4.4: Health Care and Nursing Highlights of the Second Half of the Twentieth Century

During the decades following World War II, access to health care became a Canadian public priority. However, the nursing shortage continued. Increased responsibilities and poor working conditions in hospitals led nurses to demonstrate an interest in collective bargaining. The first nursing union was formed in British Columbia in 1945.

The 1948 federal grants program offered money for health surveys, public health research, infectious disease control, and grants for hospital construction (when matched with provincial funding). The building of new hospitals created a further shortage of health care personnel. Nursing schools could not graduate registered nurses in adequate numbers to meet the demands. Auxiliary workers, such as nursing assistants, were hired by hospitals to assist the RNs.

Universal Health Care Coverage

Public apprehension about access to health care dominated the Canadian health care landscape for the last half of the twentieth century. The first Canadian health region was established in Swift Current in 1946. For less than $20 per person per year, residents received “doctor services, hospitalization, children’s dental care, and a professional public health service including nurse, immunization programs and health inspectors” (Matthews, 2006, para 3).

Two of the significant outcomes of this “experiment” were (1) an increase in doctors in the Swift Current Health Region from 19 in 1946 to 36 in 1948; and (2) as a direct result of the work of the nurses and access to doctors, a drop in the infant mortality rate to the lowest in Saskatchewan. The Saskatchewan Medicare system, based on the Swift Current model, was introduced to the entire province of Saskatchewan in 1962. The Swift Current Health Region, the first universal hospital and medical care program in North America, was a harbinger of international health care priorities in the twenty-first century (WHO, 2017).
Saskatchewan nurses have been very involved in the Canadian health care system. To find out more about the history of nursing in Saskatchewan, watch this video titled "The Role of Canadian Nurses during WW1 & WW2" (5:19) by Dr. Sandra Bassendowski, Professor, College of Nursing, University of Saskatchewan.

The introduction of UHC coverage to Canadians was a multi-step process, commencing with the passing of the national Hospital Insurance and Diagnostic Services Act (1957), which covered the cost of inpatient treatment, laboratory services, and radiology diagnostic services in acute care hospitals throughout Canada. In 1966, the Medical Care Act extended health coverage for Canadians to help cover the costs of physicians’ services outside hospitals. Canada’s national health insurance program was structured to ensure that every Canadian received medical care and hospital treatment, which was paid for by taxes or compulsory health insurance premiums. Costs were shared between the federal and provincial governments, providing the provinces met the principles of accessibility, universality, comprehensiveness, portability, and administration (CNA, 2013; Dunlop, 2006).

Health care costs spiralled after the implementation of Medicare, and a review of the publicly funded insurance programs was conducted in 1979 by Justice Emmett Matthew Hall. Dr. Helen Mussallem, then executive director of the CNA (and a World War II veteran), presented the CNA’s brief, “Putting Health Back into Health Care” to the review. This document highlighted the CNA’s belief that:

insured health-care services should be extended to include more than just acute care, that nursing services should be covered and serve as an entry point to the health-care system and that all extra premiums such as extra-billing and user fees should be banned. (CNA, 2013, p. 105)

Dr. Ginette Lemire Rodger assumed the position of executive director of the CNA following Dr. Mussallem’s retirement in 1981. Dr. Lemire Rodger conducted extensive lobbying to support the recommendations set out in “Putting Health Back into Health Care.” The Canada Health Act passed in 1984 included several of the revisions recommended by the CNA. Nursing leaders, including Dr. Lemire Rodger and Dr. Helen Preston Glass (CNA president) had been “unable to convince parliamentarians to extend coverage to services outside hospitals and other medical institutions, but they did manage to have the description of potential providers of insured services broadened to include health-care practitioners and not just physicians” (CNA, 2013, p. 106). Opening the door to funding of insured nursing services was the catalyst that promoted the presence of nurse practitioners in outpatient and nursing clinics.

**Essential Learning Activity 4.3.2**

Answer the following questions as you review the Canada Health Act:

1. What are the five standards that the provinces and territories must meet?
2. What are the responsibilities of the provinces and territories for health care?
3. What services do the provinces and territories fund?
4. What are the responsibilities of the federal government for health care?
5. What services does the federal government fund?
6. How does the federal government fund and work with First Nations and Inuit people?

To understand more about health care services for First Nations and Inuit people, visit the First Nations and Inuit Health web page on the Health Canada website. Then answer the following questions:

1. What is Jordan’s principle?
2. If a First Nations child is not receiving services and supports, who is to be contacted?

Auxiliary Workers

The federal government’s plan provided grants that were to be matched by provincial money and provided momentum for rapid hospital construction and renovation. By 1950, money had been approved for almost 20,000 additional hospital beds throughout Canada. These grants, combined with other state-sponsored health focused programs, increased the public’s demand for health care. A new category of auxiliary workers was introduced to meet these demands. The CNA was supportive of these auxiliary workers, having already developed a curriculum for nursing assistants in 1940. The provinces began to create courses and bring the licensing of this new classification of auxiliary workers under their control.

Nursing Education

Figure 4.3.1 First Graduating Class from the University of Saskatchewan, 1943

[n.d], “Nursing Students,” photo courtesy of the University of Saskatchewan Archives and Special Collections, collection number A-2636, is licensed under a Creative Commons Attribution 4.0 International License. About this photo: Visit the College of Nursing website, for more information on the history of the College of Nursing at the University of Saskatchewan.

Nursing education was a focus of Canadian nurse leaders for the last half of the twentieth century. Nursing students had become indispensable care providers for patients within the hospitals and were frequently overworked by the hospital
administration. Nurse leaders became increasingly alarmed about the quality of education provided to these students who learned on the job by providing much of the patient care. In 1946, Evelyn Mallory, president of the Registered Nurses Association of British Columbia questioned the state of nursing education:

> Are we going to continue to compromise, to muddle along with nursing education and nursing service hopelessly confused, not only in the minds of the public, but in the minds of nurses as well, as has been the case for years? Or were nurses at long last going to do some really constructive planning in relation to the preparation of professional nurses, frankly recognizing that we must have more nurses and better nurses if the needs of the community are to be met? (cited in CNA, 2013, p. 72)

In an attempt to improve the education of nurses, the CNA piloted an accreditation program for schools of nursing. The 1960 pilot accreditation project report on the Evaluation of Schools of Nursing revealed that 21 out of 25 schools failed to meet the standards. As stated by Dr. Helen Mussallem, “the students were not students, they were indentured labour” (CNA, 2013, p. 81).

Dr. Mussallem was the first Canadian nurse to complete a PhD in nursing. Her research, which focused on the development of nursing education in general educational systems, received extensive attention from both professionals and the general public. She recommended a complete revision of Canada’s nursing education system. Following publication of her research, the Globe and Mail described nursing training in the following words:

> The hospital system of training nurses is closely akin to the army system of training soldiers . . . that deprives her of some of her civil rights—she must submit to curfews, to a considerable control of her leisure time, even to dictates about her personal grooming . . . and not even be able to insist on the most basic of rights—the right to be treated as a reasonable, responsible adult in a free society. (CNA, 2013, p. 85)

Dr. Mussallem’s research brought the need for a change in nursing education to the forefront of Canadian nursing and served as a catalyst for the movement of nursing education out of the hospitals and into Canadian colleges and universities.

Figure 4.3.2 Saskatchewan Collaborative Bachelor of Science in Nursing (SCBScN)
Nursing Research

Nursing leader Dr. Ginette Lemire Rodger fought against strong gender, age, occupational, and academic prejudices within the Medical Research Council (now the Canadian Institutes of Health Research) when she joined the council in 1986 and worked to move research funding beyond bench scientists and physicians. Due to her persistence, financial support was found for both nursing research and nursing research infrastructure. Linked to this awareness of the need for nursing research, the first fully funded PhD program was opened at the University of Alberta in 1991. Dr. Lemire Rodger soon became the first graduate from a Canadian nursing PhD program. As Canadian nurses acquired the university graduate credentials required for teaching and research, they began to develop a unique body of Canadian research centred upon the discipline of nursing.

Research Note

Northern Saskatchewan is home to many Indigenous people, who live in small, often isolated, settlements. The economic conditions in the north were abysmal during the twentieth century. The first nursing stations were established in Ile-a-la-Crosse in 1927 and Cumberland House in 1929. Nursing was the backbone of health care in the North.

Following the 1944 election of the Co-operative Commonwealth Federation (CCF) in Saskatchewan, an emphasis was placed on “integration of the underprivileged of society” (McBain, 2015). This initiative was funded by taking advantage of wealth generated through the exploitation of abundant natural resources, such as uranium, found in this region. Nine additional nursing stations were established between 1941 and 1955. Only two of these stations were federal—those in Lac La Ronge and Pelican Narrows. Because small settlements were scattered across the North, it was difficult to develop the resources required to provide good medical care in the local communities. Consequently, air ambulances were established to fly patients from the nursing stations to larger centres, where they would receive the required
services.

Provincial nurses attended to the non-treaty population in the North. The few federal nurses present in the North attended to the status Indian population. Numerous jurisdictional issues arose between provincial health care and federal health care. During the latter half of the twentieth century, many provincial nurses were reprimanded for providing care to status Indians. This jurisdictional issue continues to the present day. However, the nurses never refused to provide care; they always found a way to meet the needs of the patient, regardless of treaty status.

In this YouTube video (53:00), titled “Place and Nursing in Remote Northern Communities: A Historical Perspective,” Dr. Lesley McBain discusses historical research conducted with northern Saskatchewan nurses. The research described in this video illustrates some of the challenges faced by outpost nurses while providing care to northern Saskatchewan citizens. In letters to their supervisors, individual nurses bring attention to substandard working environments, which limit their ability to deliver professional care while also having a negative impact upon the welfare of their patients.

After watching the video, answer the following questions:

1. According to this research, has the Canada Health Act had an impact on northern communities?
2. What changes would you recommend to improve health care in the North?
3. How did the frequent relocation of northern nurses impact their “moral proximity,” as described by Malone’s theory of distal nursing discussed in the video?
4. If you were a provincial northern nurse, what would you do to ensure that all people receive good care?

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**Essential Learning Activity 4.3.3**

To understand how the development of nurses’ working professionalism over the past 60 years has been linked to changes in societal attitudes, watch this video of Margaret Scaia presenting “Working Professionalism: Nursing in Calgary and Vancouver 1958 to 1977” (51:00).