situation in which hospitals now find themselves with regards to the customer-public."⁸⁹

Opinion in Quebec, as elsewhere, was divided on how to resolve the crisis in hospital financing. While these debates continued, the institutions themselves dealt with these ongoing problems, still staking their hopes on resolving the crisis through expansion .

The Hospitals

As the Report of the Committee on Hospital Problems underlined, hospitals in Quebec, including the Montreal General and St-Luc, had pinned their hopes for financial stability on private insurance, but were instead finding their financial situation deteriorating rather than improving. Yet they still clung to these kinds of private market solutions for paying patients, while asking year after year for increased government funding for indigent in-patients, and a commitment from the government to fund the

⁸⁸ NAC, MG 32, B 12, vol. 29, "Assurance-santé sur une base volontaire," *La Presse*, January 23, 1956.

⁸⁹ NAC, MG 32 B 12, vol. 29, "Private Quebec Health Plan Urged: Catholic Hospitals Say State Scheme 2nd Best," *The Gazette*, June 26, 1956.

as-yet unfunded out-patient services. In this period, the provincial government did raise the PCA rates several times, but did not respond to the demand for funding of out-patient services. In order to obtain revenues anticipated from the private market, both hospitals raised the rates of private and semi-private rooms regularly, and more than anything looked to expansion and a significantly greater number of semi-private beds for middle-class paying patients. The Montreal General, however, was able to carry out its plans much more rapidly than was St-Luc.

- **Expansion**

The agenda of the Montreal General was dominated at the beginning of this period by its move to new quarters. After careful consideration of various possibilities for expansion in the late 1940s, the Board of Management had decided that it would be most efficient to build a completely new hospital complex, thus doing away with problems caused by duplication of resources in the two sections of the hospital and by the costly process of renovating old physical plant. The hospital had joined forces with the Royal Victoria Hospital and the Children's Memorial Hospital (known today as the Montreal Children's Hospital) to run a joint fund-raising campaign. The hospital also obtained \$2.25 million when it sold its Western Division (Atwater and Dorchester) to the Children's Memorial Hospital in 1954 and \$1.5 million when it sold the Central Division (Dorchester near St-Denis) in 1955.⁹⁰ Additional funds were obtained through

⁹⁰ MA, RG 96, MGH, Report of the Board of Management, ARs 1954, 1955.

the Dominion/Provincial granting programme, but the hospital was still obliged to borrow some funds from its bank to cover capital costs incurred while waiting for money from other sources.⁹¹ Still, the hospital was in a good enough financial situation, with enough support in the community, that the Board believed it could eliminate the debt on the capital account, that is the cost of the new hospital and equipment, within a very short time.⁹²

The new hospital, situated on the mountainside on Pine Avenue, was opened in 1955. It contained 169 private beds, as compared to 188 in the old edifices; 194 semi-private beds, up from the previous 57; and 358 ward beds, down from the 400 in the old hospital. The total number of beds was now 721 as compared to 645.⁹³ The quadrupling of semi-private beds was in response to the growth of Blue Cross and other insurance plans, and was key to the Board's vision of financial autonomy and solvency. Ward beds fell both in absolute numbers and in percentage, to under 50 per cent from close to 60 per cent in the old buildings. Despite the decrease in the number of ward beds, the number of beds available for PCA patients remained about the same. However, the Montreal General's percentage of PCA patient days declined from just over 30 per cent in 1954 to just under 20 per cent in 1955, almost certainly

⁹¹ MA, MGH, Report of the Honorary Treasurer, *AR*, 1954.

⁹² MA, MGH, Report of the President of the Board of Management, *AR*, 1955. In fact, in response to a financial questionnaire circulated by the 1960 Hospitalization Insurance Inquiry Commission, the Montreal General indicated that it had no outstanding debentures, bonds or capital debts. See ANQ, E168/3, Hospitalization Insurance Inquiry Commission, "Financial Questionnaire to Hospitals," MA, MGH, June 22, 1960.

⁹³ MA, MGH, Statistics, *ARs*, 1953, 1957.

because of the move away from the downtown site. The rate did climb back to over 30 per cent by 1960, however, likely due to the economic downturn in the late 1950s (see Chart 2).⁹⁴ The number of patient days in wards at the Montreal General (including PCA patients and paying ward patients) also declined from over 115,000 in 1954 to around 110,000 by the end of the decade, a logical consequence of fewer ward beds.⁹⁵ There was some discussion before the move as to whether leaving the poor neighbourhoods around the old buildings would lead to a decrease in out-patient attendance.⁹⁶ In fact, visits did decrease from about 170,000 in 1953 to about 150,000 in 1955, and further decreased to 146,888 in 1960, although they remained a significant cost for the hospital to carry.⁹⁷ The accumulated result of the move did seem to be a decrease in the number of indigent patients using the hospital.

At St-Luc, not surprisingly, considering that the other major hospital in the area accepting PCA patients, the Montreal General, had moved, the percentage of patient days for PCA patients rose from just over 50 per cent in 1954 to almost 60 per cent in 1956 (see Chart 2).⁹⁸ St-Luc also experienced an increase of about 12,000 consultations in the out-patient clinics in 1955, the year of the General's move.⁹⁹ The General's move

⁹⁴ Quebec, Ministère de la Santé, *Rapports Annuels*, 1954, 1960.

⁹⁵ MA, MGH, Statistics, *ARs*, 1954-1960.

⁹⁶ MA, MGH, Policy Committee of the Board of Management, Minutes, January 24, 1949.

⁹⁷ MA, MGH, Statistics, *ARs*, 1953, 1955, 1960.

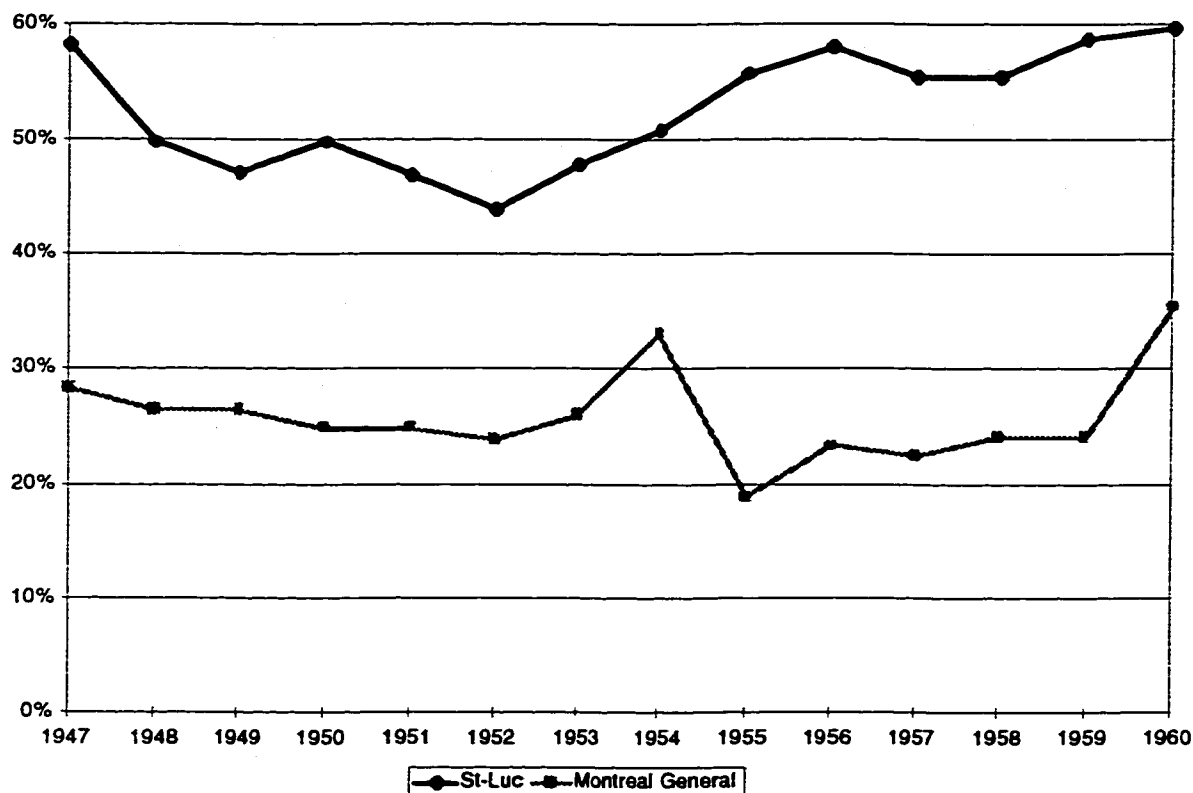
⁹⁸ Ministère de la Santé, *op. cit.*

⁹⁹ HSL, Procès-verbal de la Réunion des membres à vie, le 24 mai 1956.

put pressure on St-Luc to deal with at least a significant proportion of those patients that would not make the trek up the hill to the new hospital.

Chart 2

Percentage of Patient-Days Used for PCA Patients



Source: Ministère de la santé, Rapports annuels

St-Luc had to deal with this growth in usage while its new wing remained still several years away. While St-Luc faced similar problems as the General in its old quarters, its expectations and the concretization of its plans played out on a very different scale. While the General set in motion the process of building a new hospital,

St-Luc planned a new wing with between 200 to 300 beds, a new nurses' residence, a new laundry, and a new heating plant. These plans, like those of the General, were formulated in the late 1940s. St-Luc appealed to both the province and the City of Montreal for funds. It was deemed appropriate to approach the city because St-Luc played such an important role as hospital for one of the poorer sections of Montreal, with one of the highest rates of indigent sick. For some reason, St-Luc was the only hospital in Montreal not to request funds from the federal government, apparently preferring to use its long-standing relationship with the provincial government and to resume the tradition of personal contact between the president of the Board of Management and the provincial premier.¹⁰⁰ Montreal, which had at one point been granting funds to help hospital construction, had unfortunately ended the programme before being approached by St-Luc.¹⁰¹ Nor did the provincial government agree immediately to fund the hospital's expansion. In May 1952, Health Minister Albiny Paquette informed the hospital's Board of Management "... qu'il ne peut procéder à l'étude du projet d'agrandissement de l'Hôpital St-Luc vu les nombreux engagements déjà pris à l'égard de plusieurs hôpitaux; néanmoins, il se dit prêt à recevoir les représentants de St-Luc, le 2 juin prochain."¹⁰² Edouard Asselin, Athanase David's successor as president of the Board of Management, was also Provincial Secretary for

¹⁰⁰ HSL, Procès-verbal de la réunion du Conseil exécutif, le 23 avril 1951: Procès-verbal de la réunion du Conseil d'administration, le 6 septembre 1951.

¹⁰¹ HSL, Procès-verbal de la réunion des membres à vie, le 27 mai 1959.

¹⁰² HSL, Procès-verbal de la réunion du Conseil d'administration, le 19 mai 1952.

the Union Nationale at the time. After meetings between Asselin and Premier Duplessis, and exchanges of letters, it was only in August 1953 that the Premier agreed in principle to giving St-Luc a grant for its planned construction.¹⁰³ The grant of \$3,000,000, to be handed over in three equal payments, was approved by the provincial government in February 1954. The first instalment would be handed over ten months later; the other two in the two following fiscal years.¹⁰⁴ It was calculated that St-Luc could also benefit from approximately \$434,000 in federal grants.¹⁰⁵

After debate, the Board of Management decided to build the new nurses' residence, laundry and heating plant first, despite the fact that the income from new beds would have been very advantageous. The amount of funding available, however, fell far short of the actual cost of building the new wing, calculated at over \$9 million.¹⁰⁶ As a result, in 1960 the hospital was obliged to borrow funds in order to build the new wing.¹⁰⁷ At the end of the period under study, the hospital still did not have a solution at hand for its deficits and its overcrowding.

• Deficits Again

In the meantime, both hospitals continued to face growing deficits. The Montreal General had to deal with a significant increase in the deficit in 1955, an

¹⁰³ HSL, Procès-verbal de la réunion du Conseil d'administration, le 21 août 1953. Edouard Asselin took over as president in 1953.

¹⁰⁴ HSL, Procès-verbal de la réunion du Conseil d'administration, le 5 octobre 1954.

¹⁰⁵ HSL, Procès-verbal d'une réunion spéciale du Conseil d'Administration, le 30 janvier 1956.

¹⁰⁶ *Ibid.*

¹⁰⁷ HSL, Procès-verbal de la réunion du Conseil d'administration, le 8 avril 1960.

increase it believed was caused by the move and which would disappear when the new hospital was fully occupied and functioning. From a net deficit of \$289,211 in 1954, the hospital found itself with a deficit of \$458,000 in 1955, which the Honorary Treasurer attributed in part to expenses of a non-recurring nature, including the early closure of some wards prior to moving to the new buildings. He pointed out that with normal occupancy the deficit would have been about \$150,000 less.¹⁰⁸ He also assured the governors:

Your Board is deeply concerned with the truly staggering amount of this year's deficit, and is taking all possible measures to insure the most efficient and economical operation of the new Hospital which is now fully opened.¹⁰⁹

Unfortunately, the news the following year was not as good as predicted. The deficit stood at \$317,429, about \$140,000 lower than the previous year, but not low enough. The Treasurer did point out that the PCA shortfall, that is the part the hospital had to assume, was \$235,000. Had it been covered by the government, the deficit would have been significantly lower.¹¹⁰ In the following years the deficit dropped as low as \$211,000, but began to rise again in 1960.¹¹¹ In each of these years, the actual operating deficit, which was significantly higher, was reduced substantially through use of the various sources of income to which the Hospital had access: governors' fees, legacies, and interest on investments of endowments. (see Table 7)

¹⁰⁸ MA, MGH, Report of the Honorary Treasurer, ARs, 1954, 1955.

¹⁰⁹ MA, MGH, Report of the Honorary Treasurer, AR, 1955.

¹¹⁰ MA, MGH, Report of the Honorary Treasurer, AR, 1956.

¹¹¹ MA, MGH, Report of the Honorary Treasurer, AR, 1960.

While many hospitals seemed to be losing this source of income, the General appeared to be in a blessed situation. The hospital received over \$740,000 in legacies in 1957, over \$600,000 in 1958, and over \$1,200,000 in 1959.¹¹²

Table 7 Montreal General Hospital: Revenue, Expenditures and Deficits 1954-1959 (in 1940 dollars)					
	Revenue	Expend-iture	Gross Deficit*	Net Deficit**	Net Deficit (in current dollars)
1954	1,797,000	2,149,000	357,000	175,000	289,000
1955	1,877,000	2,341,000	463,000	274,000	458,000
1956	2,480,000	2,864,000	384,000	187,000	317,000
1957	2,577,000	2,946,000	369,000	162,000	284,000
1958	2,774,000	3,212,000	438,000	210,000	373,000
1959	3,112,000	3,460,000	348,000	118,000	211,000

Source: Montreal General Hospital, Statement of Revenue and Expenditures, Annual Reports, 1940-45

* Includes other expenditures: Interest and Bank Charges, Custodian's Fees, Appropriation to Bad Debts Reserve, Appropriation to Employees' Benefit Reserve.

** After deduction of fees, donations, endowments, grants, other revenues.

¹¹² MA, MGH, Auditors' Reports, Legacies, ARs, 1957, 1958, 1959.

Table 8 St-Luc Hospital: Revenue, Expenditures and Deficits 1954-1959 (in 1940 dollars)				
	Revenue	Expenditure	Deficit	Deficit (in current dollars)
1954	1,281,000	1,340,000	59,000	98,000
1955	1,299,000	1,366,000	66,000	111,000
1956	1,333,000	1,400,000	67,000	113,000
1957	1,413,000	1,469,000	56,000	98,000
1958	1,418,000	1,538,000	90,000	159,000
1959	1,442,000	1,526,000	84,000	151,000

Source: Hôpital St-Luc, Procès-verbaux des réunions des membres à vie 1940-45.

The main causes of the deficit had not changed: the cost of caring for indigent out-patients was singled out every year in the annual reports of both hospitals. In the 1958 *Annual Report*, for example, the Executive Director of the Montreal General pointed out that the revenues per patient in the out-patient departments amounted to \$2.69 (some patients did pay, and some services, like Workmen's Compensation, also paid for out-patient services): expenditures per patient totalled \$5.14, leaving a deficit of \$2.45 per patient, and this for each of the 143,000 visits.¹¹³ In a similar vein, the President of St-Luc's Board of Management noted in his 1957 address to Life Members:

¹¹³ MA, MGH, Report of the Executive Director, ARs, 1958.

Je me contenterai de souligner deux faits qui ressortent de ces rapports: d'abord l'augmentation extraordinaire du volume de traitements qu'on a prodigués à St-Luc l'an dernier malgré l'insuffisance de plus en plus accentuée de nos locaux; puis le lourd fardeau financier que représente pour lui les soins médicaux donnés aux pauvres par l'entremise de ses dispensaires. Sur ce dernier point, précisons que le chiffre record de 131,868 traitements et consultations ont été donnés l'an dernier dans ces dispensaires que l'on estime à \$2. en moyenne le coût de revient de chacun des ces traitements et consultations et qu'ainsi cette charité publique représente pour St-Luc un déboursé sans retour d'environ \$260,000 pour l'année écoulée, déboursement qui n'a cessé d'augmenter depuis la disparition des dispensaires de l'Hôpital général de cette zone et qui ne peut manquer de s'alourdir encore d'année en année. Il est trop évident pour qu'il soit nécessaire d'y insister, que c'est là un fardeau financier qui ne devrait pas être laissé à la charge de l'hôpital, que ce n'est ni légalement ni moralement, la responsabilité des hôpitaux de voir au traitement gratuit des indigents des municipalités intéressés.¹¹⁴

Worthy of note is Asselin's affirmation that indigents were neither the moral nor the legal responsibility of hospitals. Again the argument that came to the fore was that government — in this case apparently municipal government — should wholly shoulder the responsibility for indigents.

In 1957, the deficit actually fell, due to the increase in PCA rates in April of that year from \$7.50 to \$10.50; however there was no change in policy towards indigent out-patients. In fact, relief was short-lived, as the following year the deficit grew by \$60,000. (See Table 8)

¹¹⁴ HSL, Procès-verbal de la Réunion des membres à vie, le 10 mai 1957.

The shortfall from the Public Charities Act allocations was duly noted by both hospitals each year, even when the rate was increased.¹¹⁵ And labour costs were of course also recorded. The Montreal General finally had to face up to the unionization of its general workers in 1959 and with it the potential of higher wage demands. But even before that professional associations were pushing the hospital to raise salaries of its members.¹¹⁶ St-Luc, on the other hand, had had to deal with unions since the 1940s.

- **Cost Containment**

Both hospitals made attempts at cost containment, the methods varying little from those used in the previous periods. In 1955 St-Luc decided to use more nurses' aides to help deal with a shortage of nurses. (The General had used aides since the 1940s.) This kind of measure could also save significant amounts of money as a starting aide earned \$98 per month, while a starting registered nurse earned \$180. In addition to this, nurses' salaries at St-Luc were apparently lower than in other hospitals.¹¹⁷ In his annual report for 1955, the Honorary Treasurer talked about "économie rigide pratiquée dans nos différents départements" permitting the hospital to save about

¹¹⁵ A 40 per cent increase in PCA rates in 1957 was applauded by the MGH Honorary Treasurer for example, but in the same breath, he noted: "In spite of this increase, I wish to emphasize again that we must look to the province and the city for additional allowances to defray even more the cost of caring for indigent patients." MA, MGH, Report of the Honorary Treasurer, AR, 1957.

¹¹⁶ *Ibid.*

¹¹⁷ HSL, Procès-verbal de la réunion du Conseil exécutif, le 4 février 1955; HSL, Procès-verbal de la réunion du Conseil exécutif, le 31 mars 1955; HSL, Procès-verbal de la réunion du Conseil médical, le 8 mars 1955.

\$16,500 over the previous year in expenditures.¹¹⁸ No details were given. Salaries being the largest item in expenditures, however, it is likely that a significant part of the savings came from the employees. The hospital did take a hard line towards the unions in negotiations, refusing, for example, to agree to dues check-offs or to *sécurité syndicale*.¹¹⁹ In 1958, the Montreal General, looking for ways to reduce its deficit, held "an extremely careful review of all expenditures including the number of personnel presently employed by the Hospital."¹²⁰ The General also started experimenting with automation in some departments to increase productivity.¹²¹

The most frequently used method for increasing revenues, of course, was to increase rates, and both hospitals did this. St-Luc in particular increased them on an annual basis, and in some cases more frequently.¹²²

These efforts did not resolve the financial problems, and deficits remained high. Moreover, new challenges awaited the hospitals. By the end of the decade, the Montreal General had already outgrown some of its new facilities: the kitchens needed to expand, radiology was at maximum utilization, medical and surgical labs were inadequate, and the occupancy rates were consistently at a dangerous high of over 90

¹¹⁸ HSL, Procès-verbal de la réunion des membres à vie, le 24 mai 1956.

¹¹⁹ HSL, Procès-verbal de la réunion du Conseil d'administration, le 23 décembre, 1954. Dues check-offs meant that the union was guaranteed its dues as they were deducted at source from the workers' pay.

¹²⁰ Report of the Honorary Treasurer, Montreal General Hospital AR, 1958.

¹²¹ Report of the Department of Metabolism and Toxicology, Montreal General Hospital AR, 1957.

¹²² HSL, Procès-verbal de la réunion du Conseil exécutif, le 27 février 1956; HSL, Procès-verbal de la réunion du Conseil exécutif, le 1 avril 1957; HSL, Procès-verbal de la réunion du Conseil d'administration, le 15 décembre 1958.

per cent.¹²³ The hospital was able to add two floors of laboratory space before 1960.¹²⁴ St-Luc was of course still waiting for its expansion, and full to the rafters.

By this time, changes were evident in Quebec's political landscape, as the Duplessis era ended in September 1959 with the death of the premier. While the pace of change accelerated with Duplessis' death, resistance to many aspects of his government's policies, coming from many quarters, had been brewing for years. Among issues debated were health care, particularly problems in the hospital sector.¹²⁵ It is not therefore surprising that the government turned rapidly to an examination of this question.

The response of the hospital sector to the government's renewed interest in hospital problems was muted. The continued experience of deficit financing, the lack of responsiveness from the provincial government other than raising of PCA rates, the successes of government hospitalization insurance in other provinces, the evident failure of market alternatives to resolve hospitals' financial problems (not to speak of the problem of the public's access to hospital services), and the general public support for state hospitalization insurance all must have influenced a receptive response to the

¹²³ MA, MGH, AR Report of the Department of Dietetics, 1958; Report of the Department of Radiology, 1956; Report of the Board of Management, 1958; Report of the Executive Director, 1958.

¹²⁴ MA, MGH, Report of the Honorary Treasurer, AR, 1958.

¹²⁵ A good overview of the resistance developing in 1950s Quebec society can be found in Chapter 18, "Ici Radio Canada," in Susan Mann Trofimenkoff, *The Dream of Nation: A Social and Intellectual History of Quebec* (Toronto: Gage Publishing Ltd., 1983).

possible implementation of a Quebec scheme. The President of St-Luc noted in passing at the Annual Life Members meeting in May of 1960:

Nous osons espérer que la Commission d'enquête récemment nommé pour étudier le problème d'un système d'Assurance-Hospitalisation dans le Québec réduira notre coût d'opération.¹²⁶

This commission was the Favreau Commission, set up in early 1960 by Premier Paul Sauvé, who succeeded Duplessis after his death in September 1959. This seemed to signal a change in the government's attitude towards health insurance as indicated by a somewhat speculative article in *La Presse* in September 1959. Remarking first on the late Premier Duplessis' rejection of a federal plan, and quoting his health minister's insistence that there was no pressing need for Quebec to enter into the programme, the article went on to state that there were other cabinet ministers who did not share Duplessis' opinion on hospital insurance. Without actually stating Sauvé's opinions, the article seemed to group him with the 'pro-hospitalization insurance' forces.

The article itself was clearly in support of Quebec joining the federal hospitalization insurance programme. Arguing that Quebec was paying taxes so that others could benefit from the programme, it also noted:

Mr. Sauvé knows that for the last year, social organizations as well as medical associations, workers, farmers, and many others have been asking for the province of Quebec to join the hospital-insurance program.¹²⁷

¹²⁶ HSL, Procès-verbal de la réunion des membres à vie, le 31 mai 1960.

¹²⁷ NAC, RG 29, vol. 1072, file 502-3-4, pt. 2. Translated excerpt from *La Presse*, September 12, 1959, "Health Insurance in Quebec Soon?: The Sauvé Government appears favourable." This article appeared within days of Duplessis' death.

The author of the article judged shrewdly. Within a few months, the Sauvé government had set up a new commission to study the question of hospital deficits and hospitalization insurance.

- **The Favreau Commission: Once again pushed to action**

The need for action was by then acutely clear. At the end of the 1950s, despite substantial increases in PCA rates, the financial situation of hospitals was still critical. Significant as well was the alarming increase in the deficit the government itself was facing in the PCA portfolio, the gap between revenues and amounts disbursed for the various PCA institutions (See Chart 1). In 1949-1950, the province's deficit for all institutions under the PCA (including different categories of hospitals, sanatoriums and TB hospitals, infant homes, orphanages, etc.) was just over \$12 million.¹²⁸ By 1958-59, the total deficit was over \$80 million, with the deficit for health care standing at over \$60 million.¹²⁹ Add to this the growing deficits of the individual hospitals, and the situation was clearly calling for action. The government was pushed to respond.

At least one federal government official agreed with *La Presse* that there was strong demand for hospital insurance in Quebec. Dr. Roger B. Goyette of the Epidemiology Division of the Department of National Health and Welfare, commenting on potential for co-operation with Quebec on diverse health care matters,

¹²⁸ *Annuaire de Quebec*, "Public Health - Charitable Institutions," 1959, 1960. According to the Tremblay Commission, the deficit grew to over 21 million by 1951, however the methods of calculation may have varied.

¹²⁹ *Annuaire de Quebec*, "Public Health - Charitable Institutions," 1959, 1960.

had insisted in 1956 that this could bring closer the day when Quebec joined the hospitalization programme:

I wish to reiterate what I have said previously that the demand for hospital insurance in Quebec is probably greater than in any other province in the sense that everyone (even the doctors and the government) realizes that something must be done to meet ever-increasing hospital charges and that no one can suggest a realistic non-governmental scheme.¹³⁰

He may have been a little optimistic, considering that most hospital boards were still only demanding action within the PCA structure.¹³¹ However, especially considering that nothing had changed since the Tremblay Commission Report, either in terms of improvement of the proportion of privately insured patients or of the government taking on more responsibility for the indigent, the boards seemed to be realizing that perhaps the only realistic way out of their impasse was in fact government hospitalization insurance.

In response to the continuing crisis in hospital funding, however, the government struck another commission, the Quebec Hospital Insurance Inquiry Commission under Gérard Favreau of the Trans-Canada Corporation Fund, to study the problem of hospital debt and hospital insurance. The Commission received several

¹³⁰ NAC, RG 29, vol 1072, file 502-3-4, pt. 2, Memo from Roger B. Goyette, Epidemiology Department to Dr. C. A. Roberts, Principal Medical Officer, Health Insurance Studies, "Visit in the Province of Quebec," May 8, 1956.

¹³¹ Another example of this approach, demanding better rates from the PCA, was prominent in the plea made by Dr. Gilbert Turner, executive director of the Royal Victoria Hospital, as reported in *The Montreal Star* in April of 1956. In the article, "Indigent Patient Loss Laid To Government," Turner is quoted as stating that Quebec's PCA rate of \$7.50 per day was about half the average rate of reimbursement of other provinces.

briefs, including one from the Quebec Hospital Association (QHA, a provincial organization grouping Catholic, Protestant and Jewish hospitals, founded in 1956).¹³²

By this time, the outcome seemed assured. A provincial hospitalization insurance plan was almost certain. All other provinces had signed on to participate in the federal Hospitalization Insurance Plan. The hoped-for financial solvency through the private market had not materialized, and was farther from reality than ever before. The points raised by the QHA in their *Brief*, therefore, were centred on making the expected plan as responsive as possible to hospital concerns, while nonetheless accepting the inauguration of a state-run system. Gone was any suggestion that middle-class individuals take care of their own hospital insurance needs: the principle of universality was accepted.¹³³ The constant struggle with deficits was reflected in demands that government payment should cover real costs: it should allow for variations between hospitals that reflected the services given; and it should cover out-patient services provided in hospitals.¹³⁴ Reflecting difficulties experienced by hospitals in other provinces, the *Brief* also suggested that allowance for depreciation of immovables and interest on debts accumulated for building be factored into the *per diem* rate in order to deal with hospitals' accumulated debt.¹³⁵ Finally, the QHA proposed certain measures to ensure a level of autonomy for the hospitals: some

¹³² ANQ, E168/10, Quebec Hospital Insurance Inquiry Commission, Association des Hôpitaux du Québec, *Mémoire à la Commission d'enquête sur l'assurance hospitalisation*, July 13, 1960.

¹³³ *Ibid.*, p. 5.

¹³⁴ *Ibid.*, pp. 7-10.

¹³⁵ *Ibid.*, p. 12. This was not included in the federal plan.

financial autonomy would be reserved by allowing hospitals to keep supplementary payments for private and semi-private rooms, to keep donations and legacies, and to be able to participate in fund-raising drives.¹³⁶ The Association, extremely conscious of difficulties hospitals encountered in the past to expand or build new buildings, and noting the continued growth of Quebec's population, also asked for a mechanism by which hospital expansion would be feasible.¹³⁷ It also asked that the plan be administered by a permanent committee composed of experts in hospital administration and health care, an arm's-length mechanism to ensure there would be no political meddling.¹³⁸ No mention was made of private-sector alternatives. That battle was apparently over. What the hospitals now requested were mechanisms to set them on a stable financial basis, and to allow them to retain as much autonomy as possible inside the state-run system.

The Commission never completed its work. In fact, the AHQ was not even able to present its brief to the Commission.¹³⁹ The Liberals under Jean Lesage, Paul Martin's firm ally in the federal hospitalization insurance battles, came into power on June 22, 1960, dissolved the Commission immediately and prepared and passed a law to institute a provincial hospitalization insurance programme on January 1, 1961, thus bringing Quebec, the last outstanding province, into the national programme. While the QHA

¹³⁶ *Ibid.*, pp. 11, 14.

¹³⁷ *Ibid.*, p. 13.

¹³⁸ *Ibid.*, p. 19.

¹³⁹ ANQ (Montreal), P271, Association des Hôpitaux catholiques des États-Unis et du Canada, Box 2, Minutes of the special meeting of the Board of Directors of the QHA, July 15, 1960.

had planned to present its brief in a united front with those Catholic hospitals not in the organization, choosing to focus on the question of a non-political commission to oversee any insurance programme and still insisting on a means of dealing with hospital debt, the final bill passed by the Liberals incorporated neither of these demands.¹⁴⁰

Conclusion

Quebec's entry into the federal Hospitalization Insurance Plan closed a chapter in the creation of a national health insurance programme. While some provinces had implemented programmes already, it was necessary for the federal government to move on the question before others would join. Some provincial governments, faced with a public that wanted hospitalization coverage — but was unable to obtain it adequately in the marketplace — and confronted with the success of experiments in Saskatchewan and British Columbia in particular, were ready to join a federal plan. When the resistance of the federal Cabinet was finally overcome by a variety of pressures— Ontario Premier Frost's political manoeuvres, pressure from the CCF, a high level of public support, and a lot of diligent work in the Department of National Health and Welfare — the provinces did not take long to join the programme. Federal cost-sharing made the programme a feasible possibility for poorer provinces.

¹⁴⁰ ANQ (Montreal), P271/Box 2, Minutes of the meeting of the Board of Directors of the Quebec Hospital Association, November 18, 1960.

The resulting programme, though far from perfect, nonetheless provided almost the entire population with coverage, an immense step in terms of social security for Canadians.

Quebec's eventual adherence was almost inevitable. The situation in Quebec hospitals was growing worse by the year, as was the government's PCA deficit burden. Public opinion supported the programme, and even the Union Nationale cabinet apparently included some supporters of a government plan. The inauguration of the programme was simply hastened by the death of Maurice Duplessis.

In the period of formulation and implementation of the programme, the hospital sector in Quebec had been resistant to further state incursions, in fact stepping back from the more open position held during the war. Despite overwhelming evidence of the failure of market-based alternatives, evidence the hospital boards and administrations faced in their account books every day, hospitals still preferred to look to the market for solutions. In this they were supported by the medical profession and of course the private market providers, Blue Cross plans and the commercial insurance industry. As the hospitals' brief to the Tremblay Commission indicated, Quebec hospitals still strongly resisted further state encroachment. Nonetheless, when it became clear that the government was going to implement hospitalization insurance, they did not fight it. The efficient progress of programmes in Saskatchewan and B.C. must have encouraged at least some to feel that it would be possible to maintain their autonomy under the provincial plans.

CONCLUSION

The elaboration of any welfare measure in a liberal capitalist society is generally a long and complex process, the result of the interplay of many forces and of many compromises. This was certainly the case for hospitalization insurance in Canada. One could say that hospitalization insurance first saw the light as part of general proposals for national health insurance in the Liberal Party's 1919 election platform, was actually put on the agenda in the 1940s, and was finally enacted in 1957. As the foregoing text has shown, liberalism played a dual role in the genesis of hospitalization insurance, both in resisting it and in promoting it.

Throughout the years of debate on this policy, two facets of liberalism were in constant opposition: the *laissez-faire* liberal view that the state should play only a limited role in social welfare, and that therefore services such as hospitalization insurance were best left to the private sector, and the opposing belief that only the state could and should create a programme that would best serve the community as a whole, without undermining the position of the individual. Both of these viewpoints fit well within the parameters of liberal thought, and neither one questions the legitimacy of liberal capitalism. The difference between them centres on the extent to which each believes the state should be allowed to intervene. While the dominant trend for most of the century was the market-centred, *laissez-faire* brand of liberalism, the eventual implementation of a state hospitalization insurance programme was part of a resurgence of the more socially-oriented, state-interventionist liberal approach.

How did the supporters of these opposing viewpoints define their stance in regard to the welfare state in particular? Throughout the period under study, these opposing points of view were present in debates at all levels, in both federal and provincial governments, in the hospital sector, and in society as a whole. Whether in the federal Cabinet or in the provincial governments, in hospital organizations or in the boards of management of the two hospitals we have examined here, the *laissez-faire* position predominated in discussions about the welfare state in general and about specific programmes such as hospitalization insurance. The underlying principle, enunciated over and over at any and all levels examined, was that the individual was responsible for his own well-being and that of his family, that he must provide for possible misfortunes such as illness through insurance, or savings, or some other means. Those who could not or would not provide for themselves — the indigent — should be provided for by charity or by the state — but this provision should be clearly marked and means-tested, setting the indigent apart from those provident individuals who had the foresight to plan for their needs. The state could play a role here, but that role must clearly take second place to the market and the individual. These views conform to those residual positions discussed by Denis Guest in his study of welfare in Canada, and those examined by Fernande Roy in her discussion of liberalism in the turn-of-

century francophone business sector in Montreal.¹ The positions examined in this text were classic expositions of *laissez-faire* liberalism.

In the political arena, adherents of this brand of liberalism were legion. Federally this position was exemplified by the federal Department of Finance, by Louis St. Laurent, even by Mackenzie King. In Quebec, the situation may appear different because of the long-standing predominance of the Catholic Church in social welfare activities. Nonetheless, this phenomenon in no way detracted from the strong adherence to the principles of *laissez-faire* liberalism in the province. In fact, it gave the government the possibility to pursue this approach while assuming the Church would take care of social needs. The name of Maurice Duplessis comes first to mind as an example of a fervent booster of this form of liberalism, but one could add Alexandre Taschereau from an earlier period, as well as the members of the Tremblay Commission in the 1950s. (It is not without relevance to remember that Honoré Parent, member of St-Luc's Board of Management, was also a member of the Tremblay Commission.)

The underlying belief of the opposing state-interventionist or welfare-state liberal position was that, while individuals should be encouraged to be provident, they could nonetheless find themselves in situations where they were unable to shoulder their responsibilities through no fault of their own; illness, of course was a poignant

¹ Denis Guest, *The Emergence of Social Security in Canada* (Vancouver: University of British Columbia Press, 1980); Fernande Roy, *Progrès, Harmonie, Liberté: Le libéralisme des milieux d'affaires francophones de Montréal au tournant du siècle* (Montreal: Boréal, 1988).

example. This reality justified state intervention and the creation of universal programmes such as hospitalization insurance, because it was the most equitable, often the most economical, and, in fact, the only way to ensure access to certain essential services for the entire population.

Despite the general dominance of *laissez-faire* liberalism, many signs of the interventionist model could, nonetheless, be seen, particularly during the war years. These included the Marsh Report, the Heagerty Report, positions taken by many individuals in the civil service in Ottawa (in particular in National Health and Welfare), and of course the stance of the Godbout government in Quebec, as indicated by its establishment of the Lessard and Garneau Commissions. At the time their vision was strong enough to mute criticism from those most interested in opposing it: the Canadian Medical Association, the Canadian Hospital Council, the Catholic Hospital Council, and the Canadian Manufacturers' Association. Even among the latter opponents, the Canadian Hospital Council, for example, one could find individuals — Owen Trainor, for example — who did maintain a more pro-interventionist position.

The *laissez-faire* vision regained its ascendancy in the booming economy of the post-war period, but the alternative vision remained, as best exemplified by Paul Martin and his supporters in National Health and Welfare.

The two hospitals examined, the Montreal General Hospital and St-Luc Hospital, like their associations, the Montreal Hospital Council and the Canadian Hospital Council, certainly fell in general into the camp of *laissez-faire* liberalism. One might say this was inevitable, considering the composition of their boards, made up as

they were of the elites of their respective communities. Inheritors of the liberal voluntary hospital tradition, but functioning in a twentieth-century context, they saw their hospitals as autonomous institutions, scientific in nature, yet still fulfilling their long-standing charitable role — the original reason for their existence. In this role, they were to be assisted, but not fettered, by the state.

There were definite contradictions in this stance, in the defining of the relationship to the state and to the problem of indigents. The discourse of the hospital boards rarely wavered from insistence on their traditional autonomy from the state, stressing the hospitals' successful fulfilment of their long-standing mandate to care for the poor. Yet hospitals also had a long tradition of receiving significant levels of state support for indigents in Canada and Quebec, and they were insistent that the state provide adequate funding for the indigent.

When one examines hospitals' actual relationship to the indigent, it becomes clear that their concern was always, in fact, circumscribed by social (or class) and financial considerations. In the nineteenth century, when costs were less of a concern, as Rhona Kenneally and Judith Young note, moral regulation of the indigent — and with it the legitimation of the political and economic system — was almost on a par with physical healing.² In times of financial difficulty in the more scientific — and more

² Rhona Richman Kenneally, "The Montreal Maternity, 1843-1926: Evolution of a Hospital" (M.A., McGill University, 1983); Judith Young, "A Necessary Nuisance': Social Class and Parental Visiting Rights at Toronto's Hospital for Sick Children 1930-1970," in C. David Naylor, ed., *Canadian Health Care and the State: A Century of Evolution* (Montreal: McGill-Queen's University Press, 1992).

costly — twentieth century, especially as the market became more important to the hospitals, they tended to control services to the indigent, barring some 'phoney indigents' from out-patient clinics, and reducing services to others in clinics and in the hospital. This is reminiscent of poor law attitudes, whereby voluntary hospitals took care of the 'worthy poor' and state-financed poor house institutions saw to the 'demoralized poor.' Thus the hospitals examined in this text, as well as their professional associations, conformed in many ways to the analysis of voluntary hospitals developed by Roy Porter for England, and Charles Rosenberg and Morris Vogel for the United States.³

Eventually, with the advance of the twentieth century, as the indigent became more of a burden, due to burgeoning costs and lagging state aid, the hospitals' positions towards them seemed to harden. They even talked of abandoning them to the state entirely. This unfolded after 1945 as the hospital sector retreated from its wartime openness to state intervention and moved back towards market solutions. But the market has little room for the weak, which was why it was so important that the state increase its support for the indigent.

At the same time the hospital sector, in keeping with its *laissez-faire* orientation, insisted that the majority of the population find a solution in the marketplace. When

³ Roy Porter, "The gift relation: philanthropy and provincial hospitals in eighteenth-century England," in Lindsay Granshaw and Roy Porter, eds., *The Hospital in History* (London: Routledge, 1989); Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987); Morris J. Vogel, *The Invention of the Modern Hospital: Boston 1870-1930* (Chicago: University of Chicago Press, 1980).

this was not particularly successful, the hospital sector started creating its own solutions, the Blue Cross plans. Even when they gave qualified support to state insurance plans, as in the 1940s, they were unwilling to forego their liberal voluntarist principles, insisting that these plans be contributory (unlike the unions, which proposed that funding come from general taxation), thus ensuring that individual participants not lose their sense of responsibility.

This behaviour is in many ways similar to the *laissez-faire* liberal approach that Rosemary Stevens attributes to the voluntary sector in the twentieth-century U.S.⁴ However, this said, this study has shown significant differences with the American model examined by Stevens. Despite the hospitals' discourse of self-reliance, and their attempt to nurture this characteristic through Blue Cross and the promotion of other private schemes, and despite the potential for differential treatment of the indigent and paying patients, Canadian hospitals — the Montreal General and St-Luc included — did not routinely exclude indigent patients, as did voluntary hospitals in the United States. No dual state/voluntary system such as existed in the United States ever emerged in Canada. All public hospitals had to assume the responsibility for indigent patients, and, in general, they did.

It must be said, finally, that hospitals — both the two studied here and in general — were in many ways justified in their hesitation to support state-run

⁴ Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989).

hospitalization insurance. Previous experiences with the state — municipal, provincial, and federal — were often problematic. The federal government's over-riding controls and restrictions during the war, federal and provincial lower-than-cost payments for patients under their charge, be it for aboriginal patients, indigents, or others, and the arbitrariness and inconsistency of municipal Public Charities payments in Quebec all fuelled the hospitals' deep-seated distrust of the state.

However, it is also important to recall that, though the two hospitals and the Canadian and Quebec hospital sector in general were opposed to the encroachment of state control over their institutions and firmly believed that market solutions were preferable, when hospitalization insurance was finally introduced, the hospital sector did accept with relative grace this incursion of the state into their domain.

In many ways, in their general approach to the state and the market, the Montreal General and St-Luc hospitals maintained similar positions. In this sense, they bear out the argument developed by Fernande Roy, that the francophone business elite operated in the same liberal universe as their anglophone counterparts.⁵ Yet there were significant differences between the two boards, based principally on their membership in the two linguistic communities. Both seemed well-adapted to their particular environments. The Montreal General was a prestigious institution of the anglophone community, the oldest English hospital in Quebec, a long-time affiliate of the McGill

⁵ Roy, *op. cit.*

Medical School, and supported by the English elite, in terms both of money and time. It was wealthy for this kind of institution, and able to look to its community to raise the necessary funds for new buildings, for a large endowment fund, and for participants on the Board of Governors and the Board of Management. However, if all this failed, it could then turn to government.

St-Luc, a new hospital and one of the few lay Catholic institutions — thus without the material backing of the Church — was not in the habit of turning to its community, one which did not have the wealth of its English counterpart, for money. But it garnered significant support from the francophone business and political community in terms of active participation in the management of the hospital. Without the financial support that the Montreal General enjoyed, however, it had to look elsewhere for funding. The long-established and carefully maintained relationship with the provincial government, under both the Liberals and the Union Nationale, helped fill this need. And St-Luc, early on, distinguished itself as a major Public Charities Act hospital.

While it is important to note these differences, it is equally interesting to recall that, despite them, the two hospitals maintained essentially the same liberal positions towards the state and the market, and made the same differentiation between indigent and non-indigent patients. This brings to mind Ralph Miliband's comments on the strength of class ties in determining outlook, in this case above and beyond national

differences.⁶ Also interesting is the fact that, despite their very different resources, both faced constant deficits. Neither was able to conquer the problem: not the well-endowed Montreal General, nor the politically well-connected St-Luc. Yet, despite the chronic persistence of deficits, even after more than 15 years of growth of group and private insurance — the market solution of choice — neither would willingly move from their liberal voluntary stance.

While the hospitals waited for market solutions to develop, their most important ongoing source of government financial support was the Public Charities Act funding for indigents. Although the hospitals never ceased to criticize the PCA, mainly because the funding was judged inadequate, the measure itself was in many ways in tune with the ideological preoccupations of the voluntary sector. Thanks to the Catholic Church's struggles to keep its autonomy from the state at the inception of the Act, there was relatively little in the way of controls (there had been very little state regulation of hospitals at all before the PCA). This source of guaranteed funding with few strings suited voluntary institutions, which cherished their autonomy from the state. Hospitals were regulated, of course, to some extent through the PCA, but more by their own or related organizations such as the American College of Surgeons and the Association of Registered Nurses of the Province of Quebec.

⁶ Ralph Miliband, *The State in Capitalist Society* (London: Weidenfeld and Nicolson, 1966).

The PCA was not unusual as a social welfare measure in 1921, in that it provided public funds for private welfare services without stringent controls, that it was aimed at a specific group, and that it required means testing in order to qualify for benefits. As argued by Jean-Marie Fecteau, however, it was an important step forward in that it was an early welfare measure where the state did take on significant levels of financial responsibility.⁷ And as Margaret Little has shown in her study of Mothers' Allowance in Ontario, this kind of residual public/private welfare measure was not unusual, even as late the 1960s.⁸ But the weaknesses of the PCA were clear fairly early on. The Lessard Commission of the early 1940s made a cogent, thorough critique of the Public Charities Act as providing insufficient support for hospitals, inhibiting the needed development and expansion of the system, stifling preventive medicine, and being demeaning to those who applied for indigent status. At the same time that the Heagerty Committee in Ottawa was preparing a proposal for a national health insurance plan, the Lessard Commission was proposing a provincial state health insurance plan. Thus, if participants were able to make a cogent and thorough critique of the failings of the PCA in the 1940s, it is incumbent on historians today to be at least as thorough in their critique. Some authors, Yves Vaillancourt in particular, have developed a broad critique of the PCA.⁹ It is hoped this text will add to that critical analysis.

⁷ Jean-Marie Fecteau, "Un cas de force majeure: le développement des mesures d'assistance publique à Montréal au tournant du siècle," *Lien social et politiques* – RIAC, 33 (Spring 1995).

⁸ Margaret Little, "The Blurring of Boundaries: Private and Public Welfare for Single Mothers in Ontario," *Studies in Political Economy*, 47 (Summer 1995).

⁹ Yves Vaillancourt, *L'Évolution des politiques sociales au Québec 1940-1960* (Montreal: Les Presses de

While the Lessard Commission proposed significant changes in the system, the hospitals, in order to maintain their autonomy, were more concerned with tinkering. They made no profound criticisms of the PCA. They insisted only that it be made more generous. This had not changed when, over ten years later, the hospitals appeared before the Tremblay Commission. Once again they proposed more generous funding from the PCA for indigents and a market model for the majority of the population. They persisted in this position despite the growing deficits faced by both the hospitals and the PCA fund itself, in other words, despite the fact that their market solution was not working. This continued support for the PCA as the cornerstone of government hospital financing should hardly be surprising, however. It fit so very neatly into the self-governing model followed by the hospitals, and with their liberal ideology: the state was there to help, but it must remain secondary to the market. Both Catholic order-run and lay hospitals could agree on this, though perhaps for different reasons, since their essential common point was their insistence on the secondary role of the state. Thus, the PCA, though frequently criticized (but usually on a superficial level), would remain the central, and often the only, element of government hospital financing until 1961.

Why, if *laissez-faire* liberalism was such a strong force in Canadian and Quebec society, was hospitalization insurance implemented? This is a complex question, given

all the levels involved. One element was certainly the widespread support it garnered from the public, as seen in opinion polls on countless occasions. While Canadian and Quebec elites generally did not favour this kind of state intervention, other mass-based groups such as unions did. In Quebec, while the Catholic Church in general was against further state intervention, even there, some elements in the Church recognized that it was necessary for the state to intervene more in areas like health care. The CCF certainly played a pivotal role, by introducing its hospitalization plan in Saskatchewan, and through Stanley Knowles' persistent needling in the Commons. Political considerations were also important. Ontario's Leslie Frost is one example; here again the issue had been raised by organized labour. The fact that the market was quite simply not delivering the hoped-for solution should not be underestimated either. Finally, one must include the determination of that liberal with the alternate vision, Paul Martin, and his core of dedicated individuals in National Health and Welfare.

In Quebec, similar forces led to the eventual establishment of hospitalization insurance. Despite the relative lack of government intrusion in the hospital sector, other areas of health care had over time seen more government involvement. The case of the rural health units, which set an example of positive government intervention, comes to mind. With regard to the hospital sector, the failure of the existing system, noted by the Lessard Commission, and by others in Quebec society, was finally acknowledged by the Union Nationale in the last months of its regime, after the death of Maurice Duplessis. By this time even the hospitals had recognized that the system was not functional, and that change was both necessary and inevitable. And Quebec

hospitals had the positive example of successful implementation of hospitalization insurance in the other provinces. Finally, the law was actually brought in by the new Liberal government of Jean Lesage, a fitting indication of the arrival in power in Quebec of that stream of liberalism that believed in an expanded role for the state.

Throughout the two decades studied in this text, the various forces involved at the different levels debated how to ensure stable financing for Canada and Quebec's hospital system. In the process they inevitably influenced each other. As the two liberal positions confronted each other, having different strengths, at each level, at different times, the hospital system was evolving, attempting various solutions to the problems faced. As market solutions proved disappointing for the hospitals, and as some provinces moved ahead successfully on their own, the proposition of a state hospitalization insurance became less fearsome. Ultimately it seemed to be accepted by all levels, perhaps somewhat grudgingly, as the only viable solution.

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