BE WISE! BE HEALTHY!

Morality and Citizenship in Canadian Public Health Campaigns

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Contents

Introduction
Creating Healthy Citizens

Over the past decade, Canadians have seen an explosion of public health messages telling us to lose weight and to exercise more. Parents are urged to follow the full vaccination schedule and put aside their concerns about the (discredited) link between vaccines and autism. And, of course, public health officials continue to warn us about the risks of smoking. Such messages are part of a long tradition. For well over a century, governments and voluntary groups have run educational campaigns to encourage Canadians to adopt health habits that promise to prolong our lives, increase our quality of life, cost the state less money, and make us more efficient workers. Mostly, these messages are helpful. As a result of public health education, fewer people die of infectious disease, fewer children are maimed in accidents, and fewer people die prematurely because of smoking. But public health is not without its costs. Smoking and drinking, for all the harm they can cause, are also pleasurable. High-fat foods taste good (and may not be as harmful as nutrition professionals once believed). Riding a bike without a helmet is a lot more fun. Excessive concerns about health can lead to anxiety, eating disorders, and feelings of worthlessness.[1] Public health campaigns often further stigmatize marginalized populations, implying that they take inadequate care of their own health, even though poorer health outcomes of marginalized groups have clearly been linked to the experience of poverty and trauma.[2] Some public health interventions, such as vaccinations, are not without risk, even if that risk

is very small. And while not all public health interventions involve compulsion, some do, and this raises complex issues about people's rights over their own bodies versus the rights of others to be safe from harm. Partly as a result of such issues, public health has always been controversial.

This book will explore the history of public health in Canada from the 1920s to the 1970s, a period that saw a massive expansion of public health education programs, through the lens of the Health League of Canada, one of Canada's leading organizations promoting public health. During these decades, the Health League of Canada and its precursors urged Canadians to protect their health by drinking pasteurized milk, immunizing their children, guarding themselves against winter colds and sore feet, avoiding extramarital sex, improving their nutrition, embracing the fluoridation of the water supply, and educating themselves about chronic diseases. The league instructed Canadians that it was their responsibility as citizens to keep themselves safe from disease, and it encouraged them to look to doctors and dentists as the experts who would guide them along the path of health. The Health League was a pioneer in what many have described as the "new public health," which shifted the focus away from the environmental causes of disease (polluted water, poor housing conditions, inadequate sanitation) towards the individual, encouraging citizens to change their health habits and behaviours to help prevent disease.[3]

The Health League was not Canada's largest public health organization – indeed, it was dwarfed by federal and provincial departments of health, as well as numerous other voluntary groups, but it was the only voluntary group dedicated to pushing a broad public health agenda, as other groups pursued particular diseases or causes. It is of interest to historians because its many campaigns provide us with a window into the broader world of public health education in the middle decades of the twentieth century. The Health League was involved in all of the leading public health issues of the day, ranging from immunization and water fluoridation to nutrition education, venereal disease prevention, and industrial health. It was well connected with federal and provincial public health bodies, and most Canadians would have encountered its publicity at one point or another, whether through National Health Week, National Immunization Week, or educational campaigns about milk pasteurization or the dangers of sexually transmitted infections. The Health League also provides an interesting case study of the role of voluntary organizations in Canadian society. Groups such as the Red Cross, St. John's Ambulance, Big Sisters/Big Brothers, and many

others have played a vital role in civil society, but, in general, these groups have not been as well studied as governmental organizations.[4]

The Health League began life in 1919 as Canadian National Council for Combatting Venereal Disease (CNCCVD), led by a young Toronto physician, Dr. Gordon Bates. In 1922, it changed its name to the Canadian Social Hygiene Council (CSHC), a title it thought would be more acceptable to potential supporters and one that reflected the fact that Bates and his organization wanted to be involved in a broader program of health prevention.[5] The term "social hygiene" can encompass many different things: neither contemporaries nor historians of the movement have agreed on a definition. In the United States, contemporaries and historians generally use the term to describe the crusade launched by the American Social Hygiene Association (ASHA) to fight against venereal disease and prostitution.[6] The ASHA was an alliance of female moral reformers and physicians. One historian has described its work as a "quintessentially Progressive blend of moral zeal and technical expertise."[7] In Britain, the term has been used more expansively. David Evans describes social hygiene as combining social purity, feminism, and public health to condemn the "racial poisons" of venereal disease, alcoholism, and feeble mindedness.[8] British historian Greta Jones goes even further. She only peripherally includes venereal disease and sex education in her discussion of social hygiene. She argues that the movement aimed to regulate the working classes through a wide range of projects including "scientific eating," the compulsory detainment of the so-called mentally deficient, and maternal education. She contends that it provided an alternative to the welfare state by suggesting that biology, rather than poverty, was at the root of most health and social problems.[9] Despite differences in definitions, the social hygiene movement in both the United States and Britain was strongly linked to venereal disease prevention and was highly influenced by the eugenics movement that was sweeping the Western world at the time. Part of what distinguished social hygiene from previous reform efforts was its emphasis on biology and its faith in medical expertise. At the same time, social hygiene advocates believed that citizens' voluntary action had the power to improve the nation's health and well-being.

The Canadian Social Hygiene Council started as an anti–venereal disease group that, like its American namesake, combined medicine and morality. But, reflecting the British definition of "social hygiene," the CSHC quickly moved into a broader program of health education. Bates believed that social hygiene involved not just physical health, but also moral, mental, and social health.[10] Nonetheless, by 1935, feeling that "social hygiene" had become

too closely associated with venereal disease and sex education, the CSHC decided to adopt a name that would better reflect the scope of its ambitions, and it became the Health League of Canada.[11] Despite the broader mandate implied by the name change, this book will argue that the social hygiene roots of the organization would persist throughout the history of the league. Over the course of its existence, it would aim to prevent disease by trying to change individuals' behaviour. It would build alliances between doctors and voluntary organizations, believing that health should be the concern of all citizens. While the explicitly racialized language of eugenics faded away, the organization's emphasis on health as a duty of citizenship reflected the ongoing influence of "positive eugenics," which had long drawn connections between proper living and population health. While historians usually see positive eugenics as being about promoting the reproduction of the "fit," it also promoted health among children and families, by publicizing the importance of improved eating habits, sanitary homes, and particular health and moral behaviours.[12] As Frank Dikötter has noted, the historiography on eugenics has long focused on the more "extreme expressions of race improvement." He makes the point, however, that "eugenics belonged to the political vocabulary of virtually every significant modernizing force between the two world wars" and has a legacy that extends well beyond the Second World War.[13] The *Oxford Handbook of the History of Eugenics* also stresses the degree to which the eugenics movement in many countries strove to "bring about fitter life" through environmental reforms, public health, and education about the training and rearing of children.[14] We argue in this volume that there are important continuities between the social hygiene movement of the early decades of the twentieth century and the "health promotion" movement of the 1970s.

In their influential book, *The New Public Health: Health and Self in the Age of Risk*, Australian scholars Alan Peterson and Deborah Lupton argue that the new public health that emerged in the 1970s drew on the concept of the "entrepreneurial self" – the individual who is expected to be self-monitoring and to take account of risks and adjust behaviour accordingly.[15] Peterson and Lupton take the view that the rise of the entrepreneurial self has to do with the retreat of welfare state liberalism. Our work on the Health League suggests that models for the entrepreneurial self predate the retreat of welfare state liberalism, at least in the Canadian context. From its inception, the league counselled Canadians to avoid health risks and urged individuals to take responsibility for their choices – an indication that this model of public health could exist alongside expanding welfare state provisions. Indeed, as

James Colgrove argues in *State of Immunity,* Progressive Era health reformers in the United States differentiated themselves from their counterparts in earlier eras of public health reform by locating health risks in individual behaviour and urging people to take individual responsibility for their well-being, again suggesting that the entrepreneurial self has deep roots in the field of public health.[16] At the same time, the Health League of Canada encouraged Canadians to defer to doctors and dentists in all matters of health, helping to consolidate the prestige of medicine in this period.[17] Our book shows the considerable power of medical expertise in the middle decades of the twentieth century, as Canadians learned to adopt new health behaviours and were urged to think of health as a duty to themselves, their families, and their nation.

The ideology of social hygiene fed the CSHC's expansion into other health education work, including on the pasteurization of milk and diphtheria immunization, by the second half of the 1920s. The organization began presenting lectures and producing radio broadcasts on subjects ranging from child health to smallpox. In 1933, the council launched a magazine, *Health,* which covered a diverse array of health topics. Despite its innovations in the late 1920s and early 1930s, the organization barely survived the difficult years of the Great Depression, but an infusion of funds during the Second World War allowed it to launch new ventures. It started an Industrial Health Division to educate workers on how to improve their health and avoid absenteeism, renewed its anti–venereal disease program, significantly expanded its immunization activities, and partook in the campaign to educate Canadians about new developments in the field of nutrition. In 1944, the league launched National Health Week, a yearly crusade that drew Canadians' attention to preventive health through an exhaustive array of public talks, advertisements, radio broadcasts, and posters. Reflecting the fact that rates of death from infectious disease were declining, the organization began to put more effort into educating the country about the perils of chronic diseases like heart disease and cancer and encouraged Canadians to eat properly, avoid stress, exercise regularly, avoid excessive use of alcohol and other drugs, and pay attention to their mental health. In the 1950s, the league also became a major force in the campaign for water fluoridation.

Although most Health League activities were geared towards changing behaviour, a few of its initiatives, most notably its advocacy of milk pasteurization and water fluoridation, aimed to achieve legislative reform. But these initiatives, at least in Bates' view, were also about modifying behaviour. Bates wanted to convince people of the merits of these measures, and

he hoped that, once people understood their benefits, they would demand that the law be changed. Such advocacy was part of the active democratic citizenship required in a society that put health first. Bates believed that health and the duties of citizenship were intimately connected.

The Health League focused its efforts on public education: it distributed pamphlets, developed radio programming, showed films, mounted exhibits, created posters, and issued a constant stream of press releases. Gordon Bates, who was director during most of the years of the active operation of the league, was a vigorous (some might say obstreperous) leader with a talent for generating media coverage. As a result, the league's influence stretched beyond its small size. The Health League provides us with a window on how public health messages were constructed, the controversy that these messages sometimes generated, and how Canadians learned

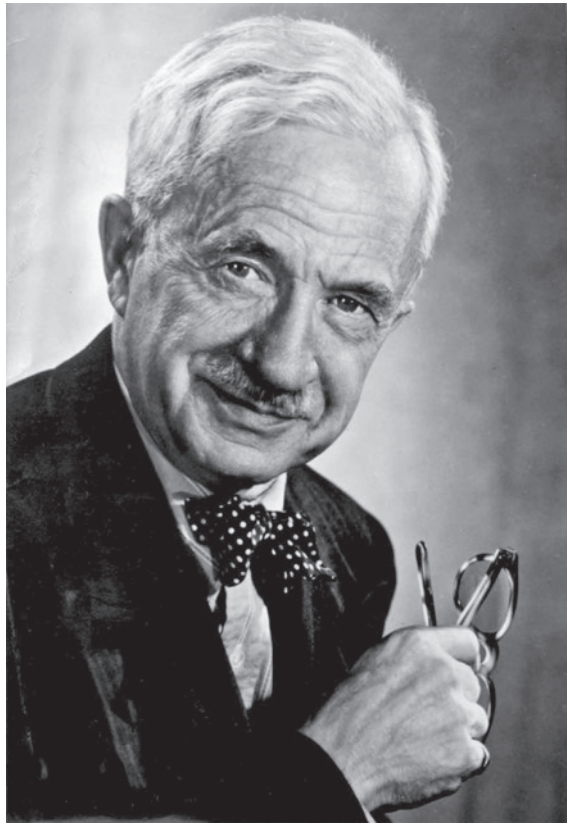

Figure 1 Gordon Bates. | LAC, MG28, I332, vol. 202.

to regulate their bodies and behaviours in new ways as they adopted the health habits advocated by the league, governments, and other organizations. Moreover, because it left extensive records – more than 250 boxes at Library and Archives Canada contain newspaper clippings, publicity materials, meeting minutes, and correspondence – the league constitutes a valuable case study. These records give a clear idea of the league's reach: clipping files, for example, show the significant publicity that its campaigns and educational programs generated across Canada.

During the years the Health League and its predecessors operated, enormous strides were made in the fight against disease. There is a fierce historical debate as to whether rising incomes (with concurrent improvements in living conditions and nutrition), public health interventions, or medical treatments made the biggest contribution to reducing mortality. Regardless of the weight assigned each factor, as living conditions improved and new vaccines and treatments were developed, deaths from infectious disease plummeted.[18] For parents, the tragedy of having a child die became an increasingly rare event. New treatments such as insulin for diabetes, sulpha drugs and antibiotics for infections, and surgical improvements, as well as important public health interventions such as better sanitation and the pasteurization of milk, also enhanced child and adult health. In the fifty years between the early 1920s and early 1970s, life expectancy increased by ten years for men and fifteen years for women.[19] While their cities became more sanitary and their food safer, Canadians gained better access to medical advice and care (or, depending on one's perspective, were more likely to be exposed to the medical "gaze"). Beginning in the late nineteenth century, the number of hospitals began to increase rapidly, and, by the 1920s, Canadians of all social classes sought hospital care for a wide range of procedures, including delivering babies.[20] As incomes rose, and access to private insurance increased after the Second World War, Canadians became more likely to see a physician if they became ill.[21] By 1961, all Canadians were entitled to free hospital care; by 1972, all Canadians had access to free primary physician care. Throughout these decades, Canadians also became better informed about health through pamphlets, exhibits, advice manuals, and the media.

The Health League and other non-governmental organizations as well as the government urged Canadians to consciously take care of their bodies (and, increasingly, their minds) for the good of themselves, their children, and their nation. British historian Dorothy Porter has used the term "health citizens" to describe the responsibilities of citizens to be healthy in, and for,

the modern state.[22] Canadians increasingly think of citizenship in terms of rights and entitlements, but, in the middle decades of the twentieth century, there was a much greater focus on the responsibilities of citizenship.[23] Bates was very much of this school: for him, being a good Canadian meant listening to health authorities, adjusting one's behaviour accordingly, and saving the state money that it would otherwise have to spend on treatment for preventable conditions. Citizenship also meant being involved: he consistently urged Canadians to join committees promoting health in their communities. Throughout his career, Bates would be a "joiner" – his affiliation to the Rotary Club would be dear to his heart, and he was also an active member of the Alliance Française. Bates was what Robert Putnam would describe in his groundbreaking book about community and social capital, *Bowling Alone,* as a "macher" – an individual who makes things happen in a community.[24]

As numerous historians have noted, Canadians intensively debated the duties and meanings of citizenship in the middle decades of the twentieth century, as Canada participated in and then recovered from two world wars, gradually drew away from Britain, and slowly and incompletely moved towards adopting bilingualism, multiculturalism, and tolerance as important components of Canadian identity.[25] The Health League participated in this conversation. It argued that taking measures to protect one's own health and the health of one's children was an essential component of Canadian citizenship. Editorials in *Health* badgered Canadians about the importance of health in a democratic society. In 1941, for example, Bates quoted Benjamin Disraeli, the nineteenth-century British prime minister, as saying that the "first duty" of the statesman was "the care of public health."[26] Bates insisted that health was a matter of national interest, not just a personal or local matter. In 1952, he called on all citizens to partake in Health Week because health was not just the concern of the individual. Individual health behaviours could affect the whole community, and he urged Canadians to talk about health in their churches, service clubs, and schools.[27] Bates believed strongly in the importance of voluntary groups in democracy, and, under Bates, the league continually reached out to women's organizations and service clubs such as the Rotary, Kiwanis, and Lions Clubs. In short, for Bates, health was the bedrock of democracy and the way forward to a stronger nation. And yet, as the discussion on Bates and medicare in Chapter 8 will reveal, he came to believe that health should be maintained not by the state through the provision of medical care, but by the individual actions of all citizens, who would keep themselves healthy by adopting the rules of health. He felt considerable unease about the increasing involvement

of government in public health infrastructure, believing that public health work could best be done through voluntary organizations.[28] Of course, this perspective was self-interested: he believed that the Health League should receive more funding, and that, if it had adequate resources, it would be better able than government agencies to provide health education.

During these decades, Canadians came to have much higher expectations for their own health and that of their children, but they also learned to examine and control their bodies in new ways and to engage in what for many were new duties, such as visiting their doctors and dentists for regular check-ups, getting their children vaccinated, and monitoring their diets. As Alison Bashford has described for Australia, "hygiene was a responsibility, a duty."[29] It was far easier for middle- or upper-class and urban Canadians to meet these responsibilities. Poorer Canadians and those living in remote regions had a much harder time fulfilling the duties of health citizenship. Not only did they have limited access to physicians, but the medical profession treated them with much greater condescension, often assuming ignorance and apathy on the part of the poor, especially poor women.

The Health League did nothing to address these inequalities, declining to address the greater difficulties faced by certain Canadians in pursuing health citizenship and failing to represent them in their profiles of the ideal health citizen. The league did attempt to reach out to working-class Canadians through its workplace programs, but these were often condescending and assumed that employers had their employees' best interest at heart. For the most part, the league represented Canadians as white and middle class. While a large literature has drawn attention to the racialized nature of many public health campaigns, the Health League is particularly striking for its unthinking whiteness. Except in its early years, when it was focused on venereal disease, the organization rarely addressed immigrants or people of colour. This is surprising, given that these population groups were often regarded in public health circles as sources of contagion.[30] Bates did express fears that recent Italian immigrants might defeat fluoridation in Toronto (see Chapter 7), but that itself is an indication that immigrants would have to work hard to fit into his model of the idealized health citizen. Mostly the league ignored racialized "others," including Indigenous people and the large number of "New Canadians" who were transforming Canadian life in the period after the Second World War, preferring instead to focus on its idealized (white) health citizen. This meant that racialized citizens and new immigrants were denied the oftentimes-valuable education that the league gave to other Canadians on how to improve their health.

While most Canadians believed that science and medicine had done much to improve health and prolong life, and many willingly adopted the practices promoted by the league, there were always pockets of resistance. Not everyone agreed that vaccination was worth the risks to themselves and their children. Some believed that raw milk had benefits over pasteurized milk, and others felt that health agencies and governments had no business interfering in their health and with their bodies – arguments very similar to those used in present-day debates over vaccination, pasteurization, and other issues.

The Strengths and Weaknesses of the League

Bates and his allies liked to define the Health League as a national organization, but it is more accurate to call it a local agency with national aspirations and some national programs. Its headquarters were in Toronto, and, in spite of efforts to create branches in other regions and to appoint board and committee members from across Canada, Torontonians played a dominant role in daily operations, often to the dismay of people from outside the city.[31] There was an active Health League organization in Vancouver, but, much to Bates' frustration, it functioned fairly separately from the main league (and will, consequently, not be examined in any detail in this book).[32] The league also had a Quebec branch, which cooperated more closely with the "national" organization, although over the years it had some significant organizational challenges.[33] The closer relationship with the Quebec branch undoubtedly was due partly to geography (it was much easier for Bates and other league employees to travel to Montreal than to Vancouver), but it also related to Bates' vision of Canada. Bates was a francophile and, beginning in his late sixties, he regularly travelled to Paris to take courses at the Sorbonne.[34] *Health* often ran editorials on the benefits of bilingualism and, from 1958 onwards, included a regular feature entitled "Learning French." This column was a somewhat odd addition to a magazine purportedly about health, but it does illustrate the league's broad vision for health citizenship. Bates also hoped that the league would be able to raise funds in Quebec at a time when many of Canada's leading corporations were headquartered in Montreal. However, these fundraising campaigns met with little success, and one of the main roles of the Quebec branch appeared to have been translating the material that emerged from the Toronto office.

The league wanted to represent and to speak to the nation, but branch offices outside Quebec and Vancouver were haphazard and short lived. People from other parts of Canada had few opportunities to shape the message,

and the Health League often remained ignorant about the challenges and opportunities that existed outside Toronto. As the director of health education in Saskatchewan and a former league employee, Christian Smith, put it in 1945:

> the League is far from reaching its potentialities in Canada. The liaison with national organizations, the distinguished names on its literature and the press service do not make it a national association. It will be truly national when it involves the common people across the country, not just as paid members or readers of the magazine, but as active participants in activities.[35]

The league often put forward strategies for organizing in other parts of the country, but it fully expected that what worked in Toronto would work elsewhere and then could not grasp why local communities failed to respond enthusiastically.[36] As a result, branch organizing was rarely successful. Instead, the league developed publicity materials in Toronto and circulated them to the rest of the country. Sometimes provincial health units embraced and used these materials; sometimes they did not. Many newspapers ran articles provided by the league, but others chose not to. Reflecting the league's reach and influence, this book has a strong focus on Toronto and Ontario, although as much as possible we have tried to outline the extent of league activities elsewhere in the country. The Health League, of course, is far from being the only central Canadian organization with illusions of representing the country as a whole. Indeed, the history of the league arguably parallels that of Canadian nationalist ambitions more broadly, from the Group of Seven to the Committee for an Independent Canada.[37] Yet, while the Health League failed to integrate the concerns and perspectives of different regions of the country, many of its campaigns had a remarkably broad reach.

The Health League was not a grassroots organization. As we will show in subsequent chapters, it was never particularly successful at recruiting members. It occasionally mobilized a network of female volunteers, most obviously in the social hygiene work of the CSHC in the 1920s and in the league's nutrition work during the Second World War.[38] There were also female staffers, although usually not in the most prominent roles. For the most part, the league was dominated by male voices. It was organized into divisions, which supported particular activities, such as milk pasteurization, water fluoridation, and food handling. Each division had a voluntary

committee associated with its work. These committees were nearly always chaired by male volunteers, and most committee members were male. This skewing reflected Bates' preference for drawing supporters from the medical and dental communities and from among business leaders and politicians, all fields dominated by men. For similar reasons, the national executive and the Honorary Advisory Board were also male dominated.[39] While the league did attempt to include representatives from other parts of the country on its committees and boards, meetings were held in Toronto, which limited the input of people from outside Toronto and Quebec.

Bates' strong personality and his control over the board ensured that the Health League operated according to his command, which had both positive and negative consequences for the organization. Bates had a talent for generating publicity. Always confident of the righteousness of his causes, he wooed doctors and politicians to pursue his agenda. Opinionated and headstrong, he often made enemies as well as allies. Throughout his long career, he did not shrink from insulting or defying those who stood in the way of his vision. As journalist Sidney Katz put it in a profile of Bates for *Maclean's* in 1955, his "formula for getting results was to frighten, shock, anger and educate."[40] Bates had less talent for organizational work. Over the years, the league was criticized for starting too many projects without finishing them and for failing to test new ideas before implementing them.

Even so, the league and its predecessor organizations can be credited with several significant achievements. In the 1920s, the CSHC played a key role in educating Canadians about venereal disease and encouraging them to seek treatment. Over the course of the decade, the number of people infected with venereal disease in Canada fell substantially. The council encouraged parents to talk to their children about sex, although, like other organizations involved in sex education at the time, it significantly downplayed the pleasurable aspects of sexuality to focus on the role of sex in reproduction and the dangers of premarital sex.[41] Another success was the league's magazine, *Health,* which published continuously from 1933 to 1980, with only a brief pause from 1969 to 1972. While the magazine never enjoyed a large subscription base, it was widely available in medical and dental waiting rooms, and the league also used its articles as press releases. The magazine helped encourage a national conversation about public health. The Health League also had a voice in Ottawa. In the mid-1920s, in an effort to stave off an attempt to cut a government grant for venereal disease education and treatment, the Canadian Social Hygiene Council created the Voluntary Committee on Health of the Senate and House of Commons, which organized

regular luncheon talks on health issues. This committee lasted until the 1970s.[42] All members of Parliament who were doctors, dentists, pharmacists, as well as female members of Parliament, were invited to join; Bates served as the secretary of the committee, giving him a powerful audience.[43]

The league also mounted large-scale education campaigns, such as Toxoid Week, National Immunization Week, and National Health Week. Starting in 1931, the CSHC helped conduct the Toronto Department of Health's Toxoid Week to promote diphtheria prevention. In 1943, the league independently established National Immunization Week, an annual campaign to promote vaccination against numerous preventable diseases. A year later, the league began to organize National Health Week, establishing and consolidating collaborative relationships with schools, churches, voluntary groups, and service clubs around Canada to execute this yearly publicity blitz. The league played an important role in lobbying for milk pasteurization and water fluoridation, and, along with other organizations, it encouraged Canadians to learn more about the role of nutrition in health. It played an important supportive role in educating Canadians about child and maternal health and about the growing threat of chronic diseases. In 1953, the league received a kind of international recognition when it was chosen by the World Health Organization (WHO) as the Canadian Citizens' Committee of the WHO.[44]

Given all of these accomplishments, why did the Health League not survive? Even while the league expanded its activities, there were signs that it was being overtaken by other organizations. During its years of operation, the federal and provincial governments significantly expanded their public health activities. By 1962, Ottawa employed more than 5,000 people in the field of public health, producing pamphlets, films, radio programs, and exhibits on a variety of health topics.[45] At the same time, the health-related activities of the government of Ontario cost over $136 million per year and employed over 11,000 people. The provincial government had a large publicity branch, which addressed topics such as nutrition, dental hygiene, child health, and industrial hygiene.[46] The league's work increasingly overlapped with services provided by provincial governments, and, over time, these governments came to the conclusion that they could do this work better themselves. Also, in the years after the Second World War, several voluntary organizations, often focused on a single disease or disability, either sprang up or expanded their operations. These organizations, which could tug at the heartstrings of people who had had friends or family members affected by the disease or disability, were far more successful at raising

funds and at organizing local and provincial branches than was the Health League, which always took a preventive and general approach to health. Organizations like the Canadian National Institute for the Blind (founded in 1918), the Canadian Tuberculosis Association (1900), the Canadian Cancer Society (1938), and the Canadian Diabetic Association (1953), outpaced the Health League in size and budget. Even smaller organizations like the Canadian Paraplegic Association, the Muscular Dystrophy Association, and the Ontario Heart Foundation had larger annual budgets than the Health League, much to Bates' despair.[47]

Crucially, Bates also failed to adapt to changing times. He had started his career as a progressive voice. Along with feminists and like-minded medical men, he was eager to open up the discussion about venereal disease and to educate people about sex. Drawing from the message of first-wave feminists, he criticized the sexual double standard and upheld the importance of confining sex to marriage. As the years passed, his views changed very little – indeed, perhaps they became more conservative. By the 1960s, when Canadians were debating the merits of legalizing birth control and the possibility of decriminalizing homosexuality, and young people were asserting that there was nothing wrong with having sex before marriage, his views seemed increasingly outdated.[48] At the same time, many decades of working in public health had increased his frustration with Canadians who refused to adopt the health measures that he saw as being in their best interests, and his tone became increasingly shrill, especially when it came to water fluoridation. Moreover, after initially being sympathetic to publicly funded physician care, Bates eventually became an opponent of the measure, even as it quickly gained strong support from Canadians. In short, by the 1960s, Bates was increasingly out of touch with a Canada that was adopting new ideas about morality, citizenship, and the role of the state.

The Health League was also losing strength with respect to its collaborators and networks. It had successfully worked with many of the leading medical figures of the first half of the twentieth century, including Alan Brown, the autocratic physician-in-chief at Toronto's Hospital for Sick Children; J.J. Heagerty, who had a long and illustrious career in the federal Department of Health and played a crucial role in some of the early studies that led to medicare in Canada; J.W.S. McCullough, Ontario's first chief provincial health officer; and Charles Hastings, Toronto's activist medical officer of health. The Supreme Court judge and prominent author William Renwick Riddell served as the president of the Canadian Social Hygiene Council and, later, the Health League until he passed away in 1945. Bates was less successful

at building connections with the physicians and other leading citizens who obtained prominence after the Second World War. Moreover, he failed to build positive links with rapidly expanding government health services at both the provincial and federal level in the postwar period. His connections with the business community also faltered.[49] Although he was able to renew the National Board of Directors and the Honorary Advisory Board in the 1950s, when the first wave of long-term allies of the league began to retire or pass away, he was not able to replace this new generation when they began to disappear in the 1960s and 1970s. This failure contributed to the gradual decline in the league's influence.

The Health League's demise can be attributed to a number of factors. Its financial security was seriously compromised when it lost United Community Fund support in the mid-1960s. Furthermore, despite Bates' protestations to the contrary, much of the organization's initial work was complete by then. Routine vaccination had become a norm, rates of child and maternal mortality had declined, and pasteurization was widespread. By the 1950s, the Health League was often fighting battles that had largely been won.[50] In addition, the general preventive approach to wellness and public health supported by the league seemed outdated. Moreover, with the passing of the Hospital Insurance and Diagnostic Services Act in 1957 and the Medical Care Act in 1966, governments had taken over much of the responsibility for their citizens' health and sickness.[51] Also, by the 1970s, the type of civic engagement encouraged by Bates was already in decline: people were attending church less regularly, were voting less often, and were drifting away from service clubs.[52] Crucially, the league was really the creation of a single individual. When Gordon Bates passed away in November 1975, the league had no succession plan, and the organization gradually withered away, although efforts are currently underway to revive the organization to focus on the dangers of spreading communicable diseases through international air travel.[53]

The League, Morality, and Public Health

Our history of the Health League emphasizes that public health campaigns in this period encouraged Canadians to adopt an entrepreneurial view of themselves and their bodies, to become aware of health risks, and to take appropriate measures to avoid these risks. Advocates presented this as a moral project and depicted Canadians who did not undertake these measures as failing in their responsibilities of citizenship. Despite the intransigence of its views, we acknowledge the real improvements that resulted

from the work of the Health League and other organizations: widespread vaccination greatly reduced childhood mortality, improved sanitation practices led to fewer cases of food- and water-borne illness, and the introduction of fluorides greatly reduced tooth decay.

Yet, public health reformers, including Bates, often passed judgment on other people's health-related behaviours, leading to stigmatization and creating new forms of regulation. Thus, such reformers depicted parents who refused to vaccinate their children as lazy, uncaring, or negligent. They viewed people who opposed water fluoridation as ignorant and anti-scientific. Public health advocates demonstrated little understanding of why people might choose not to follow the recommendations of "experts" and showed little tolerance for other points of view. Such reformers gave little consideration to the fact that people living in poverty might not be able to follow the nutritional guidelines promoted by organizations such as the Health League or that working people might not have the time or financial resources to take annual holidays and exercise regularly. As American historian Allan Brandt has argued, the language of "risk" not only makes individuals responsible for their own health, it also erases the social factors that we know have a critical impact on health outcomes, such as race and class.[54] The Health League's outlook and approach was shaped by a capitalist society that concentrated power in the hands of the wealthy and well educated. In this environment, it was easy to assume that the poor needed to be pulled out of ignorance for their own good and for the good of the nation, that women needed to be counselled on how to feed and care for their families, and that workers needed to be advised on how to avoid spreading colds throughout the factory.

While the Health League was a small organization, its history parallels the history of public health in Canada and has much to teach us about the history of health education and, in particular, the connections that were made between health and citizenship in the middle decades of the twentieth century. To date, the history of public health in English Canada is not extensive. There is a much stronger tradition of public health history in Quebec.[55] Broad overviews in English include Christopher Rutty and Sue C. Sullivan's *This Is Public Health*, a celebratory book produced for the hundredth anniversary of the Canadian Public Health Association.[56] Heather MacDougall's *Activists and Advocates* examines Toronto's Health Department between 1883 and 1983. She shows how the bacteriological revolution and increasing interest in health education transformed public health in the twentieth century, and illustrates the diversity of public health endeavours in Toronto,

including those related to sanitation, housing, food safety, disease prevention and treatment, and water and air quality.[57] Canadian scholars have contributed to an excellent literature on the history of child and maternal health in the first half of the twentieth century, including Cynthia Comacchio's *Nations Are Built of Babies,* Katherine Arnup's *Education for Motherhood*, Denyse Baillargeon's *Babies for the Nation*, and most recently Mona Gleason's *Small Matters*, which examines health history from the perspective of sick children.[58] There is also a significant literature on the history of venereal disease control, although much of it is very dated. Jay Cassel's book *The Secret Plague* examines the history of venereal disease control in Canada, while several articles examine the gender and class biases of the anti-VD campaigns before and during the Second World War.[59] Recently, the history of the Spanish flu epidemic has attracted significant attention from historians, while two outstanding works on the history of nutrition education have been published.[60] The campaign for milk pasteurization has generated a small literature.[61] With the exception of the broad overviews by Rutty and Sullivan and by MacDougall, little attention has been paid to public health in the years after the Second World War, which were arguably the years of the Health League's greatest successes. Nor has the history (with the exception of the remarkably good work on infant and maternal health and some of the recent work on nutrition) focused on how public health campaigns sought to shape people's health habits, their sense of self, and their feelings of responsibility towards their country.

This book provides a new perspective on the history of immunization, pasteurization, water fluoridation, anti-VD work, and nutrition education. It describes some of the health work that was done in factories and other workplaces, and it outlines the educational efforts that were made to combat chronic disease in the years after the Second World War. At the same time, the history of the Health League has much to teach us about the changing landscape facing voluntary organizations in a period when the role of the state was expanding rapidly. Several books have examined the history of voluntary fundraising and the growth of the United Community Funds across the country, but they have generally examined these subjects from the perspective of the funders and not the organizations being funded.[62] Although the Health League was supported by Toronto's United Community Fund and its earlier incarnations, Gordon Bates carried out a long campaign against the federated fundraising movement, which helps cast light on the tensions involved in such fundraising. As noted above, Bates also became an opponent of medicare, believing that it would transfer responsibility for

health from the individual to the state. Our discussion of the Health League and medicare helps elucidate the role of voluntary organizations in this important transition in the provision of health care in Canada.

Finally, this study of the Health League helps us understand how health, morality, and citizenship were constructed in the middle decades of the twentieth century. For public health advocates, being a good citizen involved adopting a wide range of health behaviours, from vaccinating one's children and eating nutritiously to wearing proper footwear. Bates' view that Canadians who fell ill were failing in their duty to themselves, their families, and their country was an extreme perspective, but it continues to echo today in the debates over smoking and obesity. While there is much to celebrate in the history of public health, there is also much to criticize. Public health organizations like the Health League frequently targeted women and the working classes and accused them of being ignorant and apathetic about their health. They created a culture of judgment that encouraged Canadians to look disparagingly on fellow citizens who refused or failed to fulfil the multitudinous duties of health citizenship. Ultimately, the league and other health bodies did not address many of the underlying causes of poor health, including poverty, social marginalization, and mental distress. Instead, their rhetoric blamed individuals for their own health problems, failing to recognize that, while much disease is preventable, sickness is also inevitable and cannot be avoided simply by following the rules of health citizenship.

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