Public Health and the Canadian State: The Formative Years, 1880 to 1920.
Between 1880 and 1920, the foundation of a public health infrastructure was established in Canada. This 40 year period witnessed the influx of millions of immigrants, the opening and settling of the Canadian prairies by Europeans, the development of a modern industrial economy, and unprecedented growth of Canadian cities. This Canadian industrial revolution—like the English industrial revolution some half a century earlier—spawned large cities, with few sewers, unreliable and polluted water sources, and limited municipal infrastructure for regulating their sanitary condition. The mortality rates in these mid-19th century cities were much higher than in the surrounding countryside and caused urban reformers in general and public health reformers in particular to agitate increasingly for some form of government intervention to develop, regulate and enforce sanitary laws in order to reduce these rates.

Vigorous "sanitary" movements developed in Canada by mid-19th century, particularly in Toronto and Montreal where the problem of elevated urban mortality was brought forcibly to the public agenda.1,2,3 The sanitary movements were part of broad social reform movements with causes—particularly towards the end of the 19th century—as diverse as liquor prohibition and women's suffrage. The public health component of these urban social reform movements was made of both lay and medical activists whose target was usually "city hall." In the mid-19th century, city hall was often unreceptive to the pleas of activists to build sewers, connect drains, and develop unpolluted water sources. This frustration led activists increasingly to target the provincial government as this was the locus of constitutional responsibility for health and because increasingly, it was felt that local opposition at the level of city hall could only be breached by provincial government action.

Prior to 1867, the governments of Upper and Lower Canada had been active in setting up temporary boards of health usually in the face of epidemics. Local boards of health were among the earliest public health structures created by the government in Lower Canada during the 1830s in response to the arrival of cholera. A number of such boards were created in the Maritimes and Upper and Lower Canada in response to various epidemics between the 1830s and the 1880s. Once the epidemics dissipated, these boards were disbanded. The passing by the Ontario government of a Public Health Act in 1882—modeled directly on the English Public Health Act of 1875—established the Ontario Board of Health which was arguably the first "modern" and permanent public health structure in Canada. This act signaled that a provincial government was
prepared to move decisively to fulfill its constitutional obligations in the field of health.

Under the Ontario Act local authorities throughout the province were to establish permanent Boards of Health with a salaried Medical Health Officer (MHO). The Act passed in part because of lobbying by the medical profession (which was increasingly listened to by the government as it moved from a marginal to dominant position in the practice of medicine) and in part because of pressure from a strong "sanitary" movement of lay and professional activists based mainly in Toronto. However, between 1882 and 1884, the provincial board succeeded in fostering only "50 local boards in 40 counties, and four salaried local medical officers". The Ontario Act was therefore amended in 1884 so that it became compulsory for local councils, under the direction of the provincial board, to form permanent local boards and hire MHOs.

By 1885, the provincial board had "been instrumental in the organization of 563 local boards in 600 municipalities, 283 medical officers, 160 sanitary inspectors, and many vaccination officers." The board's activism was due, in part, to the outbreak of a virulent smallpox epidemic in Eastern Canada in the fall of 1884. The effectiveness of the board's actions can hardly be doubted as only 18 smallpox deaths occurred in Ontario compared to over 7,000 in Quebec which had no permanent public health infrastructure. The Ontario experience of the 1880s was similar to England's in that forceful central government intervention (in this case provincial rather than national as in England) was necessary to overcome parochial interests which were often unwilling to use locally raised tax revenue to pay for an MHO and to pay to implement his recommendations.

Ontario's dramatic success was not lost on the Quebec government which within one year set up its own Conseil de Sante modeled on the Ontario act. The Ontario model was adopted in 1891 by Manitoba and soon thereafter in British Columbia. By 1910, most provinces had formed permanent boards of health with power to force municipalities to establish local boards and hire MHO's according to the Ontario model. Thus, between 1880 and 1910, public health departments were incorporated into the infrastructure of municipal government, under provincial legislative guidance.

While the provinces had moved decisively into new public health territory by the start of World War I, the federal government remained primarily concerned with public health as it related to immigration, quarantine, and the military. However, on the eve of World War I mass medical screening of army recruits revealed that "35 to 40 percent of young volunteers had
been rejected when they first applied or were later found unfit for military service while fully 50 percent of those conscripted had some physical defect." Military mobilization with its attendant physical examination of recruits was one of the earliest health surveys of a large sample of the male population. Military and medical authorities were shocked at the level of malnutrition and the lack of fitness of recruits. This shock fed into the, at that time, popular and widespread Social-Darwinian concerns about national health and fitness and the ability of Canada to effectively wage war. The federal government was for the first time alerted to the broad national security implications of inferior levels of health in the general population.

Also, during World War I the federal government become actively involved in both preventive public health and health services delivery for soldiers on the battlefield and at home. After the war these services were expanded as the government provided follow up treatment for thousands of veterans with disability and disease. Comprehensive care for soldiers became, for public health reformers, a model and justification for further government involvement in public health for the civilian population. This post-war attitude was summed up by Charles Hastings (Toronto's MHO) in 1919 when he said, "Every nation has been expecting every man to do his duty, and now that the war is over, every man will expect every nation to do its duty." The war had elevated the concept of state responsibility for its citizens' health from a benefit to a right in the mind of the public and forced the federal government into a realization that public health issues had national policy implications which required their active involvement and direction. One result of this new awareness and concern was the establishment of the federal Department of Health in 1919.

While the war drew the federal government more directly into the public health field, the specific issue of venereal disease control provided the model for future relationships between federal, provincial, and municipal governments in public health. The Division of Venereal Disease (VD) Control in the early years of the federal department of health "had the second largest budget in the department most of it to be distributed to provincial programs." In order to receive funds, the provinces had to set up a VD Division within their boards or health departments, provide free diagnosis and treatment for patients, and develop educational campaigns. In turn municipal governments were, with the financial assistance of the province, to operate local VD clinics free of charge.

Thus, by the end of World War I, the outlines of our current public health infrastructure were discernible. Permanent public health institutions evolved in this country somewhat latter than in Western Europe and much of the United States probably because the industrial revolution in Canada
started latter than it did in these other countries. However, the huge socio-demographic changes that were wrought in this country between 1880 and 1920 hurtled Canada into the industrial age forcing the pace of urban and public health reform. It is therefore to this era that we must look to find the roots of today's public health system.

References


5. Ibid., p.62.


