The Road Not Taken: The 1945 Health Services Planning Commission Proposals and Physician Remuneration in Saskatchewan

GORDON S. LAWSON

Abstract. This article examines the development of the medical services in Saskatchewan with respect to physician remuneration from 1915 to 1949. In particular, it seeks to determine why the Co-operative Commonwealth Federation government of T. C. Douglas did not follow the recommendations of its Health Services Planning Commission for the establishment of a state salaried medical service based on the province’s salaried municipal doctor system. The validity of the explanations in the established historical accounts of this policy decision is assessed based on empirical evidence. It provides a clearer understanding of how and why fee-for-service payment became entrenched in Saskatchewan Medicare.

Keywords. Medicare, Health Care Reform, Physician Remuneration, Saskatchewan

Résumé. Cet article s’intéresse au développement des services médicaux de la Saskatchewan de, 1915 à 1949, et au peu d’égard accordé à la rémunération des médecins. En particulier, il vise à déterminer pourquoi le Parti social démocratique du Canada (PSDC) de T. C. Douglas n’a pas suivi les recommandations de la commission sur la planification des services de santé pour l’établissement d’un service médical payé par l’État, basé sur le même système de rémunération que celui des médecins municipaux. La validité des preuves historiques qui expliquent cette décision politique repose sur des données empiriques. Ces dernières permettront une meilleure explication à savoir pourquoi et comment les frais de service de paiement sont retranchés du service de santé de la Saskatchewan.

Gordon S. Lawson, DPhil (Oxon), Senior Consultant, Public Works and Government Services Canada.

CBMH/BCHM / Volume 26:2 2009 / p. 395-427
The instrumental role of the Saskatchewan Co-operative Commonwealth Federation (CCF) government of 1944-64 in the development of Canadian Medicare has overshadowed the interpretations of many historians that the universal medical services plan introduced in Saskatchewan in 1962 was not what the CCF had intended when it first came to power in 1944. In his classic study of the Saskatchewan CCF, Seymour Martin Lipset states that the “party leaders originally envisaged a medical system in which all doctors would work on a salaried basis....”1 Frequently based on Lipset’s work, subsequent historical accounts of the establishment of Saskatchewan and Canadian Medicare often cite a Saskatchewan CCF commitment to a salaried medical service.2

The 1962 doctors’ strike has also overshadowed what existing historical accounts of the step-by-step development of Saskatchewan Medicare from 1944-62 indicate was a less dramatic, but equally formative, conflict concerning physician remuneration in 1945. In early 1945 the government’s Health Services Planning Commission (HSPC) devised a medical services plan for rural Saskatchewan that envisaged the expansion and development of the existing municipal doctor system into a salaried general practitioner service. Existing accounts maintain that Premier Thomas Clement (Tommy) Douglas (1904-1986) and his cabinet considered implementing the HSPC proposals despite the opposition of the College of Physicians and Surgeons of Saskatchewan (SCPS), but in negotiations during 1945 Douglas, in C. David Naylor’s words, “gave way” to the medical profession.3

This article seeks to determine why the Douglas government did not follow the HSPC 1945 recommendations for a salaried medical scheme. The significance of this policy decision in the development of Canadian Medicare was recognized by Malcolm G. Taylor:

What if Premier Douglas had acted on the advice of his Health Services Planning Commission to introduce a medical care program, with general practitioners paid by salary.... Had that policy option been implemented, it is obvious that, in some parts of Canada, at least, the design of the delivery system might well have been vastly different.4

Indeed, some scholars assert that the CCF government’s concessions to organized medicine in the mid-1940s led to the entrenchment of fee-for-service (FFS) payment in Canadian Medicare.5 Despite its relevance to contemporary medical reform debates and initiatives,6 this crucial policy decision has been discussed only in passing by historians of Canadian Medicare.
Historians offer three interpretations as to why the CCF did not follow the 1945 HSPC recommendations for the establishment of a salaried medical service in rural Saskatchewan. First, Taylor states that organized medicine’s opposition to salary remuneration and their threat that such a policy would compel doctors to leave Saskatchewan, and deter others from setting up practice in the province, led the Douglas government to reject the HSPC proposals for salaried state medicine. However, Taylor’s account of the Premier’s negotiations with the SCPS on 21 March 1945 suggests that the province’s salaried municipal doctors were not opposed to the HSPC proposals. Taylor intimates that the municipal doctors’ representative on the SCPS negotiating committee, Dr. R. K. Johnston, was not against a salaried scheme:

There was one discordant voice in the College delegation, that of Dr. R. K. Johnston, a municipal doctor. He reported, as chairman of the Municipal Doctor Committee, that in a survey he had conducted, seventy one municipal doctors “were almost 100% for a practise consisting of municipal contract work [salary] and outside practise [fees for major surgery], and that on the whole they favoured the municipal work as it was now operated.” But his voice was lost in the committee committed, as it was, to fee-for-service. (brackets by Taylor)

In view of the extent of salaried medical practice in Saskatchewan in the mid-1940s, one may suggest that if the municipal doctors were not opposed to the HSPC proposals, official SCPS opposition may have been less of a factor in the Douglas government’s rejection of the HSPC’s proposals than is suggested in the established historical accounts, and may even have been surmountable.

A second interpretation is offered by Naylor who maintains that Premier Douglas’ “concern was to implement programs of health services as amicably and rapidly as possible.” Naylor suggests that this factor, coupled with SCPS opposition and its threat that the HSPC plan would both compel doctors to leave and discourage immigration, exacerbating the province’s existing doctor shortage, led to Douglas’ concessions to the SCPS in 1945.

A third interpretation is presented by Lipset who suggests that the people of Saskatchewan did not desire a state salaried medical service. Lipset argued that HSPC proposals were not implemented because (a) the electorate did not understand or demand qualitative changes in medical care, and (b) there was a lack of organized pressure groups that supported qualitative changes. Contrary to Lipset, Naylor’s account suggests that there were pressure groups in Saskatchewan that supported radical reform. Naylor states that the State Hospital and Medical League (SHML) and the Saskatchewan Association of Rural Municipalities (SARM) supported the CCF salary remuneration policy.
was a broad confederation of voluntary and governmental organizations, including homemakers clubs, fraternal societies, church and farm organizations, the Saskatchewan Teachers Federation, co-operative groups, 120 rural municipalities, 6 cities, 24 towns, and 56 villages.12 SARM, in Taylor’s words, was “one of Saskatchewan’s most powerful political forces, representing as it did 302 rural municipalities.”13 These endorsements may suggest that there was significant public support for a salaried medical service in 1940s Saskatchewan.

This article assesses the three interpretations in the established historical accounts based on the available empirical evidence. The analysis begins with an exploration of the municipal doctors’ views towards physician remuneration, and the practicality of developing the municipal doctor system into a state salaried medical service. It is argued that the municipal doctor system was not the embryo of a salaried medical scheme; the majority of province’s salaried municipal doctors engaged in extensive private practice and were opposed to the establishment of a full-time salaried service that would entail the loss of their private practice privileges. The article then proceeds to determine the nature and extent of public support for a salaried service in order to test Lipset’s hypothesis that the Saskatchewan electorate did not support the establishment of such a scheme. It is argued that, contrary to Lipset’s assertion, there was considerable public support for the establishment of state salaried medical service in 1940s Saskatchewan. The CCF party’s health care policy is then examined in order to clarify its commitment to salary remuneration. It is argued that the Saskatchewan CCF, unlike the national party, was never committed to, or an advocate of, the establishment of a state salaried medical service as many historians suggest. The article proceeds to provide an historical account and analysis of the Douglas government’s medical reform initiatives and policy statements prior to the unveiling of the 1945 HSPC proposals. It is argued that the Douglas government had rejected a state salaried medical service long before the HSPC unveiled such a proposal in March 1945. Douglas’ meeting with the SCPS on 21 March 1945 to discuss the 1945 HSPC proposals is then revisited. It is argued that the salaried municipal doctor in the SCPS delegation, Dr. R. K. Johnston, did not express disagreement with SCPS opposition to the establishment of a state salaried medical service; Douglas reiterated his rejection of such a policy and did not consider implementing the HSPC proposals as several scholars suggest. The subsequent departures from the HSPC proposals are then analyzed. The article concludes with an explanation for why the CCF did not follow the HSPC recommendations for the establishment of state salaried medical service.
When the CCF came to power in Saskatchewan in 1944, a substantial number of the province’s doctors were remunerated on a salaried basis. According to a survey undertaken by the Canadian Medical Procurement and Assessment Board (CMPAB) in 1943, of the 408 practicing physicians in Saskatchewan, 130 (31.7%) were on full-time salaries and 65 (15.3%) were on part-time salary. As noted by the CMPAB, “this unusually high proportion of salaried physicians” was “due to the wide-spread adoption in the rural areas of the municipal doctor scheme.” It was through an extension and development of this indigenous medical system that the HSPC envisaged the establishment of a salaried general practitioner service in rural Saskatchewan.

The inability of many rural areas to support a doctor on a FFS basis led to the establishment of Saskatchewan’s salaried municipal doctor system in Saskatchewan between 1914 and 1930. As the system expanded during the 1930s, the scheme was adopted in areas where FFS payment was still viable, including some of the most densely populated and prosperous farm regions in the province. By 1943, the residents of 106 rural municipalities or parts thereof, 65 villages and 8 towns received general medical services, including minor surgery and maternity care, from municipal doctors. These 179 communities had a combined population of 204,788 persons, 22.8% of the 1941 population of 895,992 persons and approximately 32% of the rural population. Nine of the 106 rural municipalities with medical care schemes remunerated physicians on a FFS basis. The remaining 97 agreements with rural municipal councils and all of the 73 contracts with villages and towns paid participating physicians a straight salary for general practitioner services. In 1943, 63 of 179 rural municipalities, villages and towns with municipal medical care plans also provided coverage for major surgical procedures; 29 surgical contracts were on FFS basis. As Naylor notes, many municipal doctors were able to supplement their salaries by performing major surgery on a private FFS basis.

According to the CMPAB survey of 1943, these schemes involved 113 of the province’s 213 rural-based general practitioners. Seventy-three doctors had full-time contracts with one or more rural municipalities. Forty doctors practiced municipal medicine part-time, with contracts with part of a rural municipality, village or town.

At a glance the 1945 HSPC proposals for the establishment of a state salaried medical service appear as a continuation of the status quo for the province’s full-time municipal physicians, with the exception that they would no longer be paid for major surgery on a FFS basis. However, the established historical accounts fail to recognize that the majority of municipal doctors engaged in extensive private practice. This private
practice consisted of both general medical services and major surgery, in addition to the surgical care for their contracting municipality on a private FFS basis. This additional private income, which the municipal doctors referred to as ‘outside practice,’ was derived from two sources. First, municipal doctors were permitted private practice in the villages and towns situated within the geographical boundaries of the contracting rural municipality. Second, municipal physicians both accepted cases from, and engaged in private practice, outside the borders of the contracting municipality.

Clearly some municipal doctors’ earnings consisted almost entirely of their salaries. Municipal physicians surrounded by other doctors on contract and who did not perform major surgery, or did so on salary, appear to have been entirely removed from private practice. However, for many municipal doctors, a substantial part of their income was earned on a private FFS basis, as indicated by a SCPS survey undertaken in 1944.

At the SCPS Annual General Meeting in September 1944, Dr. R. K. Johnston of Eston, Saskatchewan, a salaried municipal doctor, reported that of the 71 physicians who replied to a questionnaire sent to all the municipal doctors, 69 stated that they supplemented their salaries with private practice on a FFS basis. Johnston’s survey also demonstrated that 70 of the 71 doctors would not be content if their incomes were restricted to their present salary. A majority of these same physicians were satisfied with their present income, i.e., municipal contract plus private practice. This suggests that FFS practice was quite substantial. According to an earlier survey conducted by Dr. J. J. Collins of Ituna, Saskatchewan, also a municipal doctor, in 1941 30% of the average municipal doctor’s gross income of $5302 was earned privately. Moreover, the private income of some municipal doctors appears to have exceeded their annual salaries. For example, the rural municipality of Tisdale reported to the 1944 Sigerist Commission that the private earnings of its municipal doctor in 1939 were greater than his $4000 annual salary. Thus the municipal doctor should not be equated to a full-time salaried civil servant as envisaged in a state salaried medical service.

The municipal doctors attached great importance to both their private income and private practice privileges, as evidenced by their efforts in the early 1940s to strengthen and enhance the scheme’s private practice provisions via the introduction of a new “model” contract. Indeed, Dr. Collin’s 1941 survey revealed that a majority of the municipal doctors preferred a “totally fee-for-service system.”

Several surveys undertaken in the late 1930s, 1941, and 1944 indicated that the vast majority of municipal doctors were content with salaried municipal contract practice. For example, Dr. J. J. Collins in the summary of his 1941 survey reported:
The district or municipality being satisfied, our problem is to determine whether our municipal doctors are satisfied. With some qualifications one might say that they are. Such remarks as these are quite clear on this point—"I like the system very much. Have been a Municipal Doctor for three years and am perfectly satisfied with my contract"—"Thoroughly satisfied after twenty-one years in Municipal practice." Others though voicing no great complaint desire some modification to it.32

Municipal physicians were favourable towards and appear to have desired the continuation of the municipal doctor scheme, provided that they were able to retain their private practice privileges. The province’s private practitioners, in contrast, were opposed to the salaried municipal doctor system. As early as 1934, the SCPS declared that municipal contract practice should be reserved for communities where FFS was not viable.33 This position, congruent with Canadian Medical Association (CMA) policy, was forcefully conveyed to the three government inquiries into the health services in 1943-1944, and in turn the Douglas government. Moreover, during the 1930s organised medicine in Saskatchewan sought to have the municipal doctor scheme eliminated through a state-financed maternity care scheme that would have provided doctors in rural Saskatchewan with sufficient income to terminate their municipal doctor contracts;34 and several schemes for province-wide FFS contributory medical insurance designed by the Saskatchewan Medical Association (SMA) Special Committee on Health Insurance (1933) and the Regina District Medical Society (1938).35 The SCPS also successfully lobbied the provincial government to permit FFS remuneration in the municipal doctor system in 1941,36 and to permit the first doctor-controlled medical insurance plan in Saskatchewan—Medical Services Incorporated (MSI) to enter into medical service agreements with municipalities.37

Despite SCPS opposition to the municipal contract practice, municipal doctors continued to express their support for the system. Indeed, an address by R. K. Johnston, Chairman of the Municipal Doctor Committee, to the SCPS Annual General Meeting of September 1943, suggests that many municipal doctors disagreed with CMA/SCPS policy that salaried contract practice should be restricted to areas where FFS payment was not viable:

I have contacted many of the Municipal Doctors to get their views, and without exception, they have told me that they consider Municipal Practice to be the ideal form of practice, patient and Doctor considered.... The Doctor feels free to carry out whatever treatment he may consider best, as only loss of time has to be considered. Eston is one of the most prosperous farming districts in the province; the Municipal doctor scheme was not introduced as a direct relief measure.... Many of you will not agree with what I have said, however, no subject is well dealt with until it has been well discussed.38
In terms of a province-wide medical services scheme, in the early 1940s, many municipal doctors and rural-based private practitioners believed that contributory health insurance on a FFS basis, as advocated by the SCPS, was not viable in many areas of rural Saskatchewan. In this context, many municipal doctors wanted to be able to continue to work on a combined salary and FFS basis within a provincial health insurance scheme. They did not, however, support the establishment of a state salaried medical service, as R. K. Johnston’s 1943 address indicates:

I have been asked to speak on behalf of the municipal doctors. The Municipal Doctor Plan is now working so satisfactorily in 105 [rural] municipalities in Saskatchewan, and yearly new areas are adopting this form of medical services, so I feel that Health Insurance can be worked equally satisfactorily for both health services. At present municipal contracts allow Doctors to engage in outside practice. I would not concur in any plan of Health Insurance which would take away the element of competition or limit the Doctor in the scope of his practice....

These sentiments appear to have been representative of the province’s municipal physicians. In a summary of the comments received from the 71 municipal doctors who responded to R. K. Johnston’s 1944 “questionnaire re Health Insurance,” Johnston reported that “Municipal Doctors are not in favour of [salaried] State Medicine” and “although fairly well satisfied with this form of practice [municipal contract plus private practice] preferred FFS remuneration by 60 to 11. A survey conducted in early 1944 by the SCPS’ Central Health Insurance Committee, charged with devising a definitive SCPS remuneration policy, also revealed that the majority of municipal doctors preferred FFS payment.

While the municipal doctor system did not include a majority of doctors favourable to a state salaried medical service, it did, however, facilitate public support for such a delivery system. The municipal doctor scheme was very popular in Saskatchewan. As Premier Douglas observed in early 1945: “no municipality, once having adopted the system has given it up of its own accord.” The establishment of a salaried medical service based on the province’s existing municipal doctor system was not viewed as “radical,” let alone a departure from the development of medical services in Saskatchewan as the debate on medical reform in 1940s Saskatchewan reveals.

THE POLITICS OF MEDICAL CARE REFORM IN 1940S SASKATCHEWAN: “HEALTH INSURANCE” VERSUS “STATE MEDICINE”

In 1940s Saskatchewan there was an understanding among the medical profession, politicians, the press and many lay organizations interested in health care reform that the establishment of a universal medical service scheme in the province entailed a choice between the following two
distinct medical services schemes, as articulated by the bipartisan Saskatchewan Legislature Select Special Committee on Social Security and Health Services (1943-44):

1) “health insurance,” with costs met from a fund created by personal contributions and state subsidy, the doctors paid by fee-for-service, capitation or by salary. 
2) “state medicine,” a non-contributory system financed entirely by taxation from general government revenues, in which members of the medical profession would become salaried civil servants.44

Both contributory health insurance and salaried state medicine had their advocates and detractors who sought to influence government policy and public opinion as to which of the two schemes should be implemented in Saskatchewan.

From the outset of the 1930s, the leadership of organized medicine in Saskatchewan was opposed to “state medicine,” as an address by the President of the SMA in 1931 illustrates:

Unless we can meet the problem we demand to have solved there is no doubt a solution will be found in the nature of state medicine....We owe to our profession and to ourselves the duty of finding a substitute that will be just as universal in its application and that will be just as effective but at more reasonable costs and more in line with the traditions of our profession.45

Accordingly, in 1933 the SMA endorsed and sought public and state support for contributory health insurance on a FFS basis in order to entrench “existing practice patterns instead of ‘state medicine.’”46

The popular movement for salaried “state medicine” in Saskatchewan was led by the Regina-based State Hospital and Medical League (SHML), which had been established on 24 April 1936. Convinced that the Liberal Government of Jimmy Gardner lacked the will to fulfil its 1934 provincial election promise to inaugurate a provincial medical care program, Alderman C. L. Dent of Prince Albert brought together the multitude of individual farm, labour, and governmental organizations interested in “socialized medicine or state control of health” into a “common front” to devise, implement, and promote the establishment of a provincial medical and hospital scheme.47

As part of an on-going initiative to direct the movement for a provincial medical services plan towards a scheme congruent with the interests of organized medicine, the Chairman of the SMA Health Insurance Committee, Dr. S. E. Moore, attended SHML meetings to “provide guidance” to this organization.48 Dr. Moore was in turn elected President of the SHML at its first annual convention on 15 October 1936.49 However, the League’s membership eventually rejected a FFS contributory health insurance plan devised by Dr. Moore, who was subsequently replaced as
President by Dr. W. H. Setka, a Prince Albert-based general practitioner who supported salary remuneration.\(^{50}\)

At the SHML’s fifth annual convention in October 1940, delegates endorsed the League’s “Eight Point Plan of State Medicine for Saskatchewan,” which envisaged a system of group practice clinics staffed by full-time salaried personnel.\(^{51}\) Despite the SCPS’ vocal criticism of the League’s proposals, the League continued to expand its membership and to acquire support for its medical scheme.\(^{52}\) At the League’s annual convention in October 1942, the executive declared that 296 organizations had affiliated with the League during 1942, an increase of 100 affiliations over the previous year. And by early 1943 each of the League’s proposed health care districts had an executive committee to administer the plan. It was in this context that the SCPS launched a comprehensive “education campaign,” consisting of newspaper and radio advertisements, to inform the public of the perceived “advantages of Health Insurance on the one hand, and the dangers of State Medicine on the other.”\(^{53}\)

The SHML responded with its own radio campaign, consisting of a series of addresses delivered by the League’s executive and senior officials of its affiliated organizations such as the Saskatchewan Wheat Pool, United Farmers of Canada, Saskatchewan Section (UFCSS), and the Saskatchewan Teachers Federation.\(^{54}\) The province’s existing forms of salaried medical practice were cited in defence of the League’s proposals:

The League advocates the clinic system of medical care with doctors, dentists, and specialists on straight salary. Is this undemocratic? We are told that by putting doctors on salaries all personal initiative will be destroyed that there will be no choice of doctor. Yet we all know of the excellent progress that has been made in this province in the control of tuberculosis by men who are on salary. Many of us have experiences with the excellent medical care provided by municipal doctors, by salaried medical health officers.\(^{55}\)

These opposing public relations initiatives corresponded with the first of three provincial government-appointed inquiries into the health services and postwar reconstruction in Saskatchewan in 1943-44:

1. Select Special Committee on Social Security and Health Services (1943-44)
2. Saskatchewan Reconstruction Council (1943-44)
3. Health Services Survey Commission (1944)

The bi-partisan Select Special Committee in its Final Report of 31 March 1944, observing that federal monies would be required and that Ottawa had opted for a contributory format, declared that its decision between state medicine and contributory health insurance had been “determined for it” and, thus, “it became no part of their task to state a preference for State Medicine or Health Insurance.”\(^{56}\) The Committee recommended
that the Legislative Assembly “endorse the principle of health insurance for all the people of Saskatchewan,” and set up a commission to administer the anticipated federal scheme. The latest draft of the proposed federal contributory Health Insurance Act at the time, left the contentious area of physician remuneration, whether FFS, capitation or salary, to the provinces to decide. Yet the Final Report of the Committee did not discuss, let alone make a recommendation concerning physician remuneration. It is significant in the context of the alleged Saskatchewan CCF commitment to a salaried medical service that the Committee’s CCF members did not express opposition to FFS during the proceedings, let alone submit a minority report recommending salaried physicians.

The Saskatchewan Reconstruction Council (SRC) acknowledged the “strong representations [that] were made with respect to state medicine,” but concluded “after due consideration” that a recommendation for the establishment of state medicine “as opposed to the [proposed Federal] Plan for health insurance would not be warranted.” The factors cited in reaching this conclusion were (1) the province could not finance a complete system of state medicine; (2) it appeared that federal assistance was contingent upon the acceptance of the Dominion proposals; (3) the “lack of administrative experience in this field...necessary for success”; and (4) the “very strong professional opposition to state medicine.” The SRC recommended that doctors be paid on a FFS basis with the exception of areas where this would result in a shortage of doctors.

The Commissioner of the Health Services Survey Commission (HSSC), Dr. Henry E. Sigerist (1891-1957) of Johns Hopkins University, submitted his report to the Douglas government on 4 October 1944. As we shall see, by this juncture Douglas had announced his intent to develop a provincial medical service from existing services and implicitly rejected the notion that this entailed a choice between salaried “state medicine” and “health insurance.” Sigerist wrote his report from this perspective and unlike the two previous government-appointed inquiries, did not discuss the merits and choose between “state medicine” and “contributory health insurance.” For the cities, he recommended “a system of compulsory health insurance, the details of which would have to be worked out.” In rural Saskatchewan, the municipal doctor system should be extended. He made no recommendation in terms of financing, i.e., general revenues or direct taxation/premiums. As noted below, Sigerist endorsed salary remuneration, but he did not call for the medical profession to be placed on salary.

The three inquiries conducted broad surveys of public opinion in Saskatchewan with respect to medical care policy. Notwithstanding the findings of the Select Special Committee, which observed a “preponderance of opinion favoured contributory Health Insurance as against
State Medicine,” these inquiries suggest that there was significant support for a state salaried medical service.\textsuperscript{63} For example, an equal number of organizations conveyed their support for “state medicine” and “health insurance” in their submissions to the HSSC. Of the three inquiries, the HSSC received the most submissions.\textsuperscript{64}

In addition to the SHML, salaried state medicine was strongly supported by the two agriculture organizations that appeared before the HSSC—the UFCSS and the Saskatchewan Federation of Agriculture (SFA), “representing the organized Producers and the Consumers’ Cooperatives”; the Regina, Saskatoon and Moose Jaw & District Labour Councils; the Prince Albert co-operative medical services clinic, the Saskatchewan Old Age Pensioner’s Association and several rural municipalities.\textsuperscript{65} The majority of these organizations indicated their support for the SHML “Eight Point Plan for State Medicine.”

The endorsement of salaried state medicine by the UFCSS and the SFA challenges the validity of Lipset’s assertion that the “farmers supported “state” medicine but to them the term meant state payment of medical care ... [and not a state salaried medical service].”\textsuperscript{66} The SFA, for example, noted in its brief to the HSSC that it supported the Canadian Federation of Agriculture’s state medicine principles “which would eliminate the fee-for-service system.”\textsuperscript{67}

With respect to physician remuneration among the supporters of health insurance,\textsuperscript{68} the three medical insurance co-operatives in Regina, Saskatoon and Melfort, like the SHML, claimed that the FFS method was not conducive to preventive medicine and demanded that doctors work on a salary or capitation basis.\textsuperscript{69} In its brief to the HSSC, the SCPS took exception with these claims: “The College deplores such statements as ‘the Medical Profession is not concerned with preventive care,’ and that ‘Fee For Service Cannot Support Preventive Health Services.’”\textsuperscript{70} The three railway union locals recommended FFS payment—the only lay organization to do so in all three public inquiries.\textsuperscript{71} The remaining supporters of health insurance, including SARM, and the representations with no stated preference for either “health insurance” or “state medicine,” did not indicate a position on physician remuneration. This indifference may suggest that many were unconcerned as to how physicians were remunerated.

SARM does not appear to have had an official physician remuneration policy, let alone to have supported the establishment of a state salaried medical service as suggested by Naylor. Indeed, an account of a SCPS-SARM meeting in 1944 in which the SARM Executive was reportedly “willing to stand for fair returns for services rendered,”\textsuperscript{72} suggests that it was agreeable to FFS payment. However, as we shall see, Douglas’ future senior health advisor would report in 1947 that there was strong support for salaried state medicine among the SARM Executive.
While the majority of people who voted for the CCF were probably indifferent as to how physicians were paid in a provincial medical care scheme, many of the party’s principal and active constituencies of support, such as the organized farming movement, labour, and the teaching profession favoured the introduction of a salaried medical service. In addition, there was the SHML and its broad and active membership that was, as stated in its brief to the HSSC, “prepared to go to the limits side by side with any government having courage and conviction that these ideals [e.g., a salaried service] can be attained.” Thus, contrary to Lipset’s assertions, there appears to have been significant support and even formidable allies for the establishment of a state-salaried medical service in Saskatchewan in the mid-1940s. Yet this support did not lead to a CCF commitment to such a scheme as suggested by many scholars.

SASKATCHEWAN CCF HEALTH CARE POLICY: SALARY OR FEE-FOR-SERVICE?

The Handbook to the Saskatchewan CCF Platform and Policy (1937) is the earliest document cited by scholars in support of their assertion that the Saskatchewan CCF originally envisaged a provincial medical services plan in which all physicians would work on a salaried basis. This document seems to have been written by Dr. Hugh MacLean (1871-1958), a Regina-based surgeon, and Vice-President of the Saskatchewan CCF until his departure to California in 1938 for health reasons. It would appear to be a verbatim excerpt from a text MacLean delivered as a radio address on 17 March 1937, in the capacity of Vice-President of the Saskatchewan CCF, and as a speech to the annual convention of the Women’s Farm Organization on 2 June 1937, in Saskatoon. Lipset presents an extensive quotation from the 1937 Handbook in Agrarian Socialism to substantiate his claim that the CCF envisaged a salaried medical service in which “the emphasis would be changed from curative to preventative measures” and doctors “paid to keep people well rather than to treat their ailments.” Stan Rands provides a similar interpretation of the 1937 Handbook. However, MacLean does not infer that the medical profession did not practice preventative medicine because they are remunerated on a FFS basis rather than salary, but because the majority of citizens could not afford, and only sought medical treatment when an illness or condition had passed beyond its preventable and curable stage:

In our present system of practice, preventative medicine is largely neglected because the members of the [medical] profession are almost wholly engaged in the curative end of practice, so that preventable deaths are not being prevented and correctable conditions are not being corrected because the people are not in a financial condition to have their condition discovered. (This excerpt from MacLean’s text is quoted in Agrarian Socialism with the crucial exception of the
clause “because the people are not in a financial condition to have their condition discovered.”

Nowhere in Lipset’s excerpt from the 1937 CCF Health Plank or in MacLean’s communications is there a declaration that a CCF government would place doctors on salary. Subsequent policy papers and statements issued by the Saskatchewan CCF leading up to and during the 1944 provincial election campaign, unlike those of the National and Ontario CCF in 1943, did not declare that a CCF government would establish a salaried medical service; nor do the resolutions pertaining to health services policy passed at the party’s annual conventions.

Prior to the 1944 provincial election, the CCF health care policy was set forth in the *CCF Program for Saskatchewan* (November 1943; reprinted April 1944); a pamphlet “Let There Be No Blackout of Health” and a newspaper advertisement “The CCF Plans Health.” In these communications the party promised to set up a complete system of “socialized medicine with a special emphasis on preventative medicine so that every resident of Saskatchewan will receive adequate medical, surgical, dental, nursing, and hospital service without charge.” At this juncture, “socialized medicine” was used as a generic term for a medical services plan provided on a universal basis. For example, the introduction to the first edition (December 43) of the SCPS’ “Bulletin” states that the object of this new communication is: “to keep the medical profession in Saskatchewan in touch with the development and turn in events dealing with socialized medicine, be it in the form of ‘Health Insurance,’ or ‘State Medicine.’” None of the CCF policy papers, nor summaries of the CCF health policy in Saskatchewan newspapers, suggest that the CCF, or the Saskatchewan public, understood their pledge to implement “socialized medicine” as a commitment to salaried physicians.

In fact, none of the above mentioned CCF policy statements indicate a position on health financing or physician remuneration. The health care policy resolutions passed at Saskatchewan CCF annual conventions are similarly vague, with the exception of the 1943 CCF convention “resolution on social services” which states that “provincial and federal government contributions to cover all costs should be made out of the Consolidated Revenue funds.” In terms of physician remuneration, however, the resolution merely states that: “all payments for professional services rendered should be made on the basis of a mutually acceptable contract for services.” This resolution lends support to the assertion of McLeod and McLeod that the Douglas-Fines Executive decided in 1943 that a provincial medical services plan should be financed with “general government revenues,” but “the question of whether doctors should work on salary or receive a fee for each service provided was left open.”
Nevertheless, several aspects of CCF health care policy and its members’ health care activism, may have suggested to some observers that the party supported a state salaried medical service. First, those organisations which conveyed their support for scheme financed entirely from general government revenues to the three government-appointed enquiries were without exception in favour of a salaried service. Second, the party criticized “health insurance” along the same lines as the advocates of salaried state medicine, such as the SHML and UFCSS. Third, some party members, including one executive member, were active in the SHML. The Vice-President of the party, P. G. Makaroff, was on the SHML executive and an outspoken advocate of salary remuneration. And the Saskatoon CCF constituency informed the Sigerist Commission that it endorsed the SHML Eight Point Plan for State Medicine. However, the “CCF Program for Saskatchewan” stated categorically that the party did not support the SHML plan.

Following the 1944 election victory, Dr. Hugh MacLean, Premier Douglas’ external health policy advisor during his tenure as Minister of Public Health (1944-49), delivered an address on health services to the Saskatchewan CCF convention on 13 July 1944. His speech was considered by the Canadian press and many observers to be the new government’s health care policy. Jacalyn Duffin contends that MacLean’s address was the blueprint for Sigerist’s Report and the subsequent development of health services in Saskatchewan. MacLean’s address suggested a personal preference for salaried medical schemes; however, he stated that either FFS or salary could be used in a provincial plan. Moreover, whatever the choice: “No scheme can or should be put into operation without asking for the cooperation of the medical profession.” MacLean’s call for co-operation appears to have guided Douglas’ negotiations for a medical services scheme for social assistance beneficiaries in August 1944—the CCF government’s first step towards the development of Saskatchewan Medicare.

SOCIAL ASSISTANCE HEALTH SERVICES PLAN

According to Taylor’s account of the negotiations between Douglas and the SCPS on 23 August 1944, based on correspondence with Dr. C. J. Houston, “differences in their ideological approaches” emerged. But “despite their differences in philosophy ... the basic understandings on the operation and the costs of the social assistance medical care program were agreed upon.” Doctors’ payments would be made on a prorated FFS basis from a pooled sum representing $9.50 per capita as part of the so-called Old Age Pensioners Agreement. On 1 January 1945 approximately 25,000 pensioners and other social assistance beneficiaries were eligible for free hospital and medical services.
While FFS payment was insisted on by the SCPS, Houston’s account of the negotiations does not suggest that Douglas sought to secure alternative payment methods.94 According to Houston’s correspondence with Taylor, at the meetings of 23 August 1944, Douglas informed the SCPS that he wished to provide medical services to old age pensioners and other wards of the state and “asked for suggestions, about methods costs etc.”95 In Houston’s recollection “there was no pre-selected position defended by either side.”96

These negotiations and their outcome may have been an early indication that the Douglas government’s chief aim was the provision of state-funded medical services as rapidly as possible; and in this context, the method of payment for medical services was negotiable. Owing to SCPS opposition to capitation and salary remuneration, for the government to insist upon alternative payment methods, would have undoubtedly delayed the introduction of medical services under a state-controlled plan. An inflexible position on physician remuneration would have led to protracted negotiations with SCPS or the even more difficult option of attempting to directly force the medical profession into a salaried service. Neither of these scenarios was agreeable to the Douglas government. As McLeod and McLeod state: “to the distress of his socialist supporters, Douglas declined to force the doctors on to a salary system in the mid-1940’s because he wanted to get his health program for the poor off to a quick start.”97 This first agreement between the CCF government and the SCPS was the first official manifestation that the Douglas government was committed to a policy of co-operation with the medical profession; it is also supportive evidence for Naylor’s interpretation that the 1945 HSPC proposals for state salaried medical service were not implemented because Premier Douglas’ primary objective was to implement health services programs as quickly and amicably as possible.

The Douglas government’s acceptance of FFS payment in the Social Assistance Health Service Plan was one of several policy decisions in the mid-1940s which facilitated the entrenchment of FFS remuneration in Saskatchewan Medicare. This was recognized by the SCPS as reflected in a memo by Dr. B. C. Leech (Chairman of the College’s Medical Committee responsible for administering medical service payments to participating physicians):

The organized profession has undertaken through the O.A.P.[Old Age Pensioners] scheme to prove conclusively that a fee for service basis of payment for medical care can operate and be adequate for beneficiaries and fair and satisfactory to both government(or contracting party) and all members of the profession who take part.98
The appointment of an expert on the Soviet health care system and a staunch advocate of salary remuneration, Dr. Henry E. Sigerist, to lead an inquiry into the health services in Saskatchewan in the autumn of 1944, may have raised suspicions among the SCPS, and expectations among the supporters of “state medicine,” that the new CCF government was planning to introduce a state salaried medical service. In an interview, published in the *Regina Leader Post*, 7 September 1944, Sigerist enthusiastically explained the Soviet medical care system of health centres staffed by salaried doctors. However, on the first day of Sigerist’s tour of the province, Douglas dismissed suggestions that his government intended to place doctors on salary, the first of several such statements during the survey. In a similar statement at the SCPS annual General Meeting in September 1944, Douglas declared that his objective was to provide all citizens with medical care “on whatever basis the government could get possible co-operation with the medical profession.” In terms of physician remuneration, Sigerist’s report of 4 October 1944 simply states that “there can be no doubt that in the future more and more medical personnel will be employed on a salaried basis.” He thus endorsed salary remuneration, but did not recommend placing private practitioners on salary or the termination of the FFS municipal doctor contracts. Nor did he advise that salaried municipal doctors be denied private practice privileges. Yet the Douglas government’s Health Service Planning Commission (HSPC) would recommend just such a policy.

**THE REJECTION OF THE 1945 HSPC SALARIED MEDICAL SERVICE PROPOSALS**

As recommended by Sigerist, the HSPC was appointed in November 1944 to implement the government’s reform agenda. The Commission’s initial members had served on the Sigerist Commission: Dr. M. del Cherniak Sheps (1913-1973), general practitioner; Thomas H. McLeod, economic advisor to the government, and C. C. Gibson, hospital administrator. Dr. C. F. W. Hammes, Deputy Minister of Health, was a member *ex officio*. Dr. M. Sheps, who had served as secretary to the Sigerist Commission, had been appointed as Douglas’ assistant shortly after the CCF victory in 1944 to ensure that the new government had personnel who were sympathetic to its health reform objectives. She chaired and was a member of both the Manitoba and National CCF research committees on health. Dr. M. Sheps and her husband Dr. Cecil G. Sheps, Director of Venereal Disease Control for the Canadian army in Alberta before he became acting HSPC Chairman in March
1946, were staunch socialists from Winnipeg’s North End with family members among the upper echelons of the Manitoba CCF. It was Dr. M. Sheps in particular, as HSPC secretary, who urged the Douglas government to establish a salaried service.

On 2 March 1945 the HSPC unveiled its rural health care proposals to its Advisory Committee, comprising representatives of the SCPS, agriculture, trade unions, SARM, and lay organizations interested in health care reform, e.g. the SHML. The HSPC proposed the division of the province into health regions that would, as personnel, equipment and facilities became available, provide a comprehensive medical and hospital service. It was recommended that a complete service be established in one of the regions in the near future as an experiment. The “general practitioner service should be a salaried service,” built upon the existing municipal doctor system. Accordingly, the HSPC’s proposed municipal doctor contract prohibited private practice. Doctors would work in group practice settings in health centres and provided with pensions, paid holidays and leave for post-graduate study. To enable communities to hire doctors on salary, equalization grants would be provided to poorer and less populous municipalities. Flat grants were recommended to “induce the more prosperous rural municipalities to enter the scheme.” It was through these grant-in-aids that the HSPC hoped to develop the municipal doctor system into a province-wide, salaried medical service.

These proposals, which were very similar to the SHML plan, were endorsed by all the members of the HSPC Advisory Committee except the SCPS delegates who “vigorously protested a vote being taken on the acceptability of the plan.” The SCPS subsequently obtained a meeting with Premier Douglas to discuss the HSPC proposals on 21 March 1945. At the outset of the meeting, Douglas was presented with a resolution stating the SCPS’ opposition to “an exclusively salaried service” and their support for “state-aided health insurance on a fee-for-service basis.” While in favour of subsidizing physicians in poor and sparsely settled areas, the doctors were opposed to grants which could be used “as a means of coercion to force a salaried system of medicine in rural areas.” Moreover, R. K. Johnston, the municipal doctors’ representative in the SCPS delegation, protested the HSPC’s proposed straight salary contract that would deny municipal doctors private practice privileges. Johnston cited his 1944 survey indicating that the municipal doctors favoured a practice consisting of “municipal contract” and “outside practice,” [private practice] which, as noted above, did not consist exclusively of FFS payment for major surgery as Taylor and Naylor suggest; the municipal doctor’s extensive private practice consisted of both general medical and surgical services to patients from within and outside the boundaries of the contracting municipality.
Hence Johnston did not inform Douglas that the municipal doctors were in favour of straight salary remuneration with the exception of major surgery on a FFS basis as Taylor infers. C. Stuart Houston’s assessment that the HSPC proposals “at once alienated the salaried municipal doctors, for it would deny them any right to private practice or to attend any one from beyond a rigid area boundary,” is a more accurate interpretation. Johnston clearly was not a “discordant voice” in the SCPS delegation as Taylor claims.

In response to the doctors’ objections, Douglas reiterated that the method by which medical service would be provided to all residents as rapidly as possible was not important. He stated categorically that his government was not committed to a salaried medical service. The government’s policy was to provide state-aided health insurance in the cities and municipal doctor scheme in the rural areas this would “still leave a very large place for private practice.” Moreover, he was willing to subsidize both FFS and salaried municipal doctor plans. Douglas “assured” the doctors that a “new plan could be worked out” that conformed with the SCPS “principles” on health insurance which included a tenet that salary contract be restricted to areas where FFS was impractical. To this end, the Premier proposed that the SCPS representatives form a subcommittee of the HSPC to “obtain the necessary revisions.”

Thus the Premier’s rejection of the HSPC recommendations for a salaried service and his so-called “capitulation” to the SCPS was immediate and not during a series of subsequent negotiations in 1945 as existing scholarship suggests. Indeed, there is no documentary evidence to suggest that after Douglas’ meeting with the SCPS on 21 March 1945, he and his Cabinet “weighed the situation and assessed the opposition of the College,” and then rejected the HSPC recommendations for a salaried service as Taylor maintains. The departures from the 1945 HSPC proposals naturally followed, without any apparent resistance by the Douglas government.

First, on 14 April 1945 the HSPC and SCPS officials devised a draft agreement on the administration of a provincial medical services plan incorporating SCPS health insurance “principles” that, if followed, would preclude the establishment of a salaried service. This text formed the basis of Premier Douglas’ widely quoted letter of 19 September 1945. Second, the HSPC proposed straight salary municipal doctor contract was not introduced; a new salary model contract that permitted private practice was devised on 22 April 1945. Third, FFS plans were eligible for the government’s medical care grant scheme introduced on 1 July 1945. Fourth, in July 1946 a FFS medical care plan was inaugurated in the Swift Current Health Region.
The latter departure was the result of local decision making rather than a provincial government initiative. The prerogative to establish health regions and the particular organization of medical services, including remuneration, resided with local health boards. Yet this policy unintentionally facilitated this departure because the first area to petition the Douglas government to be declared a health region was the least conducive to the establishment of a salaried service. Unlike other areas of the province where FFS plans were the exception rather than the rule, all five municipal doctor plans in the Swift Current area in 1945 were FFS schemes. And the senior executives of the Swift Current Health Board and W. J. Burak, who mobilized support for the regional medical and hospital services plan, were from these same municipalities. Thus the Swift Current Health Care Board did not object when local physicians demanded FFS payment.

This departure from the 1945 HSPC proposals for a salaried service was also facilitated by the policy to subsidize FFS municipal medical care plans. The Swift Current Medical Care Plan received a subsidy equal to the grants the individual municipalities in the health region were entitled to for financing municipal doctor schemes, approximately 10% of the plan’s operating budget. This medical care plan established a critical precedent with respect to physician remuneration. The government referred to the Swift Current plan as its “experimental health insurance scheme to determine the costs for a provincial-wide program.” When the provincial government tried, unsuccessfully, to encourage the establishment of regional medical services plans in the mid-1950s, the Swift Current FFS plan was proposed. However, in 1946 the predominance of FFS in Saskatchewan was far from certain.

First, in April 1946 the Saskatoon Mutual Medical and Hospital Benefit Society, a medical insurance co-operative with 16,000 members, announced a million-dollar plan to build a clinic with a staff of 40 salaried doctors and satellite operations in North Battleford and 10 additional rural centres. To pre-empt the co-operative’s plans, which a 1951 SCPS report later maintained “threatened to completely jeopardize the future of prepaid medical care in the province and the welfare of the profession in general,” Saskatoon doctors established Medical Services, Inc. (Saskatoon). In the interim, the co-operative cancelled its plans for a group-practice clinic owing to the proposed establishment of a similar facility as part of the medical school at the University of Saskatchewan.

Second, there remained the predominantly salaried municipal doctor system and the government’s grant-in-aid scheme for its expansion. Although there was only a modest extension of the system to the relief of
SCPS officials, the vast majority of municipalities continued to hire doctors on salary. In order to prevent the spread of these salaried medical care plans, MSI (Saskatoon) and Group Medical Services (Regina) expanded into rural Saskatchewan.

Third, the Swift Current Medical Care Program did not preclude the establishment of a salaried service in other health regions. Other areas might reject FFS, especially after the costs of the Swift Current plan greatly exceeded its annual budget. At a SCPS meeting on 6 September 1947, it was reported that SARM believed that the cost-overruns of the Swift Current scheme proved that salary contracts offered better expenditure control. Moreover, SARM members were reluctant to accept FFS contracts for fear of being “dragged into a health region.” Based on a meeting with the SARM executive 23 October 1947, the new HSPC Chairman Dr. Frederick Dodge Mott (1904-1981) reported that:

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

SARM also agreed with the HSPC that the salaried municipal doctor schemes should be strengthened so that they would not be “eliminated and replaced by more expensive fee-for-service plans.”

In the Swift Current Region itself, FFS payment was far from secure. At a meeting held on 10 December 1947 to discuss expenditure ceilings for regional, municipal, and provincial FFS plans, with Douglas, the HSPC, and the SARM medical care committee in attendance, the Chairman and Secretary-Treasurer of the Swift Current Health Region Board announced that:

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

In this context, participating physicians in the Swift Current medical care programme agreed to a budget ceiling for 1948. Furthermore, the Swift Current plan was an “experiment.” The Douglas government could return to the principles of the 1945 HSPC proposals. However, it would appear that the provincial government had no intention of utilizing the municipal doctor system to establish a salaried service.

At a HSPC Advisory Committee meeting in May 1947, Dr. Mott indicated that the establishment of regional medical care schemes would entail the discontinuation of municipal doctor plans; in order to retain doctors in the outlying areas of the health regions, it might be necessary to provide a special supplement to those doctors who otherwise would
be unable to earn an adequate income under a FFS plan. Mott subsequently ignored a suggestion by T. H. Thain, a trade union representative, that all doctors be placed on salary. At a Trades and Labour Congress meeting, Thain stated that the Douglas government “didn’t have the guts to implement a real scheme of socialized medicine.” Thain subsequently resigned from the HSPC Advisory Committee because of the government’s acceptance of FFS.

The supporters of salaried service, both within and outside the CCF, expressed their opposition to FFS remuneration in the Swift Current plan, and urged the provincial government and the lay health board to hire doctors on salary. Maintaining that the FFS method was “the antithesis of preventative medicine” and the Swift Current Medical Plan was “unsatisfactory” in that it was “impossible to budget satisfactorily in advance and that it has proven to be too costly,” the Saskatoon CCF constituency at its annual convention on 13 June 1947 resolved:

That in the establishment of future Health Regions, the Government bring strong pressure to bear to ensure adoption of a salary basis of payment of medical practitioners so that that the principle of “paying the doctors well to keep the people well” may have an opportunity to be realized.

This resolution was submitted to the Resolution’s committee at the Provincial CCF Convention in July 1947. The following resolution was passed: “We urge that wherever possible the Provincial Government and the Regional Health Board should encourage the hiring of doctors on a salary basis.” The Swift Current plan was also criticized by the SHML, which continued to pass resolutions at its annual conventions calling for doctors to be paid on a straight salaried basis.

Although the provincial government clearly did not intend to force private practitioners into salaried medical service, it did recruit recent graduates from Canadian medical schools to work in health regions and medical centres in Saskatchewan on a salary basis. In addition, the HSPC sought to strengthen the salaried municipal doctor plans, and pressed the Board of the Swift Current Health Region to establish a group-practice clinic with full-time salaried specialists. These efforts, coupled with the municipalities’ preference for salary as opposed to FFS plans, may have prompted Dr. Setka, President of the SHML, to state at a SARM meeting on 24 February 1948 that he was “convinced that the Province was heading rapidly into a salaried medical service.” This was not to be.

First, despite the initiatives to secure doctors on salary, the provincial government was nonetheless agreeable to the continued development of a province-wide health care system on a FFS basis, provided that there was a ceiling on expenditure. In a letter to Dr. G. Gordon Ferguson, SCPS Registrar, in 1949 clarifying the government’s policy on physician
remuneration in the FFS plans operated by individual municipalities and health regions, Douglas referred to these schemes as the “forerunners of an over-all provincial program to be developed as soon as it is feasible.” He was agreeable to paying physicians “adequately and generously for their services,” but that such programs must “be financially sound” and not “overtax the paying ability of the people concerned.”

The fact that the government was neither developing nor planning a salaried service was noted by HSPC Chairman Mott in a letter to Dr. Hugh MacLean in 1949:

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

Second, the anticipated expansion of the salaried municipal doctors system via the government’s grant scheme did not occur. The system grew incrementally until 1947, its peak year with over 210,000 persons covered (about 25% of the population), when, in the words of a Department of Health official, the “better [rural] practices [had] been taken.” Thereafter, the scheme returned to its average coverage, since 1944, of approximately 200,000 persons, where it remained until the early 1950s. When the Douglas government announced its plans to introduce a province-wide medical services scheme in 1959, the municipal doctor system had been reduced to 136 contracts covering only 103,750 persons. The doctor-sponsored FFS plans, in contrast, had enrolled 280,819 persons. In this context, one may suggest that if the CCF had followed the 1945 HSPC recommendations and provided financial assistance exclusively for salary municipal medical care plans—the system would not have been extended into a province-wide salaried medical service.

CONCLUSION

An examination of Saskatchewan CCF party health policy in the period 1934-44 reveals that the party was never committed to, or an advocate of, the establishment of a state-salaried medical service as many historians suggest. After the CCF came to power in June 1944, Premier Douglas repeatedly denied that his government intended to place the medical profession on salary. Douglas’ health policy statements in 1944, coupled with his immediate consent to FFS payment in the Social Assistance Health Services Plan, suggest that his government had rejected a state-salaried medical service long before the HSPC presented such a proposal to its advisory committee in March 1945. Indeed, when the SCPS objected to the HSPC proposals on 21 March 1945, Douglas cate-
gorically denied that his government was committed to such a plan. The various departures from the 1945 HSPC proposals occurred without any apparent resistance from the Douglas government. Indeed, it is evident that there was no confrontation between the Douglas government and the SCPS concerning salary remuneration in 1945—apart from the presentation by the HSPC to its advisory committee proposals for a salaried service in rural Saskatchewan. Taylor clearly over-emphasized the importance and intensity of the friction concerning the 1945 HSPC proposals. These correctives to the historical record facilitate a further evaluation of the existing interpretations, and the development of a more comprehensive explanation, as to why the Douglas government did not implement the 1945 HSPC recommendations for a salaried medical service.

The Douglas government would have likely implemented the HSPC physician remuneration recommendations if the medical profession had not been opposed. Based on this probability alone, SCPS opposition clearly was a factor in the rejection of the 1945 HSPC proposals as the established historical accounts suggest. Indeed, medical opposition to the HSPC proposals was greater than Taylor infers—the province’s municipal doctors were also opposed to a full-time salaried service that would eliminate their private practice privileges.

The role of the doctor shortage and SCPS threats that the development of a salaried medical service would compel doctors to leave the province and deter emigration in the Douglas government’s decision making is less discernible. The establishment of a salaried service in Saskatchewan without the co-operation of the SCPS and with the province’s doctor shortage was viewed as a viable policy by the HSPC, its advisory committee and a large number of organizations representative of Saskatchewan society. They believed that generous remuneration, pensions, and modern, well-equipped facilities would attract a sufficient number of physicians for a salaried service. The SCPS also recognized that a salaried service was a viable policy option for the Douglas government; it recognized that public opinion and the existing municipal doctor system were conducive to the development of such a scheme, and campaigned against such an outcome. Thus the doctor shortage and the threat of loss of doctors (and physician opposition) was probably less of an impediment to the establishment of a salaried medical service in Saskatchewan than Taylor and Naylor suggest. And in this context, the 1945 HSPC proposals were likely not rejected by the CCF solely on the basis of SCPS opposition and the threat of loss of doctors as Taylor suggests. Other factors must have been involved.

Although the establishment of a salaried medical service was considered to be feasible in Saskatchewan, because of SCPS opposition and the probable loss and deterred immigration of doctors, the provision of
accessible medical services to all the people, as promised by the CCF, would take longer to realize. Perhaps this was unacceptable to Douglas; as he told the SCPS on 21 March 1945, his “concern was to provide medical care to everyone as rapidly as possible.”160 This stated objective would be attained far more quickly with the co-operation of the SCPS and the development of medical services on a FFS basis. Indeed, Douglas’ statements and actions during the period 1944-45 support Naylor’s interpretation that the HSPC recommendations for the establishment of a salaried service were not implemented because Premier Douglas’ “concern was to implement programs of health services as amicably and rapidly as possible.”161 However, there was an additional critical factor that led to this policy outcome: the CCF party in Saskatchewan (and more importantly, the Douglas government) was never, as several historians maintain, committed to the establishment of a state salaried medical service.

Public support for the HSPC proposals and a state-salaried medical service was not lacking as Lipset contends. Indeed, Douglas rejected this option within an environment of considerable support for such a policy. There was a broadly based, well-organized and determined popular movement for the establishment of state-salaried medical service in the 1940s led by the State Hospital and Medical League. So strong was this movement that the SCPS launched a sophisticated public relations campaign to counter this threat. In addition to the SHML, a diverse number of agriculture organizations, trade unions, rural municipalities, medical service co-operatives and citizen organizations indicated their support for salaried state medicine to the Sigerist Commission. Several of these organizations forcefully maintained that FFS was not conducive to preventive medicine to the extent that the SCPS was compelled to counter these assertions. This segment of the movement for a salaried medical service clearly desired what Lipset considers “qualitative changes in medical care.”162 These organizations would have, in Lipset’s words, acted to “counterbalance” the SCPS if the CCF had implemented the 1945 HSPC recommendations.163

In this context, because the 1945 HSPC proposals were seen as a viable policy option without the co-operation of organized medicine, and many of the party’s principal constituencies of support, such as the organized farming movement and labour, favoured the introduction of a salaried medical service, one may suggest that if the CCF had been committed as a party, and more importantly as a government, to salary remuneration as some historians have claimed, the Douglas government would have implemented the 1945 HSPC proposals despite SCPS opposition. In the final analysis, then, it would appear that the Douglas government did not follow the 1945 HSPC proposals for a state-salaried medical service because: neither the party nor government was com-
mitted to salary remuneration; the policy of the Douglas government was to provide medical services to the people of Saskatchewan as rapidly as possible with the co-operation of organized medicine; and the medical profession, including the province’s municipal doctors, was fervently opposed to being placed on salary.

ACKNOWLEDGMENTS

The research for this article was supported by a First Year Master’s Hannah Scholarship awarded by The Hannah Institute for the History of Medicine/Associated Medical Services Inc. The author wishes to acknowledge in particular the late Ray Sentes for his supervision. C. Stuart Houston provided comments on my MA thesis which were helpful in preparing this article. I am grateful to Greg Marchildon for his guidance and constructive criticism of an earlier version of this paper. I wish also to thank two anonymous referees for their comments.

NOTES

4 Taylor, Health Insurance and Canadian Public Policy, p. 417.
7 Taylor, Health Insurance and Canadian Public Policy, p. 248.
8 Taylor, Health Insurance and Canadian Public Policy, p. 246.
9 Naylor, Private Practice, Public Payment, p. 140.
10 Lipset, Agrarian Socialism, p. 297.
11 Naylor, Private Practice, Public Payment, p. 136.
12 Taylor, Health Insurance and Canadian Public Policy, p. 85.
13 Taylor, Health Insurance and Canadian Public Policy, p. 84-85.
In 1939, the Department of National Defence established a Medical Procurement and Assignment Board to assess the medical personnel needs of both the military and the civilian population. Medical Procurement and Assignment Board, *Report of the National Health Survey conducted by the Medical Procurement and Assignment Board* (Ottawa, E. Cloutier, 1945).


Saskatchewan Archives Board, Saskatoon (hereafter SABS), Records of the Health Services Board (hereafter HSB), S-PH.4, File 2, “Health Services Board: Municipal Medical Services,” circa 1943, p. 1-4, 10-13; and Health Services Board Submission to Select Committee of the Legislative Assembly of Saskatchewan re. Social Welfare etc., Regina, 28 March 1943, p. 4-5.

Naylor, *Private Practice, Public Payment*, p. 163.


SABS, HSB, S-PH.4, File 5, C. S. MacLean to Dr. Davison, 19 February 1937.

No author, no title (hereafter n.a., n.t.), *Saskatchewan Medical Quarterly*, 8, 4 (December 1944): 18.


SABR, HSSC, R-251, File 2, “Rural Municipality of Tisdale, Brief on Medical Services, 15 September 1947,” p. 4.


Collins, “State Medicine, Health Insurance and Hiring Municipal Doctors,” p. 16.

Saskatchewan Medical Association/College of Physicians and Surgeons of Saskatchewan Archives (hereafter SMA/SCPS) File 6-14-6, “A Preliminary Report And Contribution to the Problem of State Medicine in Saskatchewan,” p. 4; Collins, “State Medicine, Health Insurance and Hiring Municipal Doctors,” p. 18, and n.a., n.t., *Saskatchewan Medical Quarterly*, 8, 4 (December 1944): 17-18;

Collins, “State Medicine, Health Insurance and Hiring Municipal Doctors,” p. 18.


35 SMA/SCPS, “Special General Meeting, Saskatoon, Saskatchewan, 28 February 1933,” p. 25-6.
36 SMA/SCPS, File “Medical Services Incorporated Regina,” Dr. G. K. Lindsay to Honourable R. J. M. Parker, Minister of Municipal Affairs, 28 February 1940; Davison, “Municipal Medical Services in Saskatchewan,” p. 12-13.
38 N.a., n.t., Saskatchewan Medical Quarterly, 7, 1 (December 1943): 14-16. For a detailed and nuanced discussion of the debate and tension within the medical profession in Saskatchewan concerning the municipal doctor system, health insurance and salaried state medicine see Gordon S. Lawson, “The Co-operative Commonwealth Federation, Health Reform and Physician Remuneration in the Province of Saskatchewan, 1915-1949,” MA thesis, University of Regina, 1988, p. 50-64.
39 N.a., n.t., Saskatchewan Medical Quarterly, 6, 1 (April 1942): 52-54.
40 N.a., n.t., Saskatchewan Medical Quarterly, 7, 1 (December 1943): 14-16.
41 N.a., n.t., Saskatchewan Medical Quarterly, 8, 4 (December 1944): 17-18.
43 N.a., n.t., Saskatchewan Medical Quarterly, 9, 1 (May 1945): 28.
44 Select Special Committee on Social Security and Health Services, Final Report, (Regina, 1944), p. 10.
46 Naylor, Private Practice, Public Payment, p. 66.
49 “State Medicine Urged for Saskatchewan,” Leader Post, 16 October 1936; “State Medicine League in First Convention Decides to Urge Plans upon Govt,” Western Producer, 22 October 1936.
50 SABS, Pamphlet Collection “Saskatchewan State Hospital and Medical League, Fourth Annual Convention, Saskatoon, Sask., October 20, 1939,” p. 6.
51 SABS, Pamphlet Collection, “Report of the Fifth Annual Convention of the State Hospital and Medical League, Saskatoon, October 8 and 9, 1940,” p. 9.
53 N.a., n.t., Saskatchewan Medical Quarterly, 6, 2 (August 1942): 4; and Saskatchewan Medical Quarterly, 5, 4 (December 1941): 30-2.
54 State Hospital and Medical League, The Case For State Medicine (Regina, 1944), University of Regina Library Special Collections.
55 Dr. W. H. Setka, “Competitive Medicine and Its Results,” radio address delivered over CKBI and CJRM, 14 February 1943. Cited in State Hospital And Medical League, The Case For State Medicine, p. 22.
56 Select Special Committee on Social Security and Health Services, Final Report (Regina, 1944), p. 10.
57 Select Special Committee on Social Security and Health Services, Final Report (Regina, 1944), p. 13.
58 The Saskatchewan Reconstruction Council was established by the provincial government on 20 October 1943 to formulate a post-war reconstruction and rehabilitation plan for Saskatchewan.


64 The Sigerist Commission received submissions from 24 rural and urban municipalities, SARM, 7 trade unions, Saskatchewan’s 4 medical services co-operatives, 2 “agriculture organizations,” 4 citizen’s organizations, the Saskatchewan Hospital Association, Saskatoon Constituency Association (CCF) and the Saskatchewan Old Age Pensioners’ Association; and the Hogarth Committee received testimony from 42 organizations; the SRC heard representations concerning health services from 26 organizations.


67 SABR, HSSC, R-251, File 6, “Submission to the Saskatchewan Health Survey Committee, Saskatoon, September 19th/44 (Saskatchewan Federation of Agriculture),” p. 1.

68 Contributory health insurance was preferred by SARM, three of the four medical insurance co-operatives in Saskatchewan, several Canadian Brotherhood of Railway Employees union locals, the Canadian Daughter’s League; the Provincial Council of Women, the Saskatchewan Hospital Association, and two rural municipalities.

69 SABR, HSSC, R-251, File 8, “Submission by the Regina Mutual and Medical Benefit Association,” p. 5: “Melfort and District Mutual and Medical Benefit Association Limited,” p. 10; “Supplemental Brief in Conjunction with the Melfort Medical Co-op Brief on Health Services [Saskatoon Mutual and Medical Benefit Association],” p. 4.


71 SABR, HSSC, R-251, File 5, “Memorandum Respecting Health Insurance, Public Health Services, etc., submitted to the Health Service Survey Commission of the Province of Saskatchewan, 26 September 1944, by the Local Unions of the Canadian Brother Hood of Railway Employees and other Transport Workers, Regina, Saskatchewan,” p. 1-2.

72 N.a., n.t., *Saskatchewan Medical Quarterly*, 8, 4 (December 1944): 8.

73 SABR, HSSC, R-251, File 8, “Brief presented at Saskatoon to Doctor Sigerist... State Hospital & Medical League,” p. 67.


75 SABS, Hugh MacLean Papers, S-A69, File 2, “Radio Address by Dr. Hugh MacLean, Vice-President, C.C.F. SASK. Section, Wednesday, March 17, 1937,” p. 2, 4; “Health
Services, Women’s Farm Organization. By Dr. Hugh MacLean, Wednesday, June 2, 1937,” p. 5, 10.

76 Lipset, Agrarian Socialism, p. 288.
77 Rands, Privilege and Policy, p. 297.
78 SABS, MacLean Papers, S-A69, File 2, “Radio Address by Dr. Hugh MacLean,” p. 2-3; and Lipset, Agrarian Socialism, p. 289.
81 N.a., n.t., Saskatchewan Medical Quarterly, 7, 3 (December 1943): 5.
85 The CCF, SHML and UFC, for example, claimed that health insurance only provided coverage to those who could afford the premiums and did not provide adequate facilities for preventive medicine.
87 SABR, HSSC, R-251, File 10, “Fred Gordon (Secretary CCF Saskatoon Constituency) to Secretary Sigerist Commission, September 16, 1944.”
90 SABS, MacLean Papers, S-A69, File 2, “An Address on Medical Health Services by Dr. Hugh MacLean At the C.C.F. Convention, Regina Saskatchewan July 12, 1944,” p. 4
91 SABS, MacLean Papers, S-A69, File 2, “An Address on Medical Health Services by Dr. Hugh MacLean…. July 12, 1944,” p. 5.
92 The nature of the “differences in ideological approach” is not discernable from Taylor’s correspondence with Houston. SABS, C. J. Houston Papers, S-A569, C. J. Houston to Malcolm G. Taylor, 25 February 1975.
93 Taylor, Health Insurance and Canadian Public Policy, p. 244.
94 McLeod and McLeod, Tommy Douglas, p. 149.
97 McLeod and McLeod, Tommy Douglas, p. 198.
100 “Doctors Will Not Be Civil Servants,” Regina Leader, 14 September 1944.
101 “Adequate Health Services for All the People Is C.C.F. Aim,” Western Producer, 28 September 1944.


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


113 N.a., n.t., *Saskatchewan Medical Quarterly*, 9, 3 (December 1945): 25.

114 N.a., n.t., *Saskatchewan Medical Quarterly*, 9, 3 (December 1945): 15-16.

115 N.a., n.t., *Saskatchewan Medical Quarterly*, 9, 1 (May 1945): 20.


118 N.a., n.t., *Saskatchewan Medical Quarterly*, 9, 1 (May, 1945): 18.

119 N.a., n.t., *Saskatchewan Medical Quarterly*, 9, 3 (December, 1945): 28.

120 N.a., n.t., *Saskatchewan Medical Quarterly*, 9, 3 (December, 1945): 28.


122 T. H. McLeod does not recall any such decision going to cabinet. Interview with author, Ottawa, 7 August 1995.

123 *Saskatchewan Medical Quarterly*, 9, 3 (December 1945): 28.


125 SMA/SCPS, File 7-4-8, “Minutes of the Meeting of the Advisory Sub-Committee on Local Health Services Held April 22, 1945,” p. 1.


128 Of the approximately 170 plans in 1944 all but 10 were on a salary basis. SABR, McLeod Papers, File 38, “Fee-For-Service Schemes.”

129 RM Pittville, RM Webb, RM. Miry Creek, RM. Riverside and the town of Cabri. SABR, HSPC, R-191, File 38, “Fee-For-Service Schemes”; Feather, “From Concept to Reality,” p. 70-1; Lester Jorgenson, “Rural Municipality of Miry Creek No. 229 and Health Region 1,” in *Bridging the Centuries* (Abbey: Miry Creek Area History Book.
Committee, 2000), p. 53-54; SCPS/SMA, ("Dr. Houston’s Municipal Contract File"), Mindel C. Sheps to Dr. C. J. Houston, 7 May 1945; and Saskatchewan Medical Quarterly, 10, 2 (July 1946), p. 8.

130 Feather, “From Concept to Reality,” p. 70-5.

131 N.a., n.t., Saskatchewan Medical Quarterly, 10, 2 (July 1946): 9.


134 “Medical Co-op Directors Authorized to Borrow Million for Development,” Saskatoon Star Phoenix, 30 April 1946.

135 Taylor, Health Insurance and Canadian Public Policy, p. 260.

136 MSI Inc. (Saskatoon) was modelled after the doctor-sponsored FFS plan established by Regina doctors in 1939.

137 SABR, Records of the Health Services Planning Commission (hereafter HSPC), R-326 (Sask. Dept. of Health, HSPC, 1938-1952), File 121b, E. J. Loer to Dr. F. D. Mott, 12 October 1946; 7 November 1946.


139 Saskatchewan Medical Quarterly, 2, 4 (December 1947): 44.

140 Dr. M. Sheps resigned from the HSPC in January 1946. She was temporarily replaced by Dr. C.G. Sheps, who became acting chairman of the HSPC (a position that had been held unofficially by Dr. M. Sheps) and Dr. O. K. Hjertass who became secretary. The Drs. Sheps would leave the province during the summer of 1946. F. D. Mott, a former senior officer in the United States Public Health Service and a graduate of the McGill University medical, was subsequently recruited to chair the HSPC. During Mott’s tenure, relations between the government and the SCPS improved.


147 SABR, Records of the State Hospital and Medical League, R-690.1, File 8, “My Memories of The State Hospital and Medical League by Joseph A. Thain,” p. 6.


of Saskatchewan: Submitted by The State Hospital and Medical League 1946, “
Health Services Review, 2, 1 (May, 1946): 6-7; “Brief To The Government … February

152 SABR, HSPC, R-326, File 2e, “Memorandum for the File: re. Employment of
Specialists by Health Region No. 1, 30 November 1948.”
153 SABS, Pamphlet Collection, “League Officials Address Sask. Assn. of Rural
154 SABR, HSPC, R-326, File 1O5c (1of 2), T. C. Douglas to Dr. G. Ferguson, 26 February
1949.
155 SABR, HSPC, R-326, File 1O5c (1of 2), T. C. Douglas to Dr. G. Ferguson, 26 February
1949.
156 SABS, MacLean Papers, S-A69, File 29, Fred Mott to Hugh MacLean, 21 March 1949.
157 SMA/SCPS, Advisory Planning Committee on Medical Care, “Memorandum on
158 SMA/SCPS, File 7-4-8, “Advisory Committee to the Health Services Planning
159 In 1950, 173 plans provided coverage to 200,000 persons, approximately 24% of the
population. Milton I. Roemer, “Prepaid Medical Care and Changing Needs in
160 N.a., n.t., Saskatchewan Medical Quarterly, 9, 1 (May 1945): 17.
161 Naylor, Private Practice, Public Payment, p. 140.
162 Lipset, Agrarian Socialism, p. 297.
163 Lipset, Agrarian Socialism, p. 297.