THE ROOTS OF MEDICARE IN CANADA ARE IN ALBERTA

"The health of the people of Canada is of vital importance …
To have the responsibility refused by the federal government,
accepted by the province, and by it passed on to the municipality,
the body with the least taxing power and least financial ability to assume it
means the maximum of expectations are met with the minimum of accomplishment.
(Archer/Wilson Brief to the Rowell-Sirois Commission, 1938)[1]

Introduction

Medicare was a centennial gift to Canadians (1967/68), but its formative steps go back at least forty years, to the first provincially conceived health insurance program. The program was to be voluntary and comprehensive, with the provincial government contribution to its funding. The Alberta (Hoadley Commission) proposal of 1932-1934 became national after its principles were included in the 1934 CMA Plan for Health Insurance and the services to be insured (medical, hospital, dental, drugs, essential nursing) and citizens (all) were re-proposed by the Haegerty Advisory Committee (1943) to the federal government. Enamored, the federal government increased the offer of funding to a universal or 100% level in 1945. The federal proposal dissolved in 1946 over taxation arguments, not over the health services or citizens to be covered. The federal government continued to take the universal funding approach in 1952 (for hospitals) and 1967/68 (for medical care).

Improved access to healthcare in Alberta was viewed as a responsibility, nee duty, by the farmer based United Farmers of Alberta (UFA) as early as 1915. After being elected in 1921, UFA government decisions demonstrated how important healthcare was to the government and to Albertans, an approach maintained by their 1935 successors the Social Credit government.

In 1933 the UFA as an organization joined the new CCF (now NDP) party, formed in Calgary (1932). When the CCF were elected as the government in Saskatchewan in 1944, Premier T.C. Douglas fast-tracked healthcare changes, by introducing a provincial tax to build and operate more hospitals. Fundamental differences began to appear between Alberta's contributory approach to funding healthcare and the Saskatchewan approach to universally fund it.

Background

Historically the settlement and growth patterns of Alberta and Saskatchewan were very similar. Both were administered by the federal Ministry of the Interior as the North West Territories until they became provinces in 1905. The construction of main and branch rail lines occurred simultaneously in the two provinces, bringing waves of new immigrants to both provinces.

After the turn of the century there were strong agricultural or farmer based interest groups formed in every province from Ontario west to BC. In Alberta the movement was formalized in 1909, through the incorporation of the United Farmers of Alberta or UFA. As the UFA philosophy and objectives became clearer and their followers more numerous, the UFA purview expanded well beyond agriculture. It encompassed many rural life issues. Healthcare was one. As they did, the UFA influence on the mainstream parties increased. Disenchanted with the rate of progress, the UFA created their own political party (1919) and were successful in being elected to power in Alberta for three successive terms (1921-1935).[2] Farmer based political parties formed governments in Manitoba and Ontario for shorter periods of time. Nationally the western farm movement became known as the Progressive Party in the House of Commons.[2]

Access to healthcare became a priority issue to the UFA during WWI, as the province faced a high rate of disabled soldiers returning from Europe.[3] The healthcare seeds were sown by farm women, after they gained the right to vote in 1915 and formed the United Farm Women's Auxiliary. Reorganized one year later (1916), they became the autonomous United Farm Women of Alberta (UFWA).

Hon. Irene Parlby,[4] who later became one of the famous Five Persons, was elected the first UFWA vice-president (1915/16), and the second president (1916-1920). She was also the UFWA health convener. In 1916 Ms. Parlby and future premier Herbert Greenfield, were appointed by the Liberal government to a committee to draft a Municipal Hospitals Act. The 1917 Act, revised in 1918, was designed to promote the establishment of hospitals in rural communities, partially funded through municipal taxes. It was one province's rural counterpart to the federal (1915) Military Hospitals Commission under (Sir) James Lougheed, which rapidly increased or acquired hospital beds after the chlorine gassing at Ypres (1915) and the anticipation of large numbers of returning disabled veterans. In 1918/19 the Spanish flu epidemic compounded the post WWI bed shortage. Many private hospitals were closed because of insufficient funds. By 1918 Ms. Parlby was declaring publicly that medical care was a right one could

expect, and the Alberta government had a duty to provide it.[5]

Through UFWA and Alberta Medical Association (AMA) encouragement, the post World War I (WWI) Alberta (Liberal) government created Canada's second Public Health department[6] (1918) and began hiring public health nurses. Then they began a District Health Nurse program (1919), to improve care in the remote areas not served by physicians. In 1920 traveling child welfare clinics were started, to serve rural and northern Alberta communities.[7]

Elected as the government of Alberta in 1921, the UFA had only one MLA with legislative experience, the Hon. George Hoadley. He had been a Conservative MLA since 1911, before switching to the UFA in the 1921 election. He was on the short list to become Premier.

George Hoadley was a British immigrant who came to Manitoba (1890) and then Alberta (1891).[8] He became a farmer, horse breeder, politician and Leader of the Conservative opposition (1918), before switching to an Independent status (1919) and then the UFA. He won his 1921 seat by acclamation. Hoadley became the longest serving member in the Alberta legislature (1909-1935). Initially Alberta's Minister of Agriculture (1921-1934), he was given the Ministry of Health portfolio (1923-1935). Supporting him on women's issues was the UFA Minister without Portfolio, Irene Parlby.

The Hoadley appointment as Health Minister in 1923 began a period of ministerial and deputy ministerial stability in healthcare that is unparalleled in Canada. There were only two Ministers of Health in Alberta from 1923-1957 (Hoadley, Cross) and two deputy Ministers from 1912-1952 (Laidlaw, Bow). Hoadley continued as Alberta's health minister under three consecutive Premiers: Greenfield, Brownlee and Reid, and rose to become the Deputy Premier.[9]

Following the Hoadley appointment in October 1923, the pace of healthcare changes in Alberta accelerated. Hoadley's objective was to improve the health of Albertans.[10] To improve rural healthcare access, his strategy was to build more municipal hospitals. To improve programs his strategy was to expand the public health, district nurse and traveling clinic programs. The latter began as a traveling dental clinic (1921). It added a physician and a nurse (1924), a surgeon (1927) and later a psychiatrist. Primarily focused in northern Alberta, the traveling clinic operated during the summer from 1924 to 1943, under a government agreement with the University of Alberta Hospital.

In 1924 Hoadley noted that the post-operative death rate in Alberta was the highest in Canada. It was even higher in rural Alberta. He amended the Alberta Hospital Act to require a second medical opinion before surgery. All tissues removed at surgery were to be examined by a pathologist.[11]

After being re-elected with an increased majority in 1926, the UFA government felt increasingly unrestricted in its political and healthcare ambitions. Hoadley placed a cap of six general (acute care) hospital beds per 1,000 in Alberta.[12] It lasted for almost 50 years. In part because concern over the high post-operative mortality rate, the UFA government amended the Alberta Medical Profession Act and regulations, to require a review of the credentials of all physicians, before they could advertise themselves as specialists. The University of Alberta Senate was appointed approving body. Specialist diplomas were issued after a credential assessment by the Faculty of Medicine. It was the first specialist recognition and approval system in Canada but it was government mandated. The 1926 amendments to the Medical Profession Act, preceded by one year the 1927 initiative of Dr. David Low and Regina's "Mighty Triumvirate", which led to the formation of the Royal College of Physicians & Surgeons of Canada in 1929.[13] The Alberta regulations remained in place until 1944.

Following the sudden death of Deputy Minister Dr. W.C. Laidlaw (1912-1926), Health Minister Hoadley enticed Dr. M.R. Bow from Regina to become Alberta's Deputy Minister of Health (1927-1952), the year Saskatchewan's Dr. M.M. Seymour retired. Bow brought with him a diploma in public health (DPH) and considerable experience in addressing and solving public health problems.[14] Deputy Minister Bow faced a plethora of challenges. The postoperative death rate remained high.[15] In 1927 Hoadley considered contracting a full time surgeon to perform surgery in rural Alberta. Alberta faced its first polio epidemic (1927). The government responded by building Canada's first polio rehabilitation hospital, a sixty bed framed pavilion on the UAH site, where the most paralyzed of the 363 polio patients were treated. Fifty-four died.

On November 2, 1927 members of the Edmonton Academy of Medicine sent a letter to the Calgary Medical Society, signified their alarm over the government's rumored initiative involving a state medicine plan.[16] The two bodies recommended the part-time Registrar Dr. G.R. Johnson become the full time Registrar, to better prepare the AMA/CPSA to face any such government legislation. The College of Physicians and Surgeons of Alberta (CPSA) responded by appointing Drs. A.E. Archer and W.A. Wilson as College (CPSA) presidents for most of the 1928-1939 decade.[17] The AMA/CPSA began their own rapid education program on state medicine and what it meant. To most physicians it meant placing doctors

on a salary. Dr. Malcolm MacEachern of the American College of Surgeons came to Edmonton to talk about the New Zealand health program. He criticized it as destructive for hospital-based physicians and surgeons. Dr. A.E. Archer did not entirely agree.[18]

The AMA/CPSA attitude toward salaried or contracted medicine was based on considerable experience. The first organized medical care (1874-1892) was brought to the two prairie provinces by contracted NWMP surgeons. Not infrequently the contracts were jointly paid by the Indian Department.

After 1886 physicians signed Canadian Pacific Railway (CPR) contracts to provide medical care to CPR employees. One led to the first group practice (Drs. J.D. Lafferty and H.G. Mackid) in Calgary in 1890. Other medical contracts were signed with coal mining and lumber companies.

Then in 1907 the Calgary Medical Society, led by the Registrar Dr. Lafferty, did an about turn. Lafferty called for the abolition of all existing medical contracts and the tendering of them.[19] Alberta physicians officially maintained that position except in mining and lumber towns. They did not support the municipal doctors' plan that began in rural Saskatchewan during WWI (1916). Some medical politicians even viewed the traveling clinic as a form of contract practice.

In 1922 the newly merged AMA/CPSA amended their Code of Ethics, calling any practice which interfered with reasonable competition, unethical.[20] Retirement home (lodge) contracts were viewed as unnecessary too,[21] even though well known future Lt. Gov. (Dr.) William Egbert (1925-1930) signed one.

The White/Pattinson Inquiry (1928-29)[22]

Long interested in government involvement in improving access to health care, the UFA annual conventions in 1919, 1923 and January 1928, passed motions requesting the government initiate a state medicine program in Alberta.[23]

In February 1928 the UFA government accepted an all party supported motion from Labour MLA's White and Pattinson, for a legislative Inquiry into State Medicine. February 1928 became even more notable, when Minister Hoadley audaciously passed the 1928 Sexual Sterilization Act, a British Empire precedent.[24] To cap the government's February 1928 legislative agenda Health Minister Hoadley tabled the Professions Disclosure Act. Hoadley wasn't satisfied that patient complaints forwarded to the CPSA, only led to a report by the CPSA to the Department of Health.[25]

The 1928/29 White/Pattinson Legislative Inquiry was limited by its terms of reference, to examine only health insurance and to "look into legislation in any country, and suggest proposals regarding surgical or medical services that nature, extent, efficiency, cost and financing, and the feasibility of adapting them in Alberta."[26]

The Inquiry found that most international health insurance plans in the 1920s included sickness, disability, and absentee coverage in their benefits. In Britain the health insurance program covered fifteen million employees and included medical and sickness benefits. Half of Britain's physicians participated in it. The French program covered one-half of the population and provided more benefits (maternity care, drugs). It also covered dependents. In Germany non-manual workers were covered. In the US there were eleven Commissions that investigated health insurance. Seven recommended it. Four were indifferent. From a preventive medicine perspective there were 330 medical officers operating public health programs. A five-year American study of health insurance was started in 1927.

In Canada the Inquiry noted Quebec had established a few county health units. Saskatchewan was happy with its rural medical contracting system. The 1921 British Columbia Royal Commission had investigated health insurance and recommended a health and sickness program, for employers/employees. The provincial government was to contribute one-fifth of the cost. No BC government action was taken.

In Alberta the Inquiry found there were seventeen municipal hospitals, a traveling clinic that provided rural dental, nursing, and medical services, and seven district health nurses, mainly in the frontier areas of Northern Alberta where there were too few citizens to support a physician. It noted the maternal death rate was 6.4 per thousand, compared with New Zealand's four and Holland's two per 1,000. There were 20-30 contract doctors in the mining and lumber towns providing care for 25,000 people. CPR employee medical contracts existed throughout the province. Several Alberta municipalities had signed municipal doctor contracts. The province had signed another ten provincial medical contracts to keep physicians in the drought stricken southeastern Palliser Triangle, as well as several full time contracts in northern Alberta. A local medical and hospital insurance program had been started by mining companies for all the miners in Drumheller.

The Inquiry ended with an outline of one American Corporation's health benefit plan for 16,000 employees, and a statement by an American politician encouraging state or salaried physicians. There was no record of any briefs being submitted to the Inquiry. Nor did its membership appear to extend beyond White and Pattinson.

The Inquiry concluded a state medical insurance plan was feasible in Alberta. It recommended a 1921 type BC plan for urban Alberta, and a rural (doctor,

hospital) insurance plan for the rest of the province. The authors noted such a plan could be costly and would need to be weighed against spending on preventive medical programs, where "great gains had been made in the recent past and shouldn't be overlooked".[27]

Hoadley took no action on the February 1929 tabled Inquiry. Instead he implemented two public health programs with Medical Officers of Health, in High River/Okotoks (his own constituency) and Red Deer. It was partially funded by the Rockefeller Foundation. The health department opened mental health and tuberculosis clinics in Calgary and Edmonton. The same month Hoadley announced a provincial doctors program for the Peace River country in Northern Alberta, paid for by the provincial government.[28] Then he amended the Municipal Districts Act to allow Districts to pay physicians from tax revenues.

A month after the White/Pattinson Inquiry was tabled, BC MLA Dr. H.A. Wrinch moved that a BC Royal Commission be appointed to investigate health insurance and maternity benefits. Accepted, it deliberated from 1929-1932. The BC Inquiry stimulated Dr. J.H. MacDermot of Vancouver to write two authoritative articles on health insurance, in the CMAJ in April/May of 1929. At their annual meeting in June 1929 the CMA council commissioned a search of the health insurance literature. State medicine was again discussed at the third Federal/CMA Health Services Conference in Ottawa in November 1929. The CMA's response was to appoint a Study Committee in 1931, with Albertan Dr. J.S. McEachern on it.[29]

After the 1929 sitting of the legislature Labour MLA's White and Pattinson annually moved that the government design a plan to implement state medicine in Alberta. Each time Hoadley turned the motion aside. The government wasn't ready, he said, and he wanted "a closer understanding between individual doctors and myself".[30]

In 1931, the first and until then the only UFA President, Henry Wise Wood retired. The UFA society took a definite left turn in its policies aimed at attenuating the Depression crises, even distancing itself from the UFA government.[31]

Little happened until January 1932. After the second editorial on state medicine by D.O. Wight of the Cardston News, there was an Oxford style debate on state medicine. Wight implored Hoadley to address it. Community interest in a voluntary prepaid medical insurance program was confirmed, when over 150 families signed $25.00 per year medical contracts to start the program on March 1, 1932.[32] It complemented the Cardston municipal hospital program that began in 1919. The concept of signing family medical contracts spread throughout Southern Alberta, to Lethbridge, Stettler and Lamont, where it reached Dr. A.E. Archer of the Lamont Clinic. He remodeled it as the Di Bozsha program.[33]

The Hoadley Commission Progress Report (1933)[34]

In February 1932, the BC Royal Commission report was tabled. Hoadley liked the Commission's recommended 2/9 government contribution toward the cost of the programs. He surprised many by accepting the annual White/Pattinson motion that month. On March 4 Hoadley appointed an all party Commission to design a health insurance plan for Alberta. It was colloquially known as the Hoadley Commission after its chairman. There were eight members including the Hons. George Hoadley and Irene Parlby, Pattinson, and Conservative Dr. W. Atkinson. The Commission was charged with making recommendations 1) "as to the best method of making adequate medical and health services available to all the people of Alberta" and to report on 2) "the financial arrangement which will be required on an actuarial basis to ensure the same".[35] The Commission began by researching all the available material, from the BC and Manitoba studies, the 1929 Inquiry, and any information that could be secured nationally and internationally.

At their first meeting on October 5/6, 1932, the initial draft of the Hoadley Commission report was circulated. Six briefs were requested. Dr. Angus McGugan was appointed the secretary. At the second meeting on November 8, the former UFA Minister of Health and future Premier R.G. Reid was in the chair. Briefs were received from the CPSA, AARN, Alberta Pharmacists and Dentists, the Alberta Hospital Association, and Labor representatives. A letter objecting to the concept of health insurance was received from the Christian Science Association. A Civil Service member of the government presented the British panel concept to the Commission.

At the third meeting on December 12 Minister Hoadley was in the chair. The next day, Drs. Archer and Wilson were interviewed. They recommended a health insurance program on behalf of the CPSA that covered hospital and medical services. So did Drs. A.F. Anderson and W.T. Washburn in their brief on behalf of the Alberta Hospital Association.

On December 14/15 the draft report was revised. The Commission expanded the program to include hospital and medical services, drugs and dental services and public health services. Commission members agreed the information available was not sufficient and the proposal should be released as a progress report. It was revised using information up to January 15, 1933, and released in March 1933. The Commission concluded that improving access to healthcare was possible through a contributory health insurance program. A second conclusion was

that any program should ultimately be an ideal one but adaptable to local needs and capable of being made province wide or dominion wide.[36]

The cut off date was the month the UFA joined the Cooperative Commonwealth Federation (CCF) party, and six months before the CCF released its Regina Manifesto in August 1933. It contained the principle that healthcare was to be as accessible as education.[37] One early member of the CCF was Rev. T.C. Douglas.[38] He failed in his first attempt to become elected as a CCF member in the 1934 Saskatchewan election. Douglas would not return to the provincial scene until 1943, when he became the CCF party leader, and 1944 when he became the Premier of Saskatchewan.

The Hoadley Commission proposal was to be based on the municipal hospital and district systems, with six to eight municipal districts in each hospital district. Citizen participation had to be large enough for the program to be financially viable. A fifty percent vote in favor, committed each hospital district to join the program. The Commission said insured coverage of long hospital stays needed to be capped. Larger cities would have to form groups to be insured, for example professions, trades, and companies. Land owners as well as individual wage earners would need to be contributors. Any contributions by the government were to be the same for the urban or rural programs. A centrally controlled administration would be needed. The fee for service system would be maintained except in remote areas, where a contract or salary would be considered. Fees would be similar to those paid by the WCB. The Commission noted surgery and specialists' fees were too high. Public health districts would have to be modified to match the boundaries of the health districts.

The report observed that three part-time municipal doctor programs existed in the province. A fourth was discontinued because of the Depression. Specialist coverage was not to be included in the original program or at least until the program was province wide.

The estimated total cost of the provincial health insurance program was $10.6 million per year. In 1934 the provincial hospital grant was $400,000 per year. It would increase to $2.2 million if the whole province was covered by the program. The cost to an average employee or wage earner would be about $32.00 per year, assuming three dependents. For a family it would be about $43.00 per year, on the average.

Plan A divided the province into hospital/health districts. The government could control which district could undertake a vote. The individual (including dependents) was to pay 7/9ths of the cost. Plan B was similar to one of the 1932 BC Royal Commission's five options. It covered employees only and excluded maternity benefits and dependents. The employer was to pay 2/9ths of the cost and the employee 5/9ths. Plan B costs were estimated at $6.54 per wage earner per year. Both Plans A and B contained a provision that the provincial government would contribute 2/9ths or 22% of the cost of the program.

In the summer of 1933 Hoadley sought to increase the number of municipal districts hiring of municipal doctors, by offering them money for a district health nurse, so long as they agreed to retain a municipal physician at the end of a three or four year period. The CPSA approached all physicians with a questionnaire, asking if they supported a health insurance plan. Physicians responded by favoring a plan on a twenty to one basis.[39]

The Hoadley Commission's Final Report (1934)[40]

No other meetings of the Commission were documented. The final report was released after the February 1934 legislative sitting. It was basically the same as the progress report. The report concluded that no single plan could be applied throughout the province. The Commission encouraged municipal districts to consider contracts and salaries (part-time or full-time) with individual physicians, or failing that district nurses, but did not make them mandatory. The Commission declined to accept the British panel concept, as the province was too rural in nature.

The recommendations of the Commission were incorporated into The Alberta Health Insurance Act, unaltered. The Act was supported by all parties, passed in February 1935 and assented to on April 23, 1935. Dr. McGugan was to canvas municipal districts for a candidate one. For Plan A it was to be Camrose. No action was taken pending the outcome of the election in August 1935.

In anticipation of the election and mindful of the rising popularity of teacher and future premier William Aberhart, Hoadley suggested the government hire him as an economic consultant at $6,000 per year. The caucus did not act on the suggestion in Hoadley's absence.[41]

In the August election every UFA member was defeated, following the Brownlee scandal of 1934 and the resignation of the Premier. The electorate overwhelmingly turned to the Social Credit party, which was more conservative and involved less government intervention. The new Social Credit government immediately prepared a budget. It was a difficult one as much of its revenue was pre-committed to cover interest and relief payments. Fiscally frozen, the government had few options but to further restrict its expenditures. It was left to individual Alberta politicians and physicians to carry forward the 1932

health insurance agreement. Given the high level of public support for the concept, the plan was destined not to be forgotten by Hon. George Hoadley and Dr. A.E. Archer.

Dr. A.E. Archer, the AMA/CPSA and the CMA

Dr. Archer was a 1902 UofT medical school gold medallist, who came to the Star/Lamont area in 1903, as a United Church missionary physician to the nearby Ukrainian settlements.[42] He was a church builder (1906) and hospital builder (1912) of the largest hospital outside Calgary/Edmonton (90 beds, 1948). It was fully accredited from 1921 onward by the American College of Surgeons. Dr. Archer was its medical superintendent (1912-1948). Archer was a founder and second president of the Hospital Association of Alberta (1920/21), and oversaw the merging of the two hospital organizations, during his AMA/CPSA presidency (1943). In 1921/22 he presided over the merger of the AMA and CPSA as AMA President. The result was 100% of Alberta's physicians became members of the AMA. Archer was President of the CPSA three times (1930, 1931, 1936). After 1932 he became actively involved in the health insurance debates, having started the Di Bozsha program in his own health district in 1933.[43] The Di Bozsha or May the Lord Give You Health program, began after families signed Cardston like medical contracts with the Lamont Clinic (1933). In 1934 the municipality of Wostok signed a medical contract covering all its citizens. The clinic was deluged with patients for the next two years.[44] Three adjacent municipalities signed a larger contract with seven doctors in an adjacent clinic, likely Vegreville.[45]

Dr. Horace Wrinch, Archer's colleague in the Methodist/United Church Mission Hospital system at Hazelton, BC, began a local prepaid health insurance program in 1909.[46] By 1926 Dr. Wrinch, had secured the support of the BC Hospital Association, but not the government, for a hospital insurance program.[47] An MLA in the BC Legislature, Wrinch's 1929 motion for a second BC Royal Commission, to assess the merits of a health insurance program, was accepted. To the Commission he said "he had long ago concluded that state health insurance was the only solution to equitable healthcare".[48] Dr. Archer was of a similar mind, particularly after confirming the difference prepaid health insurance made to the health status of his community. Archer's favored government involvement in health insurance as had the British Medical Association (1930) and Dr. Harvey Smith, the CMA President (1930/31), who outlined his views at the joint BMA/CMA annual meeting in Winnipeg in 1930.[49]

In 1929 health insurance or state medicine as it was often called, was not widely understood nor universally embraced by the medical profession. Over the forty years it was debated (1927-67), even the mention of it polarized opinions and divided physicians. To many it meant doctors on salary, or the thin edge of the wedge that led to salaried medicine. To others more familiar with the European approaches (A.R. Munroe, 1914), or those who had practical experience with it (Wrinch 1909 and Archer 1934), there was support for the concept. At the same time there was fear over its application, particularly when it came to government participation.

The first Alberta government initiative came in response to the drought in the Palliser Triangle (1926). With an up to 80% drop in incomes and access to medical care, the government signed bonuses and offered subsidies for doctors to stay in the area. The AMA/CPSA began to react to the UFA government's state medicine initiatives as early as 1927. At the third federal government/CMA conference in November 1929, the AMA's Dr. McEachern flagged health insurance as the most important topic discussed.[50] He noted the lack of preparedness on the part of organized medicine to react in unison, provincially or nationally. As the Depression progressed, access to healthcare plummeted, in direct relation to diminished incomes. The worst areas hit in Canada were the prairies.

Near simultaneous government interest in state medicine in Alberta and BC captured the CMA's attention. It began by collecting data and studying it (1929-32). The CMA was precipitated to act, when the Alberta government unexpectedly announced the appointment of the Hoadley Commission in March 1932, to design a state health insurance plan.[51] The UFA government's decision forced the CPSA to develop a set of negotiating principles and include them in their brief. They turned to the British medical insurance approach, articulated by CMA president Dr. Harvey Smith, which supported government involvement in the funding of an insurance program. The CPSA discussed the principles underlying their 1932 brief with the CMA executive. Dr. J.S. McEachern was the unobtrusive link with the CMA link.[52] The CPSA brief proposed a hospital and medical insurance program.

At a meeting held on November 26, 1932, between the CPSA's two presentations to the Hoadley Commission on November 8 and December 12, 1932, the CMA's Committee on Economics, now chaired by Dr. Smith, was charged with developing a Plan for Health Insurance in Canada.[53] The CPSA principles became the basis for the CMA Committee's Plan, tabled two years later in March 1934 (Table 1). In its report the Committee noted that no country that had introduced a national insurance program had ever discontinued it.

The CMA took a second approach to the diminished access problem in 1933. It petitioned Prime Minister

Bennett to allow relief funds paid to the provinces, to be used to pay physicians when they provided medical care for those on relief. The CMA executive met with Prime Minister Bennett in October 1933. He refused the request, saying that healthcare was a provincial responsibility.[54] When the western provincial premiers made the same request of Bennett in December 1933, his reply remained unaltered.

Tabled for one year by the CMA, the 1934 plan was reviewed by the provincial associations. The plan committed the CMA to following the British and Alberta approaches to health insurance. That approach included government participation.

The CMA resolve was tested in February 1935, when the American Medical Association refused to support health insurance under any guise. It left the responsibility for health insurance to the patient.[55] Any anticipated joint discussions on the role of government in health insurance never materialized, at the first and only joint Canadian/American annual medical meeting in Atlantic City, New Jersey, in June 1935.[56] For a comparison of the Canadian and American insurance proposals see Table 2. The seventeen CMA principles were tabled at the June meeting. They were accepted (1935) and revised over the next eight years, following the tabling of the Ontario government's agreement to pay physicians providing care for those on relief in 1935, and the demise of the proposed employer/employee limited program in BC in 1937.

To represent all physicians, the CMA needed to be united. The provincial and national organizations had always been separate, with less than 30% of Canadian doctors belonging to the CMA in the mid 1930s (Table 3). The AMA/CPSA led the movement to federate the two organizations. On October 4, 1934 CMA President, Dr. J.S. McEachern met with the combined AMA/CPSA executive as part of his cross-Canada tour. Following the pattern of two other medical associations (Manitoba, BC), the AMA/CPSA executive agreed in principle to join the CMA.[57]

Not satisfied with the progress, in September 1935 Dr. McEachern made the formal motion for the AMA/CPSA to legally join the CMA.[58] The payment of conjoint dues began in December 1936. All other provinces followed the Alberta lead in 1938, uniting or federating the CMA. To record their progress the AMA began the Alberta Medical Bulletin in January 1935.

Archer, seeing the federation movement and unification a fait accompli by 1938, and the Hoadley Commission principles enshrined in the CMA's health insurance plan, decided to take a dual approach to place the Hoadley Commission health insurance concept in front of the CMA and federal Liberal government. In 1939 Archer was elected to the CMA executive. By then the Alberta contingent was the second largest in the CMA. Archer's position, which supported the CMA principles on health insurance, resonated with the executive. His promotion was fast tracked. In June 1941 Archer was elected Vice-President and in 1942/42 he became the third CMA President from Alberta. His primary objective was to obtain CMA consensus and support for a health insurance plan, which he did in January 1943.[59]

Dr. Archer's second approach to nationalize the health insurance concept, was taken in 1940, when he ran as a Liberal in the federal election. Archer lost the election.[60]

The Edmonton Group Hospital Plan (1934)

Another spin-off from the Hoadley Commission's plan was the Edmonton Group Hospitalization Plan.[61] Consistent with their 1932 brief which recommended a joint hospital/medical insurance plan, Drs. A.F. Anderson and W.T. Washburn began a four hospital voluntary insurance program for employers and employees, in Edmonton on March 24, 1934. If the government decided to contribute 2/9ths of the cost, as per the Hoadley Commission recommendations, it could be extended to all Edmontonians. The plan was the first Blue Cross type plan in Canada. It followed the original one that started in Brownsville, Texas in 1929. Hospitals needed a cash flow on which they could rely. Adjacent Edmonton municipalities entered into contracts with some of the Edmonton hospitals. In 1948 the plan was extended by the Manning government to all Albertans, when the government agreed to contribute to it, as the Hoadley Commission had recommended in 1932. The program followed the failure of the 1946 federal health insurance proposal and the discovery of oil in 1947. Participation remained voluntary but on a grouped as opposed to an individual basis, because of the administrative costs.

Hoadley after 1935

The most unexpected outcome of the UFA government's total demise in 1935, was the post-political decision of Hon. George Hoadley to pursue his, by now passionate interest in health insurance. He approached his friend Dr. Clarence Hincks of the National Committee on Mental Hygiene (NCMH(C)) for a job. Hoadley wanted to survey existing health services in Canada, a study of the CMA had wanted since 1932. Hoadley and Hincks obtained the agreement of the NCMH(C) Board chairman Sir Edward Beatty of the CPR, to fund Hoadley for $5000 a year for three years.[62] His study, joined later by Dr. Grant Fleming, became the most comprehensive survey of public health programs to that time.[63]

Provincial communicable, death and other disease rates were accumulated in the study, using data up to 1935. After analyzing the data, the authors concluded that some mortality rates increased if the individ-

ual could not afford to access healthcare.[64] Hoadley and Fleming estimated that twenty-five percent of the Canadian population were indigent or needed a subsidy to pay any health insurance premiums.[65] The authors recognized the need for an actuarial assessment of any plan, if the health insurance program was not 100% tax back.[66] Contracts with municipal doctors were recommended for outlying rural areas where there was no doctor.[67] The document was tabled in early 1939 with the NCMH(C) Board, by then under the chairmanship of Sir (Dr.) F.G. Banting. It was published in late 1939 by Metropolitan Life. Hoadley continued his crusade by joining the Dominion Health study group based in Toronto. The Hoadley/Fleming Study of the Distribution of Health Services appeared to be referenced primarily in subsequent CCF publications.[68]

The Rowell-Sirois Royal Commission (1937-1940)[69]

At the first health ministers conference in May 1935, Hoadley called for a Royal Commission to assess the effects of the Depression in access to healthcare.[70] Prime Minister Bennett had started to address these issues with his 1935 Employment Insurance and Social Benefits Act. It was declared ultra vires by the British Privy Council. The new King government inherited the problem. It appointed the Rowell-Sirois Commission (1937-1940) instead, to determine which level of government was responsible for the social programs (pensions, unemployment, WCB, and health) not covered by the BNA Act. To help discharge its mandate the Commission appointed social scientist, Professor A. Grauer of the UofT to study public health in Canada.[71]

In their January 1938 brief the CMA seemed unaware of the Hoadley study, as it asked for a national assessment of healthcare in Canada. At the same time the CMA declined to support a national insurance plan.[72] In April 1938 Drs. A.E. Archer and W.A. Wilson presented the CPSA brief to the Commission. It specifically endorsed the health insurance concept proposed by the Hoadley Commission.[73] Following their brief, which listed the healthcare responsibilities they thought the federal government should discharge, Archer said he was pessimistic about what had been accomplished toward the development of a national program.[74]

The Social Credit Government (1935-1943)

The new Social Credit government inherited and supported the Hoadley designed health insurance proposal. Delayed for the first two years by the struggle with the provincial deficit and their own economic philosophy, the government passed eleven Acts which were declared ultra vires. Dr. M.R. Bow continued as the Deputy Minister of Health, and returned the government to a less expensive public health orientated agenda. The healthcare insurance was set aside – temporarily. The government passed the second free TB Act in Canada (1936), the first Polio Rehabilitation Act (1938), and the first free Cancer Act (1941). Bow became President of the Canadian Public Health Association in 1936, another recognition of his stature in the field of public health. While the effect of the Depression was diminishing in Alberta, in Saskatchewan it continued. There was no Saskatchewan funding available for extras let alone an expensive health insurance program.[75]

In 1938 Health Minister Dr. W.W. Cross indicated for the first time that a health insurance program could be implemented by extending the WCB program.[76] He took no further action until 1942. That year, in anticipation of the passage of a Federal Enabling Act, the Alberta government re-passed the UFA's 1935 Health Insurance Act (1942) with virtually no change. The Alberta Act and the federal Haegerty Advisory Committee proposals meshed perfectly in their coverage of services and citizens, and were similar in their proposed provincial financing expectations.

The Federal Government (1939-1946)[77]

The Rowell-Sirois Commission reaffirmed healthcare was a provincial responsibility, but the federal government could still make specified healthcare grants to the provinces.[78] After WWI, future Prime Minister King interpreted Canadians, as wanting a more humane society for winning the war. It led the Liberal party to incorporate a health insurance plan into their party platform. King expected WWII would be no different. In late 1939 the first federal interest in health insurance appeared, following the appointment of BC's Dr. Ian MacIntosh as the Minister of Health and Pensions, in a September 1939 war time reshuffle. The Prime Minister was amendable to the request to have a feasibility committee appointed to assess its merits. To orchestrate the CMA's input a wartime Committee of Seven, was appointed in June 1941. It included Dr. Archer. McIntosh and his deputy minister Dr. J.J. Haegerty quickly concluded the major parties were interested in a health insurance plan.

The federal Haegerty Advisory Committee was formally appointed in January 1942 to research health insurance. The Haegerty report was tabled in March 1943 and recommended the same coverage of services as the Hoadley Commission had in 1932, namely doctors, hospitals, drugs, dentists, and essential nursing services.[79] It assumed that public health services would continue to be paid by provincial governments. The Haegerty Commission suggested financial support by the two levels of government be about two-thirds of the estimated $230 million cost, with the provinces paying somewhere between 10-35% of the total.[80]

To continue to lead the CMA position, Archer was appointed the chairman of the Executive Committee in June 1943, the first Albertan to be so honored. The voluminous Haegerty report was turned over to the House of Commons Social Security Committee, who endorsed it with minor changes after its 1943/44 review. It was then reviewed by the finance committee of cabinet. They recommended full funding for the program sometime before the Dominion/ Provincial Reconstruction Conference in 1945.[81]

Archer stepped down from his CMA executive position, to run as a Liberal in the federal election for a second time (1945). It was rumored that King offered him the Minister of Health position.[82] As in 1940 Dr. Archer was defeated by the Ukrainian Social Credit candidate, Anthony Hlynka. The CMA then appointed Archer as their Consultant on Economics. He crisscrossed the country supporting the federal proposal. It was the Hoadley Committee's proposal of 1932, with 100% government funding.

The Social Credit Government (1943-1968)

Both Premier Manning, who succeeded Aberhart in 1943, and Health Minister Dr. W.W. Cross who inherited the UFA government's approach to health insurance (1935), accepted the concept of a government subsidized health insurance program. After the 1945 federal proposal failed over Ontario/Quebec tax objections, the Manning government supported the extension of the Edmonton group hospital insurance plan across the province in 1948. At the same time Manning and his cabinet accepted the Archer chaired AMA Committee on Economics' recommendation that a government Act be passed to enable the formation of a medical insurance company by the AMA/CPSA. It became the successful Medical Services of Alberta Incorporated or MS(ofA)I better known as MSI. The enabling Act was passed in 1947 and MSI began to operate in 1948. The first chairman of the MSI board was Dr. A.E. Archer.[83]

Premier Manning viewed the involvement of the federal government in healthcare insurance as interference in a provincial jurisdiction. After the federal government introduced its 50/50 payment plan for hospital insurance in 1957, Dr. Cross retired as the Minister of Health. In 1969, Cross' successor Dr. J.D. Ross resigned as Health Minister, following the federal government's second intervention into healthcare and the passage of the Canada Medical Care Act. Premier Manning retired too in December 1968.[84]

The First Provincial (Hoadley) Alberta Health Insurance Proposal[85]

Noted historians have researched the history of health insurance and viewed events prior to the involvement of the federal government in 1939 as marginal (Taylor 1978) (see Table 4)[86]; discontinuous in Alberta's case as documented in the CMAJ (Naylor 1986)[87]; or to have occurred in Saskatchewan (Houston 2002)[88]. With no study of the evolution of health insurance in Alberta, the role of Albertans has been overlooked.

1. The Fee for Service vs Salaried or Contracted Practice Debate: Full time physicians under four year contracts with the NWMP and Indian Department (Kittson, Nevitt, et al), brought medical care to the Alberta and Saskatchewan prairies (1874-1892). More physicians on temporary contracts came with the CPR construction crews (1883-1885). Some stayed by signing CPR employer/employee contracts (in Calgary, Banff, 1886), as Calgary became the CPR prairie and mountain region hub. Coal mining companies in Southern Alberta, signed many physician contracts in Lethbridge, Bankhead, Canmore, the Crowsnest Pass and later Drumheller. So did the lumber companies. Corporate contracted medical practice was not limited to Alberta. There were numerous other examples of corporate medical contracts outside Alberta, particularly in BC and the coal towns of Nova Scotia. The practice was never as widespread as it was in Southern Alberta, where a large percentage of physicians were providing contracted care in some form by the turn of the century.

In 1907 contracted practice received its first official rebuke from the new Calgary Medical Society, when influential Registrar Dr. J.D. Lafferty decried medical contracts as unethical and a limitation on practice. He succeeded in having many contracts tendered, but not the CPR contracts which were under the control of the CPR VP and Dr. H.G. Mackid, of Calgary. The next year (1908) Mackid expanded the CPR's prepaid medical program for its 3-5000 employees, to cover hospital care at the CGH at fifty cents per employee per month. It saved the financially strapped Calgary General Hospital.

The debate over medical contracts continued. The Lafferty principles were re-approved, after the AMA/CPSA were merged in 1921/22.[89] Despite the official attitude, contracts continued to be signed and the debate simmered. It would not be put to rest. The latest AMA/CPSA policies were promulgated in the AMB and CMAJ in 1936.[90]

The Hoadley Commission limited physician contracts to uneconomical areas of the province, as did the CMA in its Plan (1934) and Hoadley/Fleming in their study (1939).

Periodically Alberta, Saskatchewan and Manitoba physicians reviewed the municipal medical contract. Their opinions were rarely complimentary. The system lasted from 1920 to a peak of 180 contracts in 1948; with one-quarter of all the Saskatchewan municipalities, plus a few in Alberta (6) and

Manitoba (10).[91] Prairie physicians criticized it for the high turnover rates, variable terms, low amounts, and lack of a pension plan,[92] although one positive result was the reduction in write offs from uncollected fees in the 1930s. The practice suffered a near death when the provincial medical insurance programs began after WWII. The last municipal doctor contract ended in Mannville, Alberta in 1968.[93]

The provincial government entered the medical contracting field (Hoadley 1926) by paying bonuses and subsidies to keep doctors in the arid Palliser Triangle. The practice was extended to retain public health physicians in rural areas, although the provincial payments were minimal. The 1927 rumor of an ill defined state medicine program captured the AMA/CPSA's attention. Fear of a provincial salaried physician program was well founded. After Hoadley received the White/Pattinson Inquiry report in 1929, he initiated a four (all female) contract physician program in northwest Alberta. They cost half as much as a male physician or $2,000/year. Premier Aberhart ended the program in 1936.

The Depression reduced Alberta's provincial GDP by 58%.[94] Medical incomes dropped by as much as eighty percent in the driest areas. The number of Albertans who could not afford healthcare, doubled.[95] The medical profession became much more amenable to some form of civic/municipal/provincial funding.

It started in Cardston (1932) when one-half the community signed prepaid medical contracts within two months. By December 1932 both the CPSA and AHA, were in agreement with the Hoadley Commission and the White/Pattinson Inquiry, that it should be an insurance program covering physician as well as hospital services.

In a trial of the concept, Dr. Archer (1933/34) signed a Lamont Clinic agreement for prepaid medical services with the entire nearby Wostok municipality. Since the contract was with the clinic, it circumvented the ethical issue of all doctors in the community providing care, signing an agreement with the plan's trustees, and being able to convince patients to join it. The backlog of Wostok patients, demonstrated to Archer the magnitude of the unmet need for medical care, although it was very costly to his clinic.

In the preparation of their 1932 brief, the CPSA had quietly consulted the CMA, who agreed with four or five of the principles that were incorporated into the Alberta plan.[96] That request kick-started the CMA into drafting its own principles, in a Plan for Health Insurance in Canada.

In June 1935 at the joint American/Canadian medical meeting, there was enough CMA support for government involvement in an insurance program, to avoid aligning the CMA with the Americans, who refuse to participate in any insurance program. The CMA's Plan was tabled (1934) and approved (1935). It represented a milestone decision by the CMA. The Hoadley Commission proposal, which was enacted into law in April 1935, did not violate the CMA principles.[97]

Support for the CMA medical insurance Plan was strong enough to withstand a second challenge from BC, where the government offered little funding for a proposed health insurance program (1936), and then withdrew its offer before the election in 1937. Notwithstanding, fifty-nine percent of BC residents voted in favor of the program in the election referendum.[98] Elsewhere in Canada the third prepaid medical insurance program began in Ontario (1937), when civil servants signed an agreement with Dr. J. Hannah to start a provincial medical insurance program.[99] The fourth program began in the Windsor district in 1939. It was followed by the BC Medical Association's plan that started in 1940.

2. Government Funding of Hospitals: The second element of a health insurance program was the funding of hospitals by municipal, provincial and federal governments. The first example of a hospital insurance plan in Alberta arose in Medicine Hat in 1889.[100]

Until 1917, financial support for Alberta's hospitals was fragile, and their ability to handle the high return rate of WWI disabled veterans and the catastrophic Spanish Flu epidemic, well neigh impossible.

In Alberta the concept of a province wide municipal hospital program with the power to raise funds through land taxation, was led by women (the UFWA) after they gained the right to vote in 1915. The first municipal hospital opened in 1917 in the border town of Lloydminster. From there the program spread throughout rural Alberta and Saskatchewan. It quickly led to the formation of the Hospital Association of Alberta (1919) and the first and only Municipal Hospital Association (1920-1943). In 1921 the determined advocate for improved care, Irene Parlby, was appointed the Minister without Portfolio (1921-1935), responsible for women's (including health) issues. She became Hoadley's strongest cabinet supporter.

Vigorous leadership of the health portfolio, followed the appointment of the Honorable George Hoadley as Health Minister (1923).[101] By the 1920s the province was providing per diem operating subsidies to approved hospitals. The rural municipal hospital program, became so successful that Hoadley placed a moratorium on more beds (1926). By the time the White/Pattinson Inquiry (1929) deemed a state medicine program to be feasible, most urban and municipal councils in Alberta were contributing funds for hospital construction and operation. The stage was

set for the province to become more involved,[102] as it had for mental hospitals (1911), the TB hospital (1920), the polio hospital (1927) and the expansion of mental hospital services (1929).

Because of the Depression, little happened until 1932 when Hoadley appointed his Commission. After researching recent worldwide health insurance initiatives and experiences, Hoadley agreed with the CPSA and the AHA briefs that hospitals should be included under a health insurance plan. The commission recommended coverage be extended to include less expensive drugs and dental services.

In anticipation of the passage of the Hoadley Commission recommendations, the Edmonton group hospitalization plan started with four hospitals (1934), before being extended province wide by the Manning government in 1948, under the control of Blue Cross of Alberta.

In the CMA's 1934 Plan containing the principles for negotiating with governments, the inclusion of hospitals in an insurance plan was left as optional. In January 1943 the CMA approved participation in a national insurance plan. It was to be the Haegerty Committee plan, which included medical, hospital, drug and dental services.

3. Coverage of those who could not afford health insurance: The third element was funding those who could not afford to pay for it, commonly referred to as the indigent.

Although the BC Royal Commission had recommended a 1/9th provincial contribution (1921) and a further 1/9th federal contribution (1932), in an employer/employee program, no pre-1932 BC government supported paying for those with little or no income, except for a token amount in a 1936 proposal, which was withdrawn in the next revision, following objections by employers and the CMA/BCMA.

The approach to the indigent changed when Alberta's White/Pattinson Inquiry (1929) deemed a plan for all Albertans as feasible. The Hoadley Commission (1932) agreed, as did the CPSA and the AHA. It was a potentially costly decision because the size of the indigent population could only be estimated. When the Depression doubled the number of Albertans who could not access healthcare, Hoadley accepted that some level of provincial support was needed to cover the most destitute. The Hoadley Commission took the position that the design of the plan should be idealistic and long term and overlook the Depression in which it was created. It was to be phased in on a hospital by hospital district basis as funds permitted.

The federal government reacted by adamantly refusing to contribute to any medical insurance program, whether it was to the BC Royal Commission (1931), the Hoadley Commission plan, the western premiers request (1933), or the Ontario relief plan (1935). It left the profession applying to all levels of municipal and civic government, for financial assistance before withdrawing services (Vancouver 1933) and even striking (Winnipeg 1933). As McEachern stated, the BNA Act was being used as an alibi (1934).[103]

Hoadley would personally address his own unanswered question and conclude the indigent represented 25% of Canadians (1939).

The Haegerty Advisory Committee would finally address the national question and recommend that everyone be covered by the plan. Although it did not recommend a specific provincial contribution to the cost, the Alberta government did in 1942 – 2/9ths.

4. Uniting the elements into a health insurance program: The concept of health insurance began in Germany and extended to Britain in 1912. Health insurance was discussed at an annual CMA meeting in 1914. It was added to the Liberal party platform in 1919. Despite its growing acceptance worldwide as a health, sickness, absentee and disability insurance plan in Europe and the USA, interest remained limited and provincially based in Canada. The BC Royal Commissions (1921, 1928-1932) proposed an employee/employer health insurance program based on a minimum income.

As he had in his terms of reference for the White/Pattinson Inquiry, Hoadley simplified and clarified the proposal, reducing it to a pure health insurance program, devoid of absentee benefits or cash payments. He was years ahead of the European plans in defining what wouldn't be included. The date of Hoadley's decision to include hospitals is not clear. Municipal hospitals were important to him, as evidenced by his hands on control of the system. He knew that medical insurance could only be added with agreement of the AMA/CPSA. Hence his request in 1931 for more "cooperation" from individual physicians. CMA President Dr. Smith had supported it already (1930). In 1932 the CPSA also supported the inclusion of medical services, as did the CMA in its 1934 plan. Inclusion of hospital services was optional to the CMA, but desired by the CPSA and proven acceptable to the public in the Cardston and Lamont examples. Not until the federal government changed its support for a health insurance program, from an abject refusal (1933) to a tacit approval (Haegerty, 1943), would the health insurance concept be considered nationally.

5. Nationalizing the Concept: The CMA's nearly frozen attitude towards health insurance began to soften in 1929. The fear of a salaried medicine program in Alberta, and the 1929 appointment of a BC Royal Commission, prompted the CMA to begin to research the concept in 1929. At the 1930 joint CMA

meeting, CMA President Dr. Harvey Smith voiced his support for a medical insurance program. In November 1932, as the Hoadley Commission reached an accord with the CPSA, the CMA changed its study approach, to one to draft a set of medical insurance principles for negotiating with governments. The plan, based on the Hoadley accord, underwent minor revisions (1935-1941).

The Alberta accord might have dissolved or passed into obscurity following Hoadley's electoral defeat (August 1935) and the completion of Dr. J.S. McEachern's CMA Presidency (June 1935), had not Archer received a 20:1 vote of support from Alberta doctors (1933) and a moral obligation to advance the Alberta plan. Although Saskatchewan physicians were adamantly opposed to a national plan because of the municipal doctors plan, the Saskatchewan government couldn't proceed because it had no funds.

After the CMA was united (1938), Archer saw his opportunity and decided to nationalize the issue using on the Hoadley accord. By 1938, Drs. Cross/Bow were on side. The Rowell-Sirois Royal Commission would clarify responsibilities but would not recommend a health insurance plan. The Hoadley/Fleming study confirmed what Archer already had proven, that the medical-hospital-public health (Di Bozsha) model improved care indices. Archer decided to make his move. He began by joining the CMA executive in June 1939.

The first federal cabinet indication of interest came in September 1939 from the BC MP and new Minister of Pensions and Health, Dr. Ian MacIntosh. He sought the tacit approval of Prime Minister King to begin to investigate the concept on a national scale, and received it. MacIntosh appointed the Haegerty Advisory Committee (1942). The CMA appointed its Committee of Seven to advise it.[104] The Haegerty Committee produced a plan (1942/43), that recommended the same coverage of services and citizens (all) as the Hoadley Commission had recommended for Albertans. In 1943 CMA President Dr. Archer obtained the CMA's unanimous support for a national plan.

The federal Haegerty proposal was so similar to the Hoadley Commission one that the Alberta government had only to re-pass the 1935 Alberta (UFA) Act, unaltered. A 1942 Gallup poll, found 76% of Canadians were willing to contribute to a national health insurance plan,[105] an increase from the 59% support in BC in 1937, the CMA and the government were encouraged to proceed.

6. The Fourth Element – Provincial and Federal Funding: The cost of any health insurance program was dependent on the services to be covered. Physician services were one cost. Coverage of hospitals more than doubled the cost. In the pre-antibiotic era, these two were about 75% of the healthcare costs.[106] To be comprehensive, the services to be insured had been set by the Hoadley Commission (1932): doctors, hospitals, drugs and dentists.

Provincial funding was first recommended by the BC Royal Commission (1921) for a European like employer/employee benefit program. It was increased to 2/9ths of the cost in a health insurance plan with possible maternity benefits (1932), before the federal government refused to participate.

The Hoadley Commission (1932) recommended the same 2/9ths government contribution in a province wide plan, for those who could not afford the premiums. Any deficits were to be covered by increasing fees and/or through reserves. The Depression curtailed any other offers of provincial government funding.

When WWII brought the country out of the Depression and dramatically increased government GDPs, the federal government became accustomed to billion dollar war time decisions. After the ambiguities surrounding the funding of social programs were clarified by the Rowell-Sirois Royal Commission (1940), the King cabinet was ready to address the health insurance issue. Its Haegerty Committee recommended the Hoadley Commission range of services. They were estimated to cost $230-250 million per year for a national program.

The Haegerty Committee recommended a range of funding options. The Alberta government was specific when it offered 2/9ths provincial funding by re-passing the 1935 Act intact, in 1942. After the House of Commons all party Social Services Committee supported the Haegerty concept, the cabinet decided it would be easier to generate the required revenue through increased taxation rather than requiring additional premiums from individuals. The 1945 federal proposal dissolved following disagreements over the right to tax personal incomes, not the services to be covered.

The Place of Hoadley and the Hoadley Commission in Canadian Health Insurance History

Hoadley and the Hoadley Commission are inseparable. The appointment of the Commission was only one step among many taken by Hoadley, to address the UFA's goal of improving healthcare through preventative and interventional means.

By 1928 the UFA government was becoming concerned over the access to healthcare. It felt it had a responsibility to address the problem, even before the Depression. With the dramatic (50%) decrease in access to medical care caused by the Depression, and the rapid public acceptance of a prepaid medical insurance program in Cardston, alongside a pre-

existing municipal hospital program, Hoadley decided to appoint the Hoadley Commission (1932).

The heretofore relatively unknown Hoadley Commission has been viewed as an incidental or isolated initiative, by the soon to be demised and forgotten UFA government. But unlike most healthcare Commissions, it was led by two cabinet ministers and included the health leaders from all the parties to ensure all party support for its recommendations. As a result there were no changes from the last draft in December 1932 until the Act received royal assent in April 1935. By 1934 Hoadley had become Alberta's Deputy Premier. He was so passionate about solving the health access problem that he exuberantly declared in July 1935, "Humanity is on the march. Out of the great upheaval of recent years, I am confident that a greater civilization than we have known will be evolved…It is vital to the future well being of our people."[107]

Hoadley deserves recognition for the many decisions he made both before and after the 1932-1934 Commission. Hoadley was responsible 1) for interpreting state medicine as a state health insurance program; 2) for narrowing the concept from an employer/employee benefit program to a pure healthcare one, without absentee or sickness benefits; 3) for supporting the BC Commission recommendation for a 2/9th government contribution, but for a different reason – to pay for those who couldn't; 4) for designing a plan to cover all Albertans; 5) for not forcing the Saskatchewan municipal doctor program into the design of the Commission's program; 6) for recognizing the requirement for an actuarial reserve in the absence of 100% tax backed funding; 7) for calling for a federal healthcare Royal Commission (1935) that was bundled into the Rowell-Sirois Royal Commission; and 8) for his post political research and conclusion that reduced access to healthcare increased morbidity and mortality.

The Hoadley Commission itself deserves some recognition: 1) for reaching an accord with the provincial medical college to insured physician and hospital services; 2) for extending coverage to include the less expensive drugs and dental services; 3) for determining how to take voluntary participation and make it mandatory and eventually province wide, through municipal votes that guaranteed a cash flow for the program; 4) for developing a rural plan and outlining how it could be urbanized; 5) for including a control mechanism to affect the rate of implementation and thus the cost to the Treasury; 6) for identifying a separate less expensive urban Plan B, if the first Plan A was not acceptable; 7) for designing an administrative process that incorporated most of the hallmarks of today's Medicare (government operated, negotiated fees, a Commission to oversee it); 8) for being idealistic or intentionally farsighted in its proposal and not a short term or Depression limited; and 9) for leaving successive Alberta Governments with a contributory and not a universally funded provincial concept of health insurance, that would be debated for the next thirty years.

The outcome of the Commission's proposal and agreement were quickly recognizable. 1) The CMA designed a plan for health insurance for negotiating with any government. 2) The CPSA not only agreed with the Hoadley Commission proposal but never retracted, altered or qualified its position. 3) The Commission crystallized the efforts of four Edmonton hospitals to start a Blue Cross type hospital insurance, which could be integrated into the Commission's proposal. 4) The successor Social Credit government, supported the proposal in principle and later in detail, by re-passing the 1935 Act verbatim in 1942.

The UFA organization itself, would take the Alberta healthcare concept with it, when it joined the fledging CCF (now the NDP) and participated in the drafting of the Regina Manifesto (1933).

The Place of Dr. Archer in Canadian Health Insurance History

Dr. Archer led the medical profession on the health insurance issue, first in Alberta (1927-1939) and then through the CMA (1941-1946). The quiet, compassionate physician with a steely resolve, dedicated his life to improving access to medical care. It began when Dr. Archer came west as a medical missionary to the Ukrainians (1903). Then he helped start found two hospital associations (1919, 1920) before merging the AMA/CPSA (1920/21) into a more powerful body. After starting his own clinic (1925) he rotated with Dr. W.A. Wilson through the influential CPSA presidency position from 1928-1939. Archer and Wilson identified the first principles for an acceptable provincial health insurance program (1932): coverage of medical and hospital services, establishment of a commission, flowing funds through a central government body, and limiting contract physicians to uneconomical areas. They secured 20:1 support for it from Alberta's physicians (1933). Then Archer tested a combined hospital and medical contracts program with resounding success (1934), before working with the AMA/CPSA (October 1934) to develop the strategy to unite the CMA to face the health insurance issue, nationally.

After the faltering of the Hoadley initiative (1935) and the perceived failure of the Rowell-Sirois Royal Commission to recommend a health insurance program, Dr. Archer undertook to lead the CMA. He was again successful in gaining unanimous physician support for the 1943 CMA principles and the concept of a national plan, to be forward to the Haegerty

Advisory Committee. It reached the same conclusions in terms of coverage of service and citizens as the Hoadley Commission. To use Dr. Archer's expression Haegerty did not violate the CMA principles. The only person common to both agreements was Dr. A.E. Archer.

After 1944 Dr. Archer did his utmost to secure additional support for the federal proposal from many other health organizations, before unsuccessfully running again for election as an MP (1945). In 1946 he visited Premier Douglas to convince him to use a Commission to manage his plan (1946). Disappointed but not deterred by the national funding failure (1946), he returned to Alberta to assist in the establishment of the hospital and medical insurance programs, and initiate the medical (MSI) one.

The Place of Alberta in Health Insurance History

The place of Alberta has heretofore been unknown. Despite its juxtaposition position to healthcare proponents in BC and Saskatchewan, and despite its common roots with the latter, the Alberta role has been unseen on the radar screen. The adversarial and sometimes controversial healthcare initiatives in both neighboring provinces overshadowed the quick, unanimous, and harmoniously 1932 agreement in Alberta. Few could have portended that such a simple agreement would engender the resolve to see it implemented, even when it meant waiting for a decade for the right time to re-raise it, and secure national support for it.

The accord was the highpoint in the UFA's healthcare agenda, one that philosophically began during WWI. After 1915, one UFA focus was on improving the access to care for all Albertans; through the development of the municipal hospital system, improving health through public health programs, extending the traveling clinic to remote and northern areas of the province, and directly intervening in healthcare through subsidization of physicians in the Palliser Triangle and Northern Alberta. Those steps represented a pattern of progressive problem solving decisions taken in the 1920s, and designed to improve the access to and the quality of healthcare in Alberta.

As the UFA government embarked on its ultimate challenge in 1928, to introduce the Hoadley Commission designed health insurance program, it could not have predicted the strength of the agreement it had achieved. It would be supported without alteration by subsequent Alberta governments, Cabinets, Ministers of Health, the AMA/CPSA, and the public, without ever being revised or altered. With time and broader support the concept survived the economic deferral caused by the Depression. It stood the test of time, until the return of better economic conditions. Only then, as predicted by Irene Parlby,[108] did the will to implement it become a national one. That came during WWII, as the second government in Canada, the federal government, came to the same conclusion as the Hoadley Commission in its proposed coverage of services, citizens and provision of provincial funding.

From the Hoadley Commission agreement with the CPSA came the first principles for negotiating a national agreement, which Drs. Archer and McEachern embedded in the 1934 CMA plan. The Haegerty Advisory Committee proposal, developed through a federal, primarily non-medical committee while receiving periodic advice from the CMA, came to the same conclusions as the Hoadley Commission had a decade before, in terms of service coverage, citizen coverage and even funding. Not only was the Hoadley Commission concept duplicated, it was validated as the template for a national health insurance program for Canada.

Because the Alberta proposal was achieved without discord, it received little fanfare. The UFA party disappeared long before 1946, but the health insurance issue unfolded as Irene Parlby predicted. The will to address it had finally been found.[108] Only the issues of contributory versus universal government funding and the proportion of federal/provincial cost sharing, remained to be resolved.

After WWII: The challenge faced by the new Premier of Saskatchewan T.C. Douglas (1944), whose province had fallen behind Alberta in its ratio of beds and access to hospital services, was to catch up.[109] To do so he taxed all Saskatchewan citizens to support the provincial hospital insurance program (1947). When the federal government offered to cover fifty percent of the hospital insurance costs (1957), it was not a difficult decision for Douglas to take over the less expensive provincial medical insurance programs in 1962. The Saskatchewan example led to the federal Hall Royal Commission (1962-1964). It recommended the Saskatchewan universal funding approach for all Canadians. The ideological clash over contributory vs universal government funding between Alberta and Saskatchewan, was only settled when the federal government exercised its monetary and statutory power, and nationalized the Saskatchewan plan (1967/68).

In Canada's centennial year (1967), the protestations of Manning and others narrowed the proposed healthcare services to be insured, by excluding drugs and dentists, thus reducing future cost to taxpayers. In the process the federal government reduced insured healthcare coverage from those services recommended by the Hoadley Commission, to those recommended by Drs. Archer/Wilson on behalf of

the CPSA in 1932, namely hospitals and doctors.

The second Alberta government decision that protected Medicare by reducing its cost, came in 1993 when Premier Klein removed twenty-five percent or more of the beds from the system, through across the board fiscal cuts, regionalization and the creation of a third cost control centre.

Since 1968 the major changes in Canadian Medicare have centered on outlawing extra billing, and on provincial/federal disagreements over cost sharing. The federal government has reduced its contribution to the cost of healthcare in Alberta, from sixty percent in the 1945 proposal to sixteen percent in 2000. With control encapsulated in federal legislation (1968, 1983), the ability to experiment and introduce more efficient changes in the way healthcare is delivered, has been stifled, penalized or brought to a standstill. The fact that healthcare is a provincial responsibility under the BNA Act has become immaterial. The end result has been to freeze the system, stall initiative, and underachieve, even though the relative freeze on new bed construction, has still left provincial expenditures on healthcare close to fifty percent of all provincial government revenues.

Other jurisdictions (Australia, Europe) have found creative ways to control or share costs and implement efficiencies in their system, while Canadians perpetuate the myths of Medicare (Table 5).

Where there is a problem there is an opportunity. The leadership provided by Alberta politicians and physicians in 1932, now almost seventy-five years ago and long forgotten, needs resurrection. Alberta has a birthright and a BNA right to address the Medicare issues and design and make improvements to it. It conceptualized it and now has the additional resources with which to experiment with it, without diminishing its quality. It has already demonstrated leadership in the fields of medical care, education and research. The Alberta potential to take risks, be creative and find more efficient methods of service delivery, has been subrogated to the national will.

Without changes to Medicare, Canadians will continue to be forced to go abroad for care they should be receiving in Canada. Other countries have already found that by providing high quality and easy to access healthcare services, they can earn significant international revenue. Canadian healthcare services insured under Medicare, currently cost Canadians roughly one-half the cost for the same service in the USA. These high quality, efficiently performed services are being withheld from the world marketplace. Instead Canada is exporting doctors, when it should be importing patients. While Canadian taxpayers (vs American) are saving an astronomical 5% of their GDP through low Medicare costs, the system has failed to achieve its economic potential under the existing federal Acts and Regulations.[110]

As Dr. Walter Mackenzie voiced thirty years ago, "can growing discontent within our profession be blamed on a piece of legislation of good intent?" His answer was "yes."[111]

Table 1:
Comparison of the Hoadley (1932/33), CMA (1934) and Haegerty (1943) Health Insurance Proposals

Issue	Hoadley Commission	CMA Plan	Haegerty Proposal
1. Administration	Managed central fund	Independent committee	Provincial Committee
2. Boards	1 of 3 to be a doctor	To be appointed	Independent Committee
3. Professional issues	Delegated to medical profession	Delegated to medical profession	Silent
4. Districts	To be municipal hospital based, separate civic plan	Each province to determine	Each province to determine
5. Public health	Covered in plan	Under an MOH	Covered by proposal
6. Regional officer	Not mentioned	Paid by central fund	Silent
7. Indigents	Covered by government	Covered by government	Covered by government
8. Low income	Covered by plan	Covered by plan	Covered by proposal
9. Dependents	Covered by plan	Covered by plan	Covered by proposal
10. Hospital insurance	Covered by plan	To be offered voluntarily	Covered by proposal
11. Medical insurance	Covered by plan	The only benefit covered	Covered by proposal
12. Dentists Drugs	Covered by plan Covered by plan	Not covered by plan Not covered by plan	Covered by proposal

Issue	Hoadley Commission	CMA Plan	Haegerty Proposal
13. Contributors	Individual, employer, provincial government	Individual with the government to pay the employer and "indigent" premium	Covered by proposal
14. Payments by individual, employer	Set by Plan A, B	To be negotiated by each province	Federal and Provincial governments
15. Fee schedule	To be negotiated	Set by physicians	Not discussed
16. Control of fee schedule	To be negotiated	Each provincial association	To be negotiated by the province
17. Contract practice	Remote areas only	Remote areas only	
18. Deterrent fees	Not mentioned	Not to be allowed	
19. Standards	Not mentioned	Equal or better than in existence	

Reference: CMA's Plan for Health Insurance in Canada (1934), Hoadley Preliminary and Final Reports in 1933, 1934

Table 2:
The Health Insurance Principles of the Canadian and American Medical Associations (1934-35)

Canadian Medical Association Principles (1934)	American Medical Association Principles (1934)
1. That … state health insurance … [should] be administered by the departments of public health [whether or not under a Commission]	1. All features of medical service in any method of medical practice should be under the control of the medical profession.
2. That a Central Health Insurance Board and Local Insurance Boards be appointed...to advise the responsible administrative authority	2. No third party must be permitted to come between the patient and his physician in any medical relation.
3. That...medical service be the responsibility of the organized medical profession through the appointment...of a Central Medical Services Committee and Local Medical Services Committees...	3. Patients must have absolute freedom to choose a legally qualified Doctor of Medicine who will serve them from among all those qualified to practice...
4. That local areas for health insurance administration correspond to urban municipalities and rural health unit areas.	4. The method of giving the service must retain a permanent, confidential relation between the patient and the "family physician."
5. That the whole province be served by adequate departments of public health …	5. All medical phases of all institutions involved in the medical service should be under professional control, it being understood that hospital service and medical service should be considered separately.
6. That there be a State Health Insurance Fund, provincially controlled, and that "regional officers" … act as supervisors and referees …	6. Medical service must have no connection with any cash benefits.
7. That medical care for indigents be provided under the Plan, the State to pay the premiums for the indigent, who then receive medical care under exactly the same conditions …	7. Systems for the relief of low income classes should be limited strictly to those below the "comfort level" standard of income.
8. That the Plan be compulsory for persons, with dependents, having an income of less than $2,500 per annum, and for persons, without dependents, having an income of $1,200 and less per annum.	8. However the cost of medical service may be distributed, the immediate cost should be borne by the patient, if able to pay, at the time the service is rendered.
9. That the dependents of insured persons be eligible for the medical benefit.	9. Any form of medical service should include within its scope all qualified physicians in the locality …
10. That there be offered, on a voluntary basis, to those with income above the Health Insurance level, Hospital Care Insurance …	10. There should be no restrictions by non-medical groups on treatment or prescribing unless formulated and enforced by the medical profession.

Canadian Medical Association Principles (1934)	American Medical Association Principles (1934)
11. That the only benefit under the Plan be the medical benefit;	
12. That the medical benefit be organized as follows: (a) Every qualified licensed practitioner to be eligible to practice. (b) The insured person to have freedom of choice of general practitioner; (d) Additional services: (1) Specialist and consultant medical service. (2) Visiting nurse service in the home; (3) Hospital care; (4) Auxiliary services - usually in the hospital; (5) Pharmaceutical service. (6) Dental service.	
13. That the Insurance Fund should receive contributions from the insured, the employers of the insured, and the State.	
14. That the medical practitioners of each local area be remunerated according to the method of payment which they select.	
15. That the Central Medical Services Committee decide the relationship between specialist and general practitioner fees, and between medical and surgical fees.	
16. That contract-salary service be limited to areas with a population insufficient to maintain a general practitioner…	
17. That no economic barrier be imposed between doctor and patient, but that the insured be required to pay a part of the cost of medicines.	

Table 3:
Physicians belonging to the Provincial Medical Associations (1932/33) and the CMA (1936)

	Physicians Belonging To Provincial Medical Associations 1932/33		Physicians Belonging to the CMA in 1936	
Province	**Total # of Drs.**	**% Members**	**# CMA Members**	**% Members**
BC	350	100	296	46
Alberta	550	100	535	97* (actually 100)
Saskatchewan	575	100	213	37
Manitoba	600	50	166	28
Ontario	4000	35	871	22
Quebec	2650	23	313	12
New Brunswick	285	100	106	37
Nova Scotia	450	30	117	26
TOTAL	9755	44	2627	27

PEI figures not included.

**Initially it was every doctor registered in Alberta. After 1937 it was every doctor, whose registration dues were current.*

Table 4:
Analysis of Professor Taylor's Outcomes Arising from the 1940-1945 Federal Proposals

Professor Taylor's Outcomes 1940-1945	1940 or Pre-1940 Activity
1. The health status was brought to public attention.	Enlistment medical examination rejection rates already had. The physician work to rule campaigns of 1933 highlighted the problem of free care vs. no care. Strong public support for health insurance was noted as early as 1929. The deluge of patients in the Lamont Di Bozcha program (1934) highlighted the unmet care need. The federal government opposed a plan until 1935; deferred action by calling the Rowell-Sirois Royal Commission and only in late 1939, began to address the issue. BC voters voted 59% in favour of a plan in 1937. A Gallup Poll indicated national public support already at 70-80% by 1942.
High perinatal death rates	They were well known, and were included in the 1938/39 Hoadley/Fleming study using 1935 public health data.
High maternal death rates	They were included in the 1938/39 Hoadley/Fleming study using 1935 public health data.
Wide variation in infectious disease rates	They were demonstrated in the 1938/39 Hoadley/Fleming study using 1935 public health data.
2. There was rural/urban disparity in access to healthcare.	It was recognized in Alberta by the (UFA) government since at least 1921, and by the UFWA movement since 1916.
3. There was an economic barrier to access care	The CMA wanted a study of the effect of the Depression undertaken as early as 1932. Hoadley studied the care of "indigents" and their indices of care in 1936-1939. So did Grauer for the Rowell-Sirois Royal Commission in 1930-1940.
4. The magic of insurance	First request for a (health) insurance program was made by Dr. Wrinch in his BC legislative proposal of 1927. A combined hospital and medical, actuarially sound, health insurance program was proposed by the Hoadley Commission and supported in the CPSA brief in 1932 to the Hoadley Commission and in 1938 to the Rowell-Sirois Royal Commission.
5. The Haegerty Advisory Committee (1943) first defined the statistical, financial and administrative concepts of a health insurance program.	Not correct. The CMA started the international research of European/American programs in 1929. The Hoadley Commission defined the concept in 1932 on a provincial basis. The healthcare indices were analyzed in the Hoadley/Fleming study of 1939.
6. The health/medical profession is forced to come to accept a third party (government) between the doctor and the patient.	Not correct. The profession in Alberta had been asking for government participation since 1932 to pay for those Albertans who couldn't afford the premiums. The AMA/CPSA and CMA not merely foresaw a program that covered all Albertans and Canadians, but developed a set of principles to convince their colleagues of the need for a contributory insurance plan. The profession was adamant on the point that government pay for those who couldn't afford the premiums.
7. Governments had to face an aroused public opinion and the prospect of compelling pressure from federal grants.	The BC and Alberta governments had led an aroused public since 1928. Federal grants in aid or targeted grants weren't offered until 1944 and didn't start until 1947.
8. A national initiative had been developed	A provincial initiative had already been developed in Alberta in 1932. The AMA/CMA nationalized it after 1934.
	The Alberta government passed the first acceptable state health insurance Act in Canada (1932-1935). Like BC, it wanted a federal contribution. Otherwise it would have had to borrow from the federal government and/or municipally tax its citizens, to implement. The CMA and the federal government were both against state medicine in 1932.

Reference: Malcolm Taylor's Health Insurance and Canadian Public Policy, pages 67/68, McGill-Queens, 1978.

Table 5
Myths and Insights into Medicare

Naylor's List of Myths	Baltzan's Insights
1) Medicare is the glue that holds Canada together. Pierre Berton wrote a book on "The Last Best Year" – It was 1967.	1) Professional freedom and autonomy are essential principles of medical care, and must be defended at all costs.
2) Private (American) healthcare is evil; public (Canadian) is good. 30% of the Canadian healthcare system is private: dentists, drugs, pharmacists, optometrists, chiropractors, etc.	2) In the world of medical politics, fact and logic are no match for rhetoric and slogan.
3) Medicare is easily sustainable if governments would just spend more on health. Governments have been unable to agree on what proportion each should pay for over 60 years.	3) The cost of Medicare is not unreasonable nor is it unsustainable.
4) "X" will save Medicare. The focus on "x" (higher taxes or more privatization) avoids the issue at hand which is getting on with the job of taking practical steps to improve it (Reference: C. David Naylor, Time Magazine, February 7, 2005)	4) Medicare should be an insurance scheme, not a prepaid government program. 5) Healthcare is an industry and an engine for growth that should be nurtured, and not an expenditure to be constrained. (References: Michael Bliss, Contrary History: socialized medicine and Canada's decline, CMAJ 177(2): 224, July 17, 2007 and Marc Baltzan, Medical Post, September 27, 2005)

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Medicare References

1. Albert E. Archer, William A. Wilson — Final Memorandum submitted by the Council of the College of Physicians and Surgeons of Alberta to the Rowell Royal Commission. Four pages, dated March 3, 1938, Calgary, Alberta.
2. Paul V. Collins — "The Public Health Policies of the United Farmers of Alberta Government", Introduction, Masters Thesis, University of Western Ontario, October 15, 1969. For a more in-depth discussion of the pre1920 UFA/UFWA roots and formation, see Bradford Rennie's The Rise of Agrarian Democracy, The United Farmers and United Farm Women of Alberta 1909-1921, 111-95, UofT, 2000; Carl Betke's "Farm Politics in an Urban Age, The Decline of the United Farmers of Alberta After 1921" in Essays in Western History, 175-92, UofA, 1976, William Ralph's Henry Wise Wood of Alberta, pages 92-3, UofT, 1950, and William J. Morton's The Progressive Party in Canada, UofT, 1950.

   To paraphrase UFA President Wood, the new farmers' movement must shine through education, to create this spirit of (economic) cooperation among the agrarian class. "Water cannot rise above its source, neither can social progress rise higher than the level of the citizenship of the people." (Wood, Western Independent, Feb. 18 [page 12], Feb. 25 [page 13], 1920.) Hoadley pleaded the same case for cooperation with the AMA, in his 1931 AMA convention address. An introduction to the Progressive Movement by a non-Albertan can be found in A History of Farmers Movements in Canada: The Origins and Development of Agrarian Protest 1872-1924, by Foster J. Griezic, edited by Michael Bliss in the Social History of Canada series #24, pages vi-xxxiv. UofT, 1975.
3. Paul V. Collins — "The Public Health Policies of the United Farmers of Alberta Government, 1921-1935", pages 4-8.
4. Alexis Soltice — Dried Applies, Victorian Ideals, Organization Works: The Private Persona of Mary Irene Parlby, Ph.D. thesis. 749 pages, UofC, April 2005. For her Imperial ties, see Catherine A. Cavanaugh's Irene Marryat Parlby in C.A. Cavanaugh and R.R. Warne's Telling Tales, Essays in Western Women's History, pages 100-122, UBC Press, 2000.

5.	Paul V. Collins	"The Public Health Policies of the United Farmers of Alberta Government, 1921-1935", pages 4-8.
6.	Jane E. Jenkins	Baptism of Fire: New Brunswick's Public Health Movement and the 1918 Influenza Epidemic, CBMH 24(2): 317-342, 2007.
7.	Paul V. Collins	"The Public Health Policies of the United Farmers of Alberta Government, 1921-1935", pages 4-16. Also see Sharon Richardson's "Alberta's Traveling Clinic 1924-42", CBMH 19: 245-263, 2002 and the history of the District Nurse Program, "Frontier Health Care: Alberta's District and Municipal Nursing Services 1919 to 1976", in Alberta History 46(1): 2-9, Winter 1998.
8.	F.B. Watt	"Hoadley of Alberta", in MacLean's magazine, pages 13, 60-61, July 15, 1929.
9.	Robert Lampard	"The Hons. George Hoadley, Irene Parlby, W.W. Cross and the UFA Government Healthcare Program 1921-1955" in Part 2.
10.	Heber Jamieson	Early Medicine in Alberta, page 75, AMA 1947.
11.	Alberta Government	Regulations to the Alberta Hospital Act, 1924.
12.	R. Kenneth Thomson	"The Development of Hospitals Since World War II" in D.R. Wilson and W.B. Parsons' Medicine in Alberta: Historical Reflections, pages 1-21, Alberta Medical Foundation, 1993 and H.C. Jamieson's Early Medicine in Alberta, page 56, AMA, 1947. For further discussion of Alberta's hospitals see William Carney's "The Hospitals' Story: The History of the Alberta Hospital Association". Unpublished manuscript, Alberta Hospital Association, April 1987.
13.	Sclater Lewis	The Royal College of Physicians and Surgeons of Canada 1920-1960, pages 16-17, 25, opp. 40. The Mighty Triumvirate were Drs. David Low, D.S. Johnstone, S.E. Moore, and the fourth was Dr. A. MacGillivray Young, the MP for Saskatoon, who piloted the Act through the House of Commons.
14.	Robert Lampard	The profile of "Dr. Malcolm R. Bow", in Part 1.
15.	Heber C. Jamieson	Early Medicine in Alberta, page 56, Alberta Medical Association, 1947. Hoadley's point was valid. Drs. A.E. Archer and M.A.R. Young published their first 245 cases with a death rate of 1.22% in "The Mortality in Appendicitis", CMAJ 16: 1491-94, 1926 and 1.28% in the second 703 case series, CMAJ 36: 507-10, 1937. The literature reported rate was 5-7% at the beginning of the study (1921); 2.13% in Alberta in 1937 and 1.66% in Alberta when the second series was published in 1935.
16.	W. Fulton Gillespie	Secretary of the Edmonton Academy of Medicine. Letter to Dr. A.I. McCalla, President of the Calgary Medical Society, dated October 30, 1927. To it were attached the proposed motions from the Edmonton Academy of Medicine. Minutes of the Calgary Medical Society, January 3, 1928.
17.	Heber Jamieson	Early Medicine in Alberta, page 201.
18.	A.I. McCalla	Minutes of the Calgary Medical Society, January 3, 1928.
19.	Gerald McDougall, Fiona C. Harris	Medical Clinics and Physicians in Southern Alberta, pages 8-20. The authors discuss the longstanding and thorny issue of group and contract practice in Calgary. The debate started at the Calgary Medical meetings on February 12 and 19, 1907. It was led by the original 1885 CPR medical contractor, Dr. J.D. Lafferty. Every physician in Calgary voted to open up the CPR contract to competition, except the contract recipient, Dr. H.G. Mackid. He was Lafferty's original 1890 partner and current holder of the CPR medical contract. The CPR Vice-President responded by saying he wouldn't allow it and would b ring contracted doctors to Calgary if that was necessary, WCMJ 1: 125-6, 263-4, 1907; and Dr. J.D. Lafferty in Part 1. The topic boiled to the surface again in 1922-24. A caution was sent to the AMA/CPSA members discouraging the signing of contracts. It was included in the Alberta College Code of Ethics. A review of contract practice in BC to 1929 was undertaken by the BCMA. Dr. J.H. McDermot, in his report as the chairman of the Committee on Economics, suggested it be part of a Dominion-wide survey. CMA annual meeting Report to Council, pages 200-6, June 18, 1929.

	The new (1923) Minister of Health George Hoadley formalized (by regulation) the traveling medical, surgical, and dental services (1924-1942) to northern Alberta, and later to southern Alberta, as outlined in Sharon Richardson's "Alberta Provincial Traveling Clinics 1924-42", CBMH 19: 245-63, 2002. For additional references on contract practice see David Naylor's Public Payment, Private Practice, 50-5; and Malcolm Taylor's The Administration of Health Insurance in Canada, 142-62, Oxford 1956.
20. C. David Naylor	Public Payment, Private Practice, page 51, McGill-Queens, 1986.
21. CPSA	Minutes of the College of Physicians and Surgeons of Alberta, Volume 1, pages 308, 310, September 6, 1923.
22. Fred White, Chris Pattinson	"Report of an Inquiry into State Medicine", 72 pages, Alberta Government, 1929.
23. Paul V. Collins	"The Public Health Policies of the United Farmers of Alberta Government 1921-1935", 122-3.
24. Robert Lampard	"The Sexual Sterilization Act of Alberta" in Part 2.
25. CPSA	Minutes of the College of Physicians and Surgeons of Alberta, Volume 1: 379 and 1: 442, February 16, 1928.
26. Fred White, Chris Pattinson	"Report of an Inquiry into State Medicine", page 7.
27. Fred White, Chris Pattinson	"Report of an Inquiry into State Medicine", Abstract and page 42.
28. Robert Lampard	The profile of "Dr. Mary Percy Jackson" in Part 1.
29. J.H. MacDermot, Harvey Smith	CMA Minutes of the Executive Council, page 314, Winnipeg, 1931.
30. George Hoadley	"Many Problems Face Medical Men of Today", Calgary herald, September (n.d.), 1931.
31. Franklin Foster	John Brownlee: A Biography, pages 181-182, Foster Learning, 1996.
32. Robert Lampard	"The Cardston Medical Contracts", in Part 2. The article was published as "The Cardston Medical Contracts and Canadian Medicare" in Alberta History 54(4): 5-10, Autumn 2006.
33. Morley A.R. Young	"Di Bozsha. May the Lord Give You Health", New Trail, pages 9-15, UofA, January 1948.
34. George Hoadley, et al	"Progress Report of the Commission" appointed to a) consider and make recommendations to the next Session of the Legislature as to the best method of making adequate medical and health services available to all the people of Alberta; b) report as to the financial arrangements which will be required on an actuarial basis to ensure the same, 36 pages. Kings Printer, 1933. The recommended principles and coverage were outlined in Drs. A.E. Archer and W.A. Wilson submission on behalf of the College of Physicians and Surgeons of the province of Alberta to the Hoadley Commission, 11 pages, presented November 8, December 11, 12, 1932. Reaffirmation of support for the 1932-33 agreement by the College of Physicians and Surgeons of Alberta was contained in the CPSA memoranda to the Rowell-Sirois Royal Commission, 12 pages, presented April 1938. Parliamentary Library, Ottawa. "The BC Royal Commission on State Health Insurance and Maternity Benefits" Final Report outlined Plans A to E. All Plans were for Employees and/or their Dependents only. The recommended and equally shared (provincial and federal) government contributions to each plan was to total 2/9s of the total cost.
35. George Hoadley, et al	Progress Report of the Commission, pages 1, 2.
36. George Hoadley, et al	Progress Report of the Commission, page 11.
37. Morden Lazarus	Socialized Health Services, pages 57-9. Ontario Woodsworth Memorial Foundation, January 1976. For details on the CCF formation see W.L. Morton's the Progressive Party in Canada, pages 279-85. The similar Minnesota roots and ideological beliefs of Henry Wise Wood (Alberta) and Frank Eliason (Saskatchewan), are apparent in the recent George Hoffman review of "Frank Eliason" A Forgotten Founder of the CCF", Saskatchewan History 58(1): 18-31, Spring 2006.

38. Robert Lampard	My grandfather Rev. R.S. Leslie was the Progressive Party Speaker in the Saskatchewan Legislature (1929-34) under Premier J.T.M. Anderson. He ran second and Rev. T.C. Douglas ran third in the provincial election of 1934, in the Weyburn constituency. They remained lifelong friends. My mother took elocution lessons from Mr. Douglas in 1932-33. Together they won the grade 12 oratorical competition, with the speech "Japan: friend or foe". My cousin Eleanor McKinnon was the secretary to Mr. Douglas for thirty-five years.
39. George E. Learmonth	"Medical Services in Alberta", CMAJ 30: 202-3, February 1934. The survey was made in 1933. A survey was conducted in Ontario in 1934 with a similar 20:1 support for a plan that covered low income persons. Interest in a plan was also raised by doctors in BC, Saskatchewan and Manitoba from 1932-35, as outlined in Naylor's Public Payment, Private Practice, 66-7.
40. George Hoadley	"Final Report of the Legislative Commission". 39 pages. Tabled March 1934. Kings Printer. The Hoadley Commission members accepted the state (Alberta) was responsible for a contribution of 2/9 of the cost. The Commission added important qualifications: the plan would cover everyone without regard to income. It would provide full coverage of benefits and would not rely on a guaranteed federal grant.
41. (George Hoadley)	Fury and Fidelity: The Onset of the Great Depression, in Alberta in the 20th Century, Volume 6: 23, UWC, 1997.
42. Robert Lampard	Profile of "Dr. A.E. Archer", in Part 1.
43. Morley A.R. Young	"Di Bozcha. May the Lord Give you Health", pages 15-9.
44. Murray Ross	Personal Communication, March 9, 1998. Mr. Ross was the long term CEO of the AHA and the son of C.W.W. Ross, the administrator of the Lamont Clinics. The clinic provided about $35,000 in services for about $7,000 in payments.
45. Albert E. Archer	CPSA minutes, Volume 2, page 221, July 18, 1940.
46. Bob Burrows	Healthcare in the Wilderness. A History of the United Church Mission Hospitals, page 32, Harbour Publishing, 2004.
47. Robert Lampard	The profile of "Dr. A.E. Archer", in Part 1.
48. Horace C. Wrinch	"Royal Commission on State Health Insurance and Maternity Benefits", 23, Kings Printer, 1932.
49. J.H. Horociwz	"Highlights of the Evolution of Health Insurance of Canada", Department of National Health and Welfare, 2, September 1955. Horociwz gave as his source Dr. Harvey Smith's "Presidential Address to the third joint British and Canadian Medical Association" at the meeting held in Winnipeg, June 1930, and published in the CMAJ milestone for the medical for the medical profession in the field of health insurance". Dr. Smith's obituary in the CMAJ 43: 86-7, supported Archer's view.
50. Proceedings	Third Conference on the Medical Services in Canada, House of Commons, November 20, 21, 1929, Kings Printer, 1930.
51. Robert Lampard	The profile of "Dr. J.S. McEachern", pages 193-196, Part 1.
52. Smith and Fleming	Discussion of the "Plan for Health Insurance in Canada", in the CMAJ Supplement, pages 27-30, September 1935. For McEachern's views see "The President's Address to the Canadian Medical Association", CMAJ 31(2): 119-23, August 1934 and "The Annual Meeting", CMAJ 33: 204-6, August 1935.
53. W. Harvey Smith, A. Grant Fleming	"A Plan for Health Insurance in Canada". CMAJ Supplement 25-62, September 1934.
54. G.A.B. Addy, et al	Position paper and reply by the Prime Minister following a meeting on October 6, 1932 with the CMA delegation re: Medical Care of the Unemployed, CMAJ 29: 554-556, November 1933.
55. Hirschfield, Daniel S.	The Lost Reform: The Campaign for Compulsory Health Insurance in the United States, pages 46-65, 1974. The American Medical Association's Ten 1934 Principles were listed on page 177.

56. Robert Lampard	The profile of "Dr. J.S. McEachern", in Part 1. Also discussed in the "Third CMA meeting in Alberta, 1934", Alberta Doctors Digest 30(2): 13-17, March/April 2005.
57. (J.K. Mulloy, D.S. Macnab)	Motion drafted along with Dr. J.S. McEachern, to merge "in principle" with the CMA. Minutes of the joint meeting of the AMA/CPSA October 4, 1934, CPSA, Volume 2, pages 49-53.
58. John S. McEachern	Motion to accept unanimously approved. AMB 1(3): 9, October 1935. For Dr. McEachern's plan see the AMB 1: 7-13, April 1935.
59. Albert E. Archer	The Progress of the Association, CMAJ 47: 116-117, August 1942; The Position of the Canadian Medical Association on Health Insurance, CMAJ 47: 261-262, August 1942; Special Meeting of General Council, CMAJ 48: 93, February 1943, and 48: 251-260, March 1943. In his valedictory address: The Challenge to Organized Medicine, Dr. Archer outlined the trials and tribulations the CMA faced in his year as President (1942/43) as reported in the CMAJ 49(1): 77-82, August 1943. Dr. T.C. Routley outlined the Principles of Health Insurance in the CMAJ 47: 367-371, October 1942 and the AMB 8: 13-19, April 1943. Dr. H.E. MacDermot wrote A Short History of Health Insurance in Canada in the CMAJ 50: 447-454, May 1944; and a long history in his History of the Canadian Medical Association, Volume II, pages 59-84, 1958. For a more detailed discussion of the deliberations see Malcolm G. Taylor in Whose Responsibility? Public Health in Canada 1919-1945, in Doctors, Patients, and Society, page 220, WLP, 1982.
60. Oleh W. Gerus, Denis Hlynka	The Honorable Member for Vegreville: The Memoirs and Diary of Anthony Hlynka, MP, pages 25-46, UofC Press, 2005.
61. Andrew F. Anderson, W.T. Washburn	"History of the Royal Alexandra Hospital" (RAH), 12 pages, c1960. Deposited in the RAH Archives. Also see J.R. Vant and Tony Cashman's More Than a Hospital, pages 124-125, UAH, 1986; and the Anderson/Washburn AHA "Brief to the Hoadley Commission", December 11-12, 1932, one page. Deposited in the Alberta Legislative Library.
62. Robert Lampard	"The Hons. George Hoadley, Irene Parlby, W.W. Cross and the UFA Government Healthcare Program 1921-1935", in Part 2.
63. George Hoadley, Grant Fleming	The Study of the Distribution of Medical Care and Public Health Services in Canada, 184 pages. The National Committee for Mental Hygiene (Canada), 1939.
64. George Hoadley, Grant Fleming	The Study of the Distribution of Medical Care and Public Health Services in Canada, pages 61-96.
65. George Hoadley, Grant Fleming	The Study of the Distribution of Medical Care and Public Health Services in Canada, pages 70-72, 93.
66. George Hoadley, Grant Fleming	The Study of the Distribution of Medical Care and Public Health Services in Canada, pages 162-175. H.H. Wolfenden was retained by the CMA and then the federal government. His report to the CMA was highlighted in the CMAJ 42(5): 470-475, May 1940.
67. George Hoadley, Grant Fleming	The Study of the Distribution of Medical Care and Public Health Services in Canada, pages 129-134.
68. Morden Lazarus	Socialized Health Services, a Plan for Canada, pages 13, 28, 54, 57. Ontario Wordsworth Memorial Foundation, January 1976.
69. Newton W. Rowell, J.O. Sirois	Report of the Royal Commission on Dominion-Provincial Relations, pages 168-171. For further discussion of this important report see Malcolm C. Taylor's Health Insurance and Public Policy, 10, 11, McGill-Queens, 1978, and C. David Naylor's Public Payment, Private Practice, 92-3, 97-8, 109.
70. George Hoadley	CMAJ Supplement, page 35, September 1935. The resolution calling for a Royal Commission was unanimously passed at the first meeting of the Ministers of Health in Canada on April 25-26, 1935. The chairman Dr. Donald M. Sutherland, the federal Minister of Pensions and Health, proposed a survey of medical services in Canada. Prime Minister Bennett agreed to the survey but was defeated in the federal election of 1935. Hoadley would do it personally. CMAJ 38: 290-292, March 1938.
71. Albert E. Grauer	"Public Health: a study prepared for the Royal Commission on Dominion-Provincial Relations". 126 pages, mimeograph form, 1939. The report covered the same topics as the Hoadley-Fleming Study of Medical Services (1936-39) suing primarily 1935 and 1936

statistics. The study encouraged federal leadership, supported the grant-in-aid concept as used to treat the post World War I VD problem, encouraged Aboriginal TB care to be transferred to the provinces and defined gaps and overlaps in the public health system. The first draft was completed in August 1938 and the final draft in the spring of 1939. The analysis of mental hygiene data was based on NCMH(C) General Director Dr. C.M. Hincks research (pages 69-70). It implied there was an open relationship between the two authorities. Grauer concluded that a public health program wasn't necessarily cost saving but improved the health, welfare and efficiency of the population (page 72). Dr. Grauer, Ph.D. was the Director of Social Services at the University of Toronto. He also wrote Appendix 6, a 98 page report on Public Assistance and Social Insurance for the Commission. A summary of the key public health statistics to 1941 (infant mortality, maternal mortality, communicable disease deaths, etc), was provided in M.G. Taylor's Health Insurance and Canadian Public Policy, pages 6-7.

72. George S. Young, T.C. Routley — A submission by the Canadian Medical Association to the Royal Commission in Dominion-Provincial Relations (Canada, 1937). All the provincial submissions to the Rowell-Sirois Royal Commissions on Medical and Social Services were reprinted in the Hoadley/Fleming study, pages 153-161.

73. A.E. Archer, W.A. Wilson — "Final Memorandum submitted by the Council of the College of Physicians and Surgeons of Alberta to the Rowell Royal Commission", dated March 3, 1935, Calgary.

74. Albert E. Archer — CPSA minutes, Volume 2, page 160, April 28, 1938.

75. J.M. Ulrich — State Medicine Held Inopportune, AMB 1: 10, April 1936. Confirmed by Dr. Lillian A. Chase who added, "A delusion held by many voters is that state medicine means free medicine". CMAJ: 684, June 1936. Former Saskatchewan Premier J.T.M. Anderson said that same year it "would have to be on a compulsory basis and absolutely free from political influence" in the Canadian Doctor 2(12): 30, December 1936.

76. Walter W. Cross — "Says Health Insurance is Under Study". Alberta Medical Bulletin 3(3): 13, July 1938.

77. Malcolm C. Taylor — The 1945 Health Insurance Proposals in Health Insurance and Canadian Public Policy, The Seven Decision that created the Health Insurance System, pages 1-68, McGill-Queens, 1978.

78. Newton W. Rowell, J.O. Sirois — Report of the Royal Commission on Dominion-Provincial Relations, pages 168-171, Ottawa 1940.

79. John J. Haegerty — For an in-depth discussion of the Haegerty Advisory Committee deliberations, see Health Insurance and Public Policy, 19-28; and C. David Naylor's Private Practice, Public Payment, 97-111.

80. Malcolm G. Taylor — The 1945 Health Insurance Proposals, page 21, in Health Insurance and Canadian Public Policy, the seven decision that created the Canadian health insurance system, McGill-Queens, 1978.

81. Malcolm G. Taylor — The 1945 Health Insurance Proposals, pages 18-22, 36-68.

82. Kent Harrold — Personal communication with Dr. Robert Lampard, September 29, 2005. Mr. Harrold, the thirty-year chairman of the Lamont Healthcare Center Board, indicated Dr. Archer was not wildly enthusiastic about politics. The offer could not be corroborated by Mr. Harrold's aunt. Dr. Archer certainly knew Mackenzie King.

As a youngster Kent Harrold sang with Dr. Archer in the United Church choir. He spoke of how highly regarded Archer was in Lamont and remembered him "as gracious and skillful, with an unassailable social responsibility".

83. William B. Parsons — "Medicine in Alberta: The War Years", 105-7 and "The History of Prepaid Medical Care in Alberta to 1969", 33-44, reprinted in Part 2.

84. (Donovan J. Ross) — Dr. Ross continued to assist the implementation of the federal government's Canada Medical Act changes after he transferred to the Mines and Minerals portfolio in 1969, for his last two years in cabinet. His disagreement with the federal intrusion was longstanding as outlined in his presentation to the Hall Royal Commission in the Edmonton Journal, February 12, 1962. His obituary referred to him as Alberta's first fedicare opponent in the Edmonton Journal, page 7, June 4, 1984.

85. Robert Lampard	Alberta is the Root of Medicare. Alberta Doctors Digest 31(1): 6-7, January/February 2006; Medicare's Roots are in Alberta: Federal proposal same as Alberta's plan. Alberta Doctors Digest 31(2): 22-25, March/April 2006;' and Medicare's roots are in Alberta: Dissecting the roots, Alberta Doctors Digest 31(3): 16-18, May/June 2006.
86. Malcolm G. Taylor	Health Insurance and Canadian Public Policy, pages xiii-xiv. Taylor failed to note how the 1932 BC Royal Commission affected the timing and terms of reference of Hoadley and the Hoadley Commission, in the Hall Royal Commission reports, health insurance review, Volume I, pages 381-442, Queens Printer, 1964.
87. C. David Naylor	Private Practice, Public Payment, pages 53-54, 65-66.
88. C. Stuart Houston	Steps on the Road to Medicare, why Saskatchewan Led the Way, pages 69-88, McGill-Queens, 2002.
89. David Naylor	Private Practice, Public Payment, pages 51-52.
90. (G.E. Learmonth)	Contract Practice in Alberta, CMAJ 35: 321-322, September 1936. Originally published in the AMB 1(6): 4-6, July 1936, it was revised and republished in the AMB 4(2): 9-12, April 1939. Actual mining and medical contracts were reprinted in the Pattinson/White Inquiry (1929) and CMAJ 163(12): 1586-1587, December 12, 2000.
91. Malcolm G. Taylor	In "The Evolution of Health Insurance in Canada", Hall Royal Commission, Volume 1, page 385 and The Administration of Health Insurance in Canada, page 3, Oxford 1956.
92. Gordon Fahrini	Prairie Surgeon, pages 69-72, Queenston house, 1976. Saskatchewan Municipal Doctors were not entirely satisfied either, as noted by David Naylor in Private Practice, Public Payment, pages 50-51.
93. Robert Lampard	The last municipal doctor was Dr. David Hasinoff from Mannville, who ended his contract in 1968. Personal communication from Dr. Joseph T. Fernando who succeeded him, March 17, 2007. Confirmed by Dan Hasinoff, his son, March 22, 2007.
94. Greg P. Marchildon	The Great Divide in The Heavy Hand of History, pages 51-66, CPRC, 2005. Marchildon quotes the Alberta income drop as 61%, at its worst.
95. Heber C. Jamieson	Early Medicine in Alberta, page 56. According to Dr. Archer, many doctors were collecting 20-50% of their fees. Dr. W.H. McGuffin surveyed Calgary physicians in the early 1930s and found 25% were getting along reasonably; 50% were operating from day to day; 25% were in serious difficulty, as quoted in G.M. McDougall's Medicine Clinics and Physicians of Southern Alberta, page 9, 1991. The Depression was estimated to have "doubled" the amount of free care. CMAJ 29: 553-556, November 1933.
96. Smith and Fleming	Discussion during the approval of the "Plan for Health Insurance in Canada", in the CMAJ Supplement, pages 27-30, September 1935.
97. Albert E. Archer	CPSA Minutes, October 4, 1934, pages 49-53.
98. C. David Naylor	Private Practice, Public Payment, pages 70-89. The BC milestones in public health (public health nursing, traveling clinics, health units, venereal disease, tuberculosis, provincial laboratory, vital statistics), varied to one to fifteen years behind Alberta's. For the Alberta Acts see the profile of Dr. Bow in Part 1 and the Milestones in Alberta Medicine in Part 2. For the BC milestones see Megan J. Davis' The Relationship of Public Health to Medical Care, CPMJ 25: 461-465, 1934. Competent Professionals and Modern Methods: State Medicine in British Columbia During the 1930s, Bulletin of Medical History 76: 56-83, 2002.
99. C. David Naylor	Private Practice, Public Payment, page 101. A list of all the Legislation Medical and Hospital Prepayment Acts to 1950 is provided in Malcolm Taylor's The Administration of Health Insurance in Canada, page 35, Oxford 1956.
100. Marcel M. Dirk	A Health Outlook. The Centennial History of the Medicine Hat Regional Hospital, pages 17-18, 1989.
101. Heber C. Jamieson	Early Medicine in Alberta, page 75.
102. R. Ken Thomson	"The Development of Hospitals Since World War II", in Medicine in Alberta, Historical Reflections, page 2, AMF, 1993. Reprinted in Part 2. The provincial government began contributing $1.00 per patient day to Municipal Hospitals in 1918.
103. Robert Lampard	The profile of "Dr. J.S. McEachern", in Part 1.

104. C. David Naylor	Private Practice, Public Payment, pages 102-107. The role of the Committee of Seven was outlined by Dr. T.C. Routley in an editorial on The Position of the Canadian Medical Association on Health Insurance, CMAJ 47(3): 261-262, September 1942.
105. C. David Naylor	Private Practice, Public Payment, page 122. CMA President Dr. Gordon Fahrini emphasized how important the indication that 75% "would be willing to pay for it", was to the three major vested interest groups: the federal government, the public and the medical profession, in his Valedictory speech, June 1942, CMAJ 47: 72-74, July 1942.
106. George Hoadley	"Final Report of the Legislative Commission", pages 35-37, Kings Printer, 1934.
107. George Hoadley	Public Health, Alberta Medical Bulletin, Volume 1(2): 4-5, July 1935.
108. Irene Parlby	"State Medicine". An address to the UFWA, 1934 Annual Convention Report, pages 11-14, January 1934.
109. Joan Feather, et al	1) Horse Trading and Health Insurance: Saskatchewan and Dominion-Provincial Relations, 1937-1947, Sask. History 39(2): 94-106, Autumn 1986. 2) Early Medical Care in Saskatchewan, Sask. History 37(2): 41-54, Spring 1984. 3) From Concept to Reality: Formation of the Swift Current Health Region and 4) Impact of the Swift Current Health Region: Experiment or Model? in Prairie Forum 16(1): 59-80 and 16(2): 225-248, 1991. Other articles on Saskatchewan health insurance research include: 5) An Inalienable right: the CCF and Rapid Health Care Reform, 1944-1948, Sask. History 43(3): 101-116, Autumn 1991 by Duane Mombourquette; 6) Prelude to Medicare: Institutional Change and Continuity in Saskatchewan, by Aleck Ostry, 1944-1962 in Prairie Forum 20(1): 87-105, Spring 1995, and C. Stuart Houston on Matt Anderson's 1939 Health Plan: How Effective and How Economical?, in Sask. History 57(4): 4-14, Fall 2005.
110. Richard E. Gold	Health Care Reform and International Trade, pages 223-250, in Health Care Reform and the Law in Canada edited by T. Caulfield and B. von Tigerstrom, UofA, 2002.
111. Robert Lampard	The Profile of "Dr. Walter C. Mackenzie", in Part 1.