

# *The Course of Medical Opinion on State Health Insurance in British Columbia, 1919-1939\**

by Margaret W. ANDREWS\*\*

*It is widely assumed that North American doctors have generally opposed introduction of compulsory state health insurance; studies of Canadian doctors suggest that they came to support such programs in the 1930s because of income loss during the Great Depression. This paper studies the attitudes of British Columbia doctors on the question in the 1920s and 1930s and concludes that they came to support introduction of state health insurance in the relatively prosperous 1920s in order to loosen the rein imposed on their rising financial expectations by the unpaid work they customarily performed for needy patients.*

*On croit généralement que dans l'ensemble, les médecins nord-américains se sont opposés à l'étatisation de l'assurance-maladie. Des études sur le corps médical canadien laissent néanmoins entendre que les médecins de ce pays en sont venus à donner leur appui à de tels programmes au cours des années 1930, par suite d'une baisse de revenus engendrée par la Crise. Dans l'article qui suit, l'auteur étudie l'évolution de l'attitude des médecins de la Colombie-Britannique sur cette question et montre que c'est dès les années vingt, pourtant relativement prospères, que les médecins de cette province ont commencé à être en faveur de la prise en charge par l'État de l'assurance-maladie. L'objectif qu'ils visaient ainsi était de réduire le fardeau que représentait pour eux les soins gratuits à une clientèle nécessiteuse, eu égard à la croissance de leurs aspirations financières.*

It is widely believed that opposition has been the characteristic reaction of North American doctors to state-administered health insurance. This generalization is substantially correct for the United States and has increasingly become so for Canada in the second half of this century: there have been such incidents as the Saskatchewan doctors' strike in the 1960s and doctors' "extra billing" and opting out of government insurance plans in the 1980s. It does not, however, fairly describe Canadian doctors' attitudes during the first half of this century, particularly not those of British Columbia doctors during the interwar years, when state health insurance first became a live political issue in Canada.<sup>1</sup>

---

\* The author gratefully acknowledges a travel grant from the E. O. Holland Fund of Washington State University and the research assistance of Bette Meyer, whose work was supported by a Summer Research Grant from Washington State University.

\*\* Department of History, Washington State University.

<sup>1</sup> There was a striking difference in doctors' attitudes toward state health insurance in the United States and Canada during the first half of the twentieth century. For attitudes in the United States, see Odin W. ANDERSON, "Health Insurance in the United States, 1910-1920", *Journal of the History of Medicine and Allied Sciences*, V (1950): 363-96; John

As of 1920 the profession had no firm and consistent position on the question, but by 1925 doctors in the province clearly supported establishment of a provincial health insurance system on the understanding that it would cover much of the treatment they had been providing without pay, and that it would not fundamentally alter the patient-doctor relation, as they believed the panel system introduced in Britain by the National Insurance Act of 1911 to have done. Their support continued until 1936 when the provincial legislature passed a health insurance act which did not meet the doctors' need for higher and more reliable pay: it did not provide for care of the indigent and provided for care of low-income workers and their families from a fund which doctors thought would pay less than such patients themselves. The act was not implemented, and organized medicine soon introduced an insurance scheme of its own, by means of which it could both support demand for its product and win acceptance for the principle that wide availability of health care should not place an economic burden on doctors.

It has been said that it was the Great Depression that caused Canadian doctors to support state health insurance in the 1930s,<sup>2</sup> but this was not the case in British Columbia. It is true that in the early years of the Depression the proportion of non-paying patients in the province increased (to 52 percent in 1933)<sup>3</sup> and hardened doctors' determination to change the assumption that they were willing to provide services free of charge to a substantial proportion of the population. It is also true that in those same years spokesmen for the medical profession began to express willingness to

---

Gordon FREYMAN, "Leadership in American Medicine, a Matter of Personal Responsibility", *New England Journal of Medicine*, CCLXX (1964): 710-20; Roy LUBOVE, *The Struggle for Social Security 1900-1935* (Cambridge, Mass.: Harvard University Press, 1968), ch. 4; Arthur J. VISELPEAR, "Compulsory Health Insurance in California, 1915-18", *Journal of the History of Medicine and Allied Sciences*, XXIV (1969): 151-82; Daniel S. HIRSHFIELD, *The Lost Reform, the Campaign for Compulsory Health Insurance in the United States from 1932 to 1943* (Cambridge, Mass.: Harvard University Press, 1970); Carleton B. CHAPMAN and John M. TALMADGE, "Historical and Political Background of Federal Health Care Legislation", *Law and Contemporary Problems*, XXXV (1970): 334-47; Ronald L. NUMBERS, *Almost Persuaded, American Physicians and Compulsory Health Insurance, 1912-1920* (Baltimore: Johns Hopkins University Press, 1978).

For attitudes in Canada, see H. E. MACDERMOT, "A Short History of Health Insurance in Canada", *Canadian Medical Association Journal*, L (1944): 447-54; Malcolm G. TAYLOR, *The Saskatchewan Hospital Services Plan* (Regina: Saskatchewan Health Service Planning Commission, 1949); Wallace A. WILSON, "Health Insurance — a Flashback", *British Columbia Medical Journal* II (1960): 795-808; E. H. TOLLEFSON, *Bitter Medicine* (Saskatoon: Modern Press, 1964); C. Howard SKILLINGTON, *The Road to Medicare in Canada* (Toronto: Del Graphics, 1972); Robert S. BOTHWELL and John R. ENGLISH, "Pragmatic Physicians: Canadian Medicine and Health Care Insurance 1910-1945", *University of Western Ontario Medical Journal*, XLVII, no. 3 (1976): 14-17; Malcolm G. TAYLOR, *Health Insurance and Canadian Public Policy* (Montreal: McGill-Queen's University Press, 1978).

<sup>2</sup> BOTHWELL and ENGLISH, "Pragmatic Physicians"; Robin F. BADGLEY and Samuel WOLFE, *Doctors' Strike, Medical Care and Conflict in Saskatchewan* (Toronto: Macmillan, 1967), pp. 26, 41; TOLLEFSON, *Bitter Medicine*, p. 13; TAYLOR, *Saskatchewan Hospital Services Plan*, p. 98.

<sup>3</sup> George W. WEIR, "State Health Insurance", Address given to the British Columbia Medical Association, 17 September 1934, p. 5. Copy in the Legislative Library of British Columbia.

abandon to a significant extent economic individualism and to accept a degree of collective control over their professional work. Both these trends complemented and encouraged support for health insurance, but that support first emerged in the relatively prosperous 1920s, not in the depressed 1930s. The course of medical opinion on state health insurance in British Columbia between the wars was not primarily governed by fluctuations in prices and employment, but was rather a reflection and a part of a much broader and longer-term trend in the history of our culture — toward the use of monetary wealth as sole medium of social control, in this case replacing a customary responsibility which had been part of the social definition of “doctor”.

\* \* \*

It is generally accepted that late nineteenth- and early twentieth-century doctors worked without pay for a significant number of patients. The confidential nature of medical practice makes it impossible to provide conclusive proof that such was the case in British Columbia, but available evidence supports that hypothesis. The daybooks of a certain successful Vancouver doctor of the late nineteenth century suggest that he was paid for only 40 to 60 percent of his work. A 1920 editorial in the *Vancouver Daily Province* refers glowingly to doctors' financial sacrifices: “The most generous citizens in other vocations are no more bountiful than the average doctor whose bounty is known only to those who share it”. A 1934 government survey of B.C. doctors showed that 29 percent of their patients in 1929 did not pay for the medical attendance they received.<sup>4</sup>

A related generally accepted hypothesis — that the supply of doctors in the late nineteenth and early twentieth centuries was greater than the demand for their services would dictate — is also supported by available evidence for British Columbia. A ratio of 5 doctors per 10,000 population was asserted to be desirable by Abraham Flexner in his influential report of 1910 on medical education in the United States and Canada; in Vancouver, the ratio varied in the period 1898-1920 between 12 and 18 per 10,000, with a slight tendency to increase over time. The willingness of doctors to attend patients at night and on weekends and to travel considerable distances also attests to the excess of supply over demand, as does the short duration of many Vancouver medical practices (one to three years being by far the most common duration between 1898 and 1920).<sup>5</sup>

The performance of much unpaid work was natural given the poor market position into which doctors' excessive numbers put them, but

---

<sup>4</sup> *Vancouver Daily Province* (hereafter *Province*), 21 June 1920, p. 6; Weir, “State Health Insurance”, p. 5; Margaret W. ANDREWS, “Medical Attendance in Vancouver, 1886-1920”, *BC Studies*, no. 40 (Winter 1978-79): 53.

<sup>5</sup> Abraham FLEXNER, *Medical Education in the United States and Canada* (New York: Carnegie Foundation, 1960, reprint of 1910 edition), p. 14; ANDREWS, “Medical Attendance in Vancouver”, pp. 34, 38, 39, 47.

analysis solely in terms of supply and demand cannot account for the long continuance of this state of affairs; important non-economic mechanisms were at work in the system for distributing health care. Although doctors took their unpaid work into account in setting their fees (so that those who paid were in effect subsidizing those who did not), unpaid work was generally seen as an act of charity on the part of doctors, and the reward of recognition as public benefactors was important in determining doctors' behaviour.

At this time, however, scientific medicine had begun to mature, and public awareness of its capabilities was growing. In the four decades prior to 1920 there was a continually increasing variety of medical products available: new types of surgery, new diagnostic aids, new drugs, new immunizing agents — all of which significantly increased doctors' ability to cure and prevent ill health. Although fear of doctors died slowly, health education programs instituted by public schools and municipal health departments, wartime experience with military health measures, and receipt of medical treatment under workmen's compensation laws all tended to increase consumer acceptance of medical products in the decade before 1920. In British Columbia, the secretary of the provincial Board of Health noted such acceptance as a "lively interest in health questions" during World War I.<sup>6</sup>

Thus, as the twentieth century progressed, doctors' opportunity for paid work increased. Doctors in Vancouver prospered sufficiently between 1898 and 1920 to bear, apparently without raising their fees, the rise in overhead costs implicit in their shift from home to downtown office and from partnership to individual practice.<sup>7</sup> Increased acceptance of the value of medical care is strongly suggested by the increase in admissions to Vancouver's major hospital — from 18 per 1,000 of the city's population in 1904 to 84 per 1,000 in 1920.<sup>8</sup>

As demand for medical services increased, doctors continuing the tradition of extensive unpaid service were giving up income, whereas in the period of significant excess of supply they would at most have been giving up time, and perhaps not even that — free service to needy people being, as we have seen, among the trademarks of the profession. State health insurance offered doctors a way to loosen the rein unpaid work imposed on

<sup>6</sup> BRITISH COLUMBIA, BOARD OF HEALTH, *Annual Report*, 1917, pp. G5-G6; 1918, pp. A5-A6.

<sup>7</sup> ANDREWS, "Medical Attendance in Vancouver", pp. 36-7, 55, note 54. According to the official scale of fees set by the Vancouver Medical Association (first issued in 1898 and revised periodically thereafter), there was up to 1920 virtually no change in fees for home or office visits or in mileage charges for visits outside the city; fees specified for some common procedures were also unchanged over that period — the minimum fee for a normal confinement, for example, remained \$25 until 1922. (VANCOUVER MEDICAL ASSOCIATION, *Constitution, Bylaws and Scale of Fees*, 1910, 1922; British Columbia Medical Association Archives, Frank Turnbull, "Confidential Observations about the Fee-for-Service Method of Payment for Medical Care" [1956], p. 3.)

<sup>8</sup> VANCOUVER GENERAL HOSPITAL, *Annual Report*, 1904, p. 19; 1920, pp. 89, 105; CITY OF VANCOUVER, *Annual Report*, 1922, pp. 68-69.

their expectations without abandoning their responsibility to provide at least minimal treatment according to need.

In British Columbia, many doctors were prepared for practice under a state insurance system by the experience of practice under contract to mining or logging companies or to the Canadian Pacific Railway — an accepted form of practice in which the doctor, the patient, and an agency of fiscal control all participated in deciding on a course of treatment. Similarly, no undue threat to doctors' autonomy was perceived in existing relations with government, which on the one hand required doctors to supply vital statistics, quarantine data, and the like, and on the other supplied doctors with laboratory services, vaccines, compensation for practicing in sparsely populated areas, even direct employment. In particular, doctors perceived the B.C. Workmen's Compensation Act of 1916 as providing them with work and income they would not otherwise have had.<sup>9</sup>

Thus, so long as doctors could expect the measure of government control to be modest, they could contemplate it with equanimity, and could see their acceptance of control as a new altruism replacing the direct financial sacrifice inherent in their traditional provision of unpaid service. In the words of a 1933 editorial in the province's principal medical organ:

The word "charity" has assumed new meanings, and has become a symbol for a form of socialized and deputized giving, a collective generosity — so that personal and individual charity on our part has become an impossibility, without injury to ourselves and inadequacy as regards the recipients. Free medical service, which once represented our gift to society, is now no longer practicable or of real value — and we must express our liberality in other terms, possibly of a more abstract kind — such as willingness to abandon our individualism to a certain extent, to socialize our service largely, to pool our resources for the common good, and to become to a degree servants of a larger body, the state, rather than entirely personal attendants of the individual person or family.<sup>10</sup>

Doctors' attitudes toward health insurance evolved in the 1920s and 1930s largely in response to royal commissions and health insurance legislation initiated by the provincial government and under the aegis of professional medical organizations. Through the editorial policies of their journals, reports of special investigative committees, lectures and discussion series associated with regular business or luncheon meetings, and tours of the province by their leaders, medical associations brought the matter of health insurance to the attention of British Columbia doctors frequently during the period of this study, nearly always encouraging them to see how

---

<sup>9</sup> Harry M. CASSIDY, *Public Health and Welfare Reorganization* (Toronto: Ryerson, 1945), pp. 41-56; John NORRIS, "The Country Doctor in British Columbia: 1887-1975", *BC Studies*, no. 49 (Spring 1981): 17-18; British Columbia Medical Association Archives, Record Book of Dr Wallace Wilson, (Vice-Chairman, Health Insurance Committee [hereafter HIC], British Columbia Medical Council, College of Physicians and Surgeons of British Columbia), "Problems of Health Insurance" (21 December 1936), Schedule XI ("Value of Workmen's Compensation Board Work in B.C."); HIC, "The Income of British Columbia Physicians", p. 1.

<sup>10</sup> *Vancouver Medical Association Bulletin* (hereafter *VMA Bull.*), IX, no. 12 (September 1933): 217.

some scheme could be of benefit to the profession.<sup>11</sup> In fact, since doctors' attitudes toward health insurance were publicly expressed primarily through briefs prepared by local or provincial medical associations and in meetings of cabinet ministers with delegations from those organizations, and since spokesmen for those organizations met the press on behalf of the profession (even preparing a radio script to present their position on health insurance in 1936), there is an important sense in which it is reasonable to identify doctors' attitudes with those expressed by their professional organizations.<sup>12</sup>

B.C. doctors were first obliged to consider the issue of health insurance in November 1919, when the Liberal government of John Oliver responded to public interest in social reform and appointed a royal commission to study compulsory health insurance along with several other social welfare measures.<sup>13</sup> Medical organizations in the province received advance notice of government interest in the question from J. W. McIntosh, an M.L.A. who advocated compulsory health insurance and who was also a doctor. Early in the year, McIntosh urged the Vancouver Medical Association to take a stand; the VMA promptly set up a committee which studied insurance systems in effect in Europe, consulted with other local medical societies, and in due course submitted a brief to the royal commission.<sup>14</sup>

The commission also received briefs from the local medical societies of Victoria and the Fraser Valley and heard testimony from individual doctors as it toured the province. The testimony of the medical profession indicates that doctors were not yet ready to support state health insurance strongly. They feared that health insurance would oblige them to lower their fees and work to government order. Despite that fear the medical testimony as a whole did not reject health insurance outright, but called instead for protection of doctors' interests by building in certain key features of the status quo of medical practice — free choice of doctors by

<sup>11</sup> For example, *VMA Bull.*, I, no. 1 (October 1924): 10; I, no. 7 (April 1925): 15; I, no. 8 (May 1925): 16; IV, no. 8 (May 1928): 250-52; IX, no. 10 (July 1933): 176; XII, no. 8 (May 1936): 169-73; XII, no. 10 (July 1936): 232.

<sup>12</sup> Doctors in British Columbia were said to be following the lead of a group of specialists in Vancouver. Provincial Archives of British Columbia (hereafter PABC), Add. MSS. 3, v. 67 (hereafter Pattullo Corr.), file 8, George M. Weir to T. D. Pattullo, 15 February 1937; unsigned communication to T. D. Pattullo, 12 March 1937. In the summer of 1936 when the health insurance act had been passed but not yet implemented, the Executive Secretary of the British Columbia Medical Association reported that this recent visit up the Coast, to the Bulkley Valley, and the Omineca, Cariboo, and Bridge River areas showed that doctors in the hinterland were "100% behind their elected authority, the B.C. Medical Council and its Health Insurance Committee". *VMA Bull.*, XII, no. 10 (July 1936): 232. The radio script mentioned is HIC, "Health Insurance: the Financial Shortages, the Inadequate Scope, and the Problem of the Indigents".

<sup>13</sup> D. L. MATTERS, "A Report on Health Insurance", *BC Studies*, no. 21 (Spring 1974): 28-32.

<sup>14</sup> PABC, GR 706, box 1, file 5, "Report of the Joint Committee, 'Finance Committee' and 'State Medicine Committee' to the Vancouver Medical Association" (n.d. [prior to 19 November 1919]); British Columbia Medical Library Service, Keith Library (Vancouver) (hereafter MLS), Vancouver Medical Association Minutes, 13 January 1919, 6 October 1919, 20 October 1919, 27 October 1919, 11 November 1919.

patients and payment on the basis of services rendered — and by having health insurance administered non-politically, on the model of Workmen's Compensation. The position of a few doctors was quite radical: the Medical Health Officer of Victoria held that "the proper way of health insurance is for all and that the funds should be raised by a tax on incomes". More typical was the position of the VMA: "Our attitude is not one in opposition, we are opposing nothing that is good, we are looking for evolution..., but we do ask that it be a reasonably safe evolution and not a violent revolution."<sup>15</sup>

The portion of the commission's report dealing with health insurance was submitted in March 1921; it recommended a system of health insurance which was to be compulsory for all wage-earners under 65 who earned \$3,000 or less per year. As benefits to the insured and their dependents, it recommended medical, surgical, dental and hospital treatment, drugs and appliances, and cash payments for time lost due to sickness and for funeral expenses. Insured persons were to have free choice of doctors; doctors were to be paid according to a fixed schedule of fees. Costs were to be paid by the insured wage-earners (40 percent), their employers (40 percent), and the province (20 percent).<sup>16</sup> This proposal had clear material advantages for doctors: it would provide payment for a wide variety of medical services rendered to a large group whose members frequently could not pay for medical care.

No government action was taken on the report during the next few years, purportedly because of uncertainty whether health insurance was constitutionally a federal or provincial matter. By 1928 the federal parliament had determined on the basis of federal justice department advice that health insurance was within the jurisdiction of the provinces, and the Conservative British Columbia government of S. F. Tolmie appointed another royal commission the following year to study the matter. Meanwhile, the provincial Liberal Party had decided to work toward the establishment of a health insurance programme, and even the business-dominated Provincial Party had made a gesture of support for the idea.<sup>17</sup>

During the years between the two royal commissions, although health insurance received only sporadic public attention, doctors in British Columbia made two proposals. In 1924, the health insurance committee of the British Columbia Medical Association (BCMA) considered putting an experimental system into effect in Vancouver and vicinity; costs would be

---

<sup>15</sup> PABC, GR 706, box 1, file 2, (British Columbia, Commission on Health Insurance [1919-1921], Report [dated 18 March 1921]), pp. 72-74; *ibid.*, files 3 and 4 (British Columbia Commission on Health Insurance [1919-1921], Proceedings), especially pp. 411-31, 467-73, 653-74. The quotations given are from the Proceedings, file 3, p. 387 and file 4, p. 662.

<sup>16</sup> PABC, GR 706, box 1, file 2, pp. 107-08.

<sup>17</sup> BRITISH COLUMBIA, LEGISLATIVE ASSEMBLY, *Journals*, LII, p. 127 (4 December 1922); *Province*, 2 February 1929, p. 20; BRITISH COLUMBIA, ROYAL COMMISSION ON STATE HEALTH INSURANCE AND MATERNITY BENEFITS, *Progress Report* (Victoria: King's Printer, 1930), pp. Z5-Z6, Z11-Z12; Margaret A. ORMSBY, *British Columbia: A History* (Vancouver: Macmillan, 1958), p. 429; Martin ROBIN, *The Rush for Spoils* (Toronto: McClelland and Stewart, 1972), p. 201.

borne entirely by the insured, and participation would (necessarily) be purely voluntary. Considering that such a voluntary and unsubsidized system would be merely "a social experiment for people with fair salaries", doctors of the region did not agree in large enough numbers to participate and the proposal was dropped. In 1925 the same committee turned its attention to government schemes. It strongly supported the recommendations of the 1921 royal commission report, with two suggested amendments: lowering the income ceiling for coverage and increasing the employee contribution to 60 percent.<sup>18</sup>

In 1930 the BCMA submitted a brief to the second royal commission in which its support for the recommendations of the first royal commission was reiterated in the form of a concrete proposal for a health insurance act embodying the principles of compulsion, comprehensive benefits, free choice of doctors, payment on a fee-for-service basis, and the sharing of costs among the insured, their employers, and the province. Their proposal was progressive in that it recommended that preventive as well as therapeutic care should be covered, that the insured be assessed a percentage of their wages rather than a fixed amount (a provision which benefited the most poorly paid), and that treatment of the indigent — "those from whom no payment can be collected, as they are either unable to work, or at least to earn a minimum wage" — "should be paid for". It cited for authority the 1916 "Brief for Health Insurance" of the radical American Association for Labor Legislation.<sup>19</sup>

Such progressivism is common in journal articles and editorials written by leading British Columbia doctors in the early years of the Great Depression. For example, R. E. McKechnie, urging the establishment of provincial laboratories to do diagnostic tests much more cheaply than internists in private practice, suggested reasonable fees for those who could pay and free work for those who could not: "The Provincial Government has found it in the public interest to provide free examination for various diseases, tuberculosis, diphtheria, typhoid, venereal diseases, etc. But why limit it to these diseases?"<sup>20</sup> The editorial pronouncements of the *VMA Bulletin* were often progressive, even radically reformist; for example:

We must look at [health insurance] from a new angle, new to us that is. Hitherto our whole conception of medical practice has been along individualistic lines, and for most of us, along therapeutic lines mainly. We must consider sickness and its cure from a community standpoint, and with an emphasis, hitherto unknown, on preventive medicine.<sup>21</sup>

<sup>18</sup> PABC, GR 707, box 1, file 5, exhibit 52, letter from Stan Clark to the members of the Health Insurance Committee of the British Columbia Medical Association, 5 October 1923; MLS, Vancouver Medical Association Minutes, 14 November 1923; "Report of Industrial Sub-Committee on Health Insurance", *VMA Bull.*, I, no. 4 (January 1925): 12-17.

<sup>19</sup> In fact the BCMA presented two briefs; the second, being better developed than the first, is the basis for the discussion here. For the briefs, see "Health Insurance", *VMA Bull.*, VI, no. 9 (June 1930): 197-200; VII, no. 2 (November 1930): 35-43.

<sup>20</sup> R. E. McKECHNIE, "Concerning Specialists", *VMA Bull.*, XI, no. 1 (October 1934): 11.

<sup>21</sup> *VMA Bull.*, VI, no. 9 (June 1930): 185.



When health insurance was first mooted ..., social conditions were entirely different. The vast majority of people were working ... And health insurance, as a remedy for the undoubted evils of our present system of caring for the sick, was ... based on the theory of contribution by all workers to a fund. ... But now an entirely new picture presents itself. ... Unemployment is not only seasonal, nor due to the laziness of the worker. It is due to other conditions of technology, of world trade and tariffs, of international relations. ... "Is Health Insurance an adequate solution?" or must we dig deeper? Is it not possible that we shall have to go more to the root of the matter and try to think out a scheme which will be more elastic, more comprehensive, more suited to *any* rearrangement of the elements in our social compound?<sup>22</sup>

For good or evil the feet of our civilization are set on the path that leads to socialization of every department of life. For ourselves, we are frank to say that we think it is for good.<sup>23</sup>

Massive unemployment during the depression helped harden doctors' reluctance to do unpaid medical work, particularly for patients on relief. Editorials demanding payment for medical attendance of those on relief began to appear in the *VMA Bulletin*, some doctors occasionally refused to attend non-paying patients, and the VMA threatened a mass refusal of attendance on city relief patients.<sup>24</sup> While doctors' incomes were falling<sup>25</sup> and they felt they needed more paying patients, most government agencies expected them to serve more non-paying patients. Their negotiations for payment for medical care of those on relief met with limited success. Doctors in unorganized parts of the province were partially reimbursed by the provincial board of health, and the Vancouver city council made regular grants to the VMA for disbursement to doctors who presented bills for treatment of patients on relief, but doctors in many municipalities (Kelowna and Penticton, for example) had no success whatsoever.<sup>26</sup>

In March 1935 the Liberal government of T. D. Pattullo presented a draft bill on health insurance to the Legislative Assembly. The bill provided much that doctors had been calling for — compulsory participation for breadwinners and their dependents in specified low-income groups, a wide range of benefits, payment for medical treatment of the indigent, patients' free choice of doctors to treat them, opportunity for all doctors to

<sup>22</sup> *VMA Bull.*, X, no. 3 (December 1933): 45.

<sup>23</sup> *VMA Bull.*, X, no. 2 (November 1933): 25.

<sup>24</sup> *VMA Bull.*, VIII, no. 1 (October 1931): 3-4; VIII, no. 5 (February 1932): 81-82; VIII, no. 9 (June 1932): 174; XI, no. 8 (May 1935): 169; XI, no. 11 (August 1935): 236-37.

<sup>25</sup> A survey conducted by the Health Insurance Committee of the British Columbia Medical Council reported that the average net income of physicians of the province declined from \$4,624 in 1929 to \$3,006 in 1933, and net median income from \$3,643 to \$2,460. Although average net income increased to \$3,630 in 1935, and net median income to \$3,019, levels remained lower than in 1929. HIC, "The Income of British Columbia Physicians" ("May 5, 1937" is typed at the top of the page from which these figures have been compiled). Conversion to 1929 dollars suggests a less dramatic decline, but does not alter the observed trend. CANADA, DOMINION BUREAU OF STATISTICS, PRICES BRANCH, *Prices and Prices Indexes 1919-1943* (Ottawa: King's Printer, 1945), p. 58.

<sup>26</sup> *VMA Bull.*, X, no. 4 (January 1934): 73-4; X, no. 7 (April 1934): 124; XI, no. 8 (May 1935): 169; XI, no. 11 (August 1935): 236-37; XIII, no. 2 (November 1936): 35; XIII, no. 8 (May 1937): 162; XV, no. 6 (March 1939): 155. In 1934, Vancouver doctors received about 25 percent of the value of the bills they submitted; in 1937, up to 41 percent.

participate in the scheme, representation of doctors on administrative committees, and payment on the basis of fees for service rendered — but it also placed several important restrictions on the funds it made available for payment to doctors. The indigent were to be covered only after they had been resident in the province for two years, and payment for their treatment then was to be at only half the standard rate under the act. The province's financial contribution was to be limited to the costs of treatment of the indigent plus half of all administrative costs and was further to be limited by an absolute ceiling independent of costs. The contribution of employees and employers — the only other funds available to the system — were to be limited to three and two percent respectively of wages. The providers of services — doctors, for the most part — were to absorb as losses any excess of costs over available funds.<sup>27</sup>

In September 1935 the health insurance committee of the Council of the College of Physicians and Surgeons submitted a statement of the profession's reaction to the bill. The statement was markedly more conservative in tone and substance than the 1930 BCMA brief. It endorsed government health insurance in general and approved most specific points which had by now become familiar planks in the doctors' platform but objected strongly to the points of financial disadvantage to doctors, particularly to half-pay for treatment of the indigent and to the absolute ceiling placed on government contributions to the system. Doctors had reason to believe that the costs of the proposed system were likely to be higher than anticipated, and they believed that the bill failed to consider that implementation of an insurance plan would greatly increase the amount of work doctors would be asked to do.<sup>28</sup> As they saw it, the bill was intended to exploit the tradition of medical philanthropy. "No business man would enter into an agreement to furnish an amount of work for a fixed sum which was questionably adequate for that work with the possibility of being called on for 50% more work without remuneration."<sup>29</sup> In response, the government hearing committee to which the briefs had been presented, citing "the desirability of obtaining the cooperation of the medical profession", recommended a number of changes in the draft, including provisions that the government pay full fees for indigents and that no fixed limit on its financial responsibility be specified.<sup>30</sup>

Although the next health insurance bill (introduced into the legislature in March 1936 after having been modified by a deeply divided Liberal caucus) did not completely ignore the doctors' objections, it did neverthe-

<sup>27</sup> BRITISH COLUMBIA, DEPARTMENT OF THE PROVINCIAL SECRETARY, *A Plan of Health Insurance for British Columbia* (Victoria: King's Printer, 1935).

<sup>28</sup> PABC, GR 391, box 1, file 5, "Public Hearings of the Health Insurance Committee Re 'A Plan of Health Insurance for British Columbia'" (1935), pp. 225, 354-70; HIC, "Amended Report of the Health Insurance Committee of the Council of the College of Physicians and Surgeons of British Columbia" (submitted 24 September 1935); HIC, "The Financial Picture Presented by Health Insurance", part II, pp. 1-2.

<sup>29</sup> HIC, "Amended Report of Health Insurance Committee", p. 11.

<sup>30</sup> BRITISH COLUMBIA, DEPARTMENT OF THE PROVINCIAL SECRETARY, *Report of the Hearings Committee on the Draft Health Insurance Bill for British Columbia* (Victoria: King's Printer, 1935), pp. 6-9. The quotation is from p. 7.

less exacerbate doctors' fears that their incomes would drop if the proposed system was implemented. Particularly disturbing to doctors were its failure to provide any insurance coverage for the province's 100,000 indigents, its reduction of employee and employer contributions to two and one percent respectively of wages, and its restriction of provincial contributions to a maximum of \$50,000. This bill was passed with only minor changes on 31 March 1936.<sup>31</sup>

The health insurance plan authorized by the 1936 act was a greatly watered-down version of those previously proposed by Pattullo's government and the two royal commissions, particularly in the matter of government funding, and doctors were understandably reluctant to cooperate in its implementation. According to either royal commission report, the government would have contributed at least 20 percent of the plan's cost, and the draft bill set government expenditure at a maximum of \$1,200,000; the \$50,000 maximum specified by the act was insignificant in comparison. Through 1936, doctors' resistance was expressed primarily in an exchange between the health insurance committee of the Council of the College of Physicians and Surgeons and the provincial Health Insurance Commission appointed soon after passage of the act and charged with its implementation and subsequent administration. Early in 1937, just weeks before insurance collections from employers and employees were to commence, a working agreement had yet to be reached. The health insurance committee mailed to the 700 or so doctors practicing in the province a ballot with the question "Are you prepared to work the Health Insurance Act as it now stands?" Votes returned were 13 yes, 622 no.<sup>32</sup>

Since the benefits outlined in the act could not be guaranteed without the doctors' cooperation, cabinet ministers and the director of the Health Insurance Commission urged that implementation of the act be postponed. Premier Pattullo concurred, and despite a popular referendum in June 1937 which favoured "a comprehensive plan of health insurance progressively applied" by about a 3 to 2 margin, the postponement proved permanent.<sup>33</sup>

<sup>31</sup> *Province*, 16 January 1936, p. 2; 3 March 1936, p. 2; 6 March 1936, p. 5; 17 March 1936, p. 1; 26 March 1936, p. 9; 1 April 1936, p. 1; HIC, Information from the Committee on Health Insurance of the College of Physicians and Surgeons of British Columbia to College members, 31 January 1936; HIC "Health Insurance: the Financial Shortages; the Inadequate Scope; the Problem of the Indigents". For the act itself, see BRITISH COLUMBIA, *Statutes*, 1936, c. 23. Health Insurance was unacceptable to many Liberal M.L.A.s. See Pattullo Corr., file 6, G. M. Weir to T. D. Pattullo, 6 December 1934; *Province*, 30 March 1936, p. 6; 1 April 1936, p. 1.

<sup>32</sup> *Province*, 27 February 1937, p. 5; WILSON, "Flashback", pp. 800-2. In October 1936, there were 701 doctors in active practice in British Columbia (135 of these were specialists); a further 124 were licensed but not practicing. HIC, "Income of British Columbia Physicians".

<sup>33</sup> Pattullo Corr., file 8, John Hart to T. D. Pattullo, 11 February 1937; *ibid.*, Allan Peebles to A. Wells Gray, 19 February 1937; *Province*, 13 February 1937, p. 5 (Bruce Hutchison's column, "Log of the Capital"); 15 April 1937, p. 6; 4 June 1937, p. 8; 9 October 1937, p. 14; *Vancouver Sun*, 21 May 1937, p. 5; *Canadian Annual Review of Public Affairs, 1937-1938*, pp. 495-96; Donald Kellie BELL, "Health Insurance in British Columbia" (M.A. thesis, University of British Columbia, 1939), pp. 178-79; CASSIDY, *Public Health and Welfare Reorganization*, pp. 91-2.

Although doctors' resistance was the immediate cause for the death of state health insurance in British Columbia, a more fundamental cause was the Liberal government's reluctance to provide a measure which was well funded and offered a wide range of benefits to those designated as appropriate recipients. The succession of government insurance proposals steadily reduced monies available for the scheme and held fewer and fewer attractions for doctors. By 1937 B.C. doctors so distrusted the government that they would not accept Pattullo's assurances that if the plan caused them economic hardship it would be modified. George Weir, Minister of Health and father of the health insurance measure, suggested in February 1937 (when the outcome of the doctors' vote was clear) that certain concessions be made, concessions for which he claimed funds were available. Such a step might well have mollified the doctors, who were negotiating from a position which offered ample room for compromise: the College's health insurance committee had negotiated for arrangements which would have yielded an average net annual income considerably higher than the average net annual income being received by B.C. doctors.<sup>34</sup> But Pattullo was not prepared to make the suggested concessions; health insurance had divided his caucus and outraged both those in the general public who wanted more generous benefits and wider eligibility and those who felt the cost of the plan was inappropriate in a period of economic depression.<sup>35</sup>

Despite their opposition to the act of 1936, British Columbia doctors remained convinced that health insurance could work to their advantage. In 1940 the medical profession in British Columbia capitalized on the attention health insurance had received as a political issue in the preceding few years by inaugurating the Medical Services Association plan, a system of group prepayment for medical services with contributions collected for the plan by employers. The plan, influenced by successful doctor-administered schemes established in Ontario and drawn up by the committee on economics of the Council of the College of Physicians and Surgeons in 1939, embodied principles which the profession had been advocating for fifteen years: organized medicine controlled its operation, the plan was primarily limited to low-income employees, it allowed free choice of par-

<sup>34</sup> Pattullo Corr., file 8, W. B. Farris to T. D. Pattullo, 25 January 1937; T. D. Pattullo to John Hart, 10 February 1937; G. M. Weir to T. D. Pattullo, 15 February 1937; *Province*, 6 February 1937, p. 2. The College's health insurance committee argued that \$8,333 gross income per year was necessary, even though the average gross income for B. C. doctors in 1935 had been \$5,931, because the demand for medical care would at least double under health insurance. HIC, "Unsatisfactory Medical Plans — Costs and Details", p. 2.

<sup>35</sup> H. F. ANGUS, "Health Insurance in British Columbia", *The Canadian Forum*, XVII, no. 195 (April 1937): 12-14; *Province*, 12 March 1936, p. 4; 25 March 1936, p. 4; 31 March 1936, p. 1; 9 February 1937, p. 1; 13 February 1937, p. 5; 2 June 1937, pp. 6, 22; 4 June 1937, p. 8; 9 October 1937, p. 14. Pattullo wrote, "No measure which has a large and militant portion of the public against it can function to the best advantage. Would it not be well, therefore, to postpone the Act and submit the question to a referendum. ... A referendum would place the responsibility definitely on the public as a whole." Pattullo to Hart, 10 February 1937.

ticipating doctors by the insured, and it provided for adequate payment of doctors on a fee-for-service basis.<sup>36</sup>

\* \* \*

The course of medical opinion on state health insurance in British Columbia between the wars is best interpreted as expressing the development of a business-like understanding of medical professionalism, as indicated in the following:

To my mind our most vulnerable weakness as a profession has been our failure to realize that we have emerged, by a process of evolution, from a scientific, philosophic and philanthropic profession into an ultra-scientific business. In our emergence we have failed as an organization to adopt the principles or even learn the rudiments of business, into whose world we have slowly intruded individually.<sup>37</sup>

This passage from the 1938 Vancouver Medical Association Osler Lecture exercises the familiar theme that an unwarranted financial burden was placed on doctors by medical professionalism as generally understood, but recognizes in its choice of tense ("our failure has been") that that understanding was already a thing of the past for many leading doctors when the lecture was given. The progressive idealism characteristic of doctors' discussions of health insurance in the early 1930s is quite absent from the Medical Services Association plan, under which redistribution of wealth among the insured is motivated actuarially, not socially. By 1940, B.C. doctors generally proposed that the indigent be treated by salaried doctors in government clinics.<sup>38</sup> The profession had declared itself no more responsible for the distribution in society of the wealth inherent in medical care than other professionals in business were for the distribution of the wealth inherent in their products.

<sup>36</sup> *VMA Bull.*, XII, no. 10 (July 1936): 230-31; J. A. HANNAH, "Medical Economics", *Canadian Medical Association Journal*, XXXIX (1938): 79-80; MLS, Archive Files, "College of Physicians and Surgeons", "Details of a Scheme to Provide Medical Service by Prepayment", (2 September 1939); [Medical Services Association], *Draft of Proposed Medical Service Plan for Employees in Groups of Ten or More* ([Vancouver?], 1939); Medical Services Association, *Medical Service Plan* (Vancouver, 1940); *VMA Bull.*, XV, no. 12 (September 1939): 342-3; XVII, no. 1 (October 1940): 5, 12, 15; XVII, no. 2 (November 1940): 42. The Legislative Library of British Columbia has copies of both the MSA publications cited.

<sup>37</sup> *VMA Bull.*, XIV, no. 7 (August 1938): 164.

<sup>38</sup> *VMA Bull.*, XV, no. 2 (November 1938): 39; XV, no. 3 (December 1938): 58; D. M. Baillie, "'This Clinic Business': Whither B.C. Medicine?", *VMA Bull.*, XV, no. 7 (April 1939): 21.