Differences in the History of Public Health in 19th Century Canada and Britain.

The development of a public health infrastructure in Canada over this and the last century was due to a complex mix of conditions. Public health reform was carried out within broad movements for social reform which swept through many cities in Europe and North America during the industrial revolution of the mid and late 19th century. In Canada, public health reform started later than in Britain, and contended with vastly different urban and rural environment. English sanitarians like Chadwick were building public health infrastructures in very old but rapidly changing cities and in densely settled pastoral rural regions. However, in Canada public health reform movements functioned in relatively new cities which were trying to erect basic industrial, housing, and sanitary infrastructure while often absorbing immigrants on a scale not seen in Europe. Also, outside the cities, the Canadian condition of widely scattered populations often living in wilderness conditions had no counterpart in Western Europe.

The newness and vastness of Canada produced a set of public health challenges which required adaptation of British sanitarian models to new conditions. Besides the difficulties of newness and geography, the division of Canada into English and French speaking regions with their own traditions had an enormous impact on public health reform. For example, in 1885 a smallpox epidemic started in Eastern Canada. By the time the epidemic was finished 3,164 people had died in Montreal but only 30 in the entire province Ontario.¹ The Ontario Board of Health (formed just a few years earlier) acted quickly and decisively to isolate cases and vaccinate contacts so that deaths from the disease were minimized.

In Quebec there was no permanent Board of Health to direct a response to the epidemic. In the summer of 1885 while the epidemic was raging in Montreal, "because of anti-vaccinationists, merchants who feared their factories might by closed, and city fathers unwilling to approve payment of expenses, compulsory vaccination was not begun until September. Intense public opposition greeted the announcement of mandatory vaccination. Rioting broke out; mobs stormed the city health office, threatened to kill the medical health officer, and stoned his home. Only when the militia was called out could order be restored."²

As historian Micheal Bliss has pointed out, in his description of the Montreal smallpox epidemic, most francophones in the city’s east end refused vaccination and quarantine efforts spearheaded mainly by the anglophone doctors in the city. Many church and lay leaders of the francophone community in Montreal viewed vaccination as an English plot...
to weaken the French Canadian nation and actively resisted it. These divisions between English and French in Montreal which hamstrung effective public health action were also aggravated by the hanging of Louis Riel in 1885 which unfortunately fanned the flames of ethnic tension contributing to resistance to vaccination among the French Canadian population at the height of the Montreal epidemic. 3

Massive immigration, particularly from Ireland in the mid and late 19th century also posed unique problems for Canadian public health reformers. The dramatic entry of cholera into Canada brought mainly by Irish immigrants in a series of epidemics between 1830 and 1880 produced in the mind of the public a link between immigration and disease. Public health reformers viewed immigrants of the this era with ambivalence. One the one hand they were needed to open up the country but on the other hand they were seen as contributing to the "uncleanliness" of the cities which these sanitarians were attempting to cleanse. The sheer size of subsequent immigration, particularly at the end of the 19th century also created tremendous challenges for public health reform particularly in the burgeoning Canadian cities.

The geographic, ethnic, and historic conditions in Canada were much different than in Britain. The political environments within which public health reform unfolded were also different. In terms of medical organization in Canada, the profession needed several more decades here compared to England to coalesce, and establish security in the field of medical practice. The CMA was not formed until 1869 and prior to confederation the Royal Colleges in London actively undermined the Canadian profession’s attempts to organize itself. Certainly, in the late 19th century the medical profession was weaker here and any efforts they exerted for public health reform were diluted as they were directed at several provincial governments rather than, as in Britain, one central government.

As the Canadian state evolved in the 19th century it also lagged behind in the area of statistical information collection. According to Heather MacDougall, the sanitary reform movement, in order to be successful, had three requirements. First, it required information gathered on mortality and morbidity levels so that the main public health problems could be conceptualized and measured. Second, it required activists to publicize this information in order to mobilize public and professional opinion. Third it required the existence of a reasonably sophisticated municipal infrastructure to actually carry out and police legislated reforms. 4

After all, the ability of a John Snow to conduct his "Broad Street Pump" investigations depended on the existence of a municipal and statistical
gathering administrative structure that was capable of tracking individuals, identifying the source of their water supply, and registering deaths. While public health reformers as early as the 1840s in Lower Canada had like Chadwick in Britain at the time advocated a regular system of birth, marriage, and death registration, such a system evolved more slowly in this country.

In the mid-19th century Canadian public health reformers had to rely more on information generated by the international public health movement rather than accurate locally generated statistics. For example in Toronto, with the most advanced sanitary movement at the time, with "only the limited sanitary surveys carried out in 1866 and 1867 to guide them, most citizens had little knowledge of slum life and its potential threat to their health. This lack of knowledge was in emphatic contrast to the British experience. There, lobbying groups such as the Health of Towns and Social Science associations vied with government agencies in producing studies and reports which graphically detailed the environmental problems facing British centers." 5 This resulted in a public which was less well informed than in Britain and less effective citizen/professional advocacy.

Finally, public health reforms in Britain were developed within the context of the national Poor Laws for which there was no equivalent in 19th century Canada. Edwin Chadwick, who was the director of the Poor Law Commission stated that "pauperism was in numerous instances the consequence of disease for which the individual could not be held responsible, and that disease was an important factor in increasing the burden of the poor rates". Public health reform in Britain started out within the framework of the Poor Law and was essentially seen as a utilitarian measure to reduce the drain of welfare payments on the state.

It was also within the context of the Poor Law that Chadwick created the world's first Medical Health Officers (MHO's). He suggested the appointment of a "district medical officer independent of private practice, and with the securities of special qualifications and responsibilities to initiate sanitary measures." 6 As originally envisaged by Chadwick the MHO was to operate entirely in a preventive health capacity at the local government level. There was a separate cadre of Poor Law doctors whose function was entirely curative.

However, in Canada when (after the 1880s) permanent health boards and MHOs began to be legislated into existence they did not start up within a Poor Law framework as in Britain. Instead of a national Poor Law local municipalities and charities paid for the upkeep and health problems of indigents and transient. When MHO's and public health departments
developed in Canadian cities council members tended to pressure the MHOs to operate in a curative capacity in order to deal cheaply with the health problems of their indigents.

This is illustrated by the fight which occurred between city aldermen and public health advocates in Toronto City Council in 1883 as they attempted to develop a job description for the city's first permanent MHO. The by-law outlining the job description "mirrored the views of the aldermen with the result that the officer (MHO) was expected to examine the sick poor, provide curative services to injured city employees, offer public vaccination on a monthly basis, and collect the federal government's statistics. He was permitted to undertake preventive efforts such as investigating nuisances and providing advice on sanitation, disease control measures, and food supplies only at the request of the mayor, the Markets and Health Committee, and the General Inspector of Licenses." 7

Clearly while many classical sanitarian concepts came from Britain in the 19th century they were usually implanted in Canada at a slightly later time and on geographical, historical, and political territory which was uniquely Canadian and served to modify these British models.

References


2. Ibid. p.48.


5. Ibid. p. 75.
