ECONOMIC POLICY TRENDS

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UNEQUAL BURDEN: LEARNING FROM CANADA'S RESPONSES TO THE INFLUENZA PANDEMIC OF 1918-20

Analyzing Canada's responses to the 1918-20 influenza pandemic can offer insights into the current policy and social context of the coronavirus pandemic, while also helping to ensure we do not repeat past mistakes.

In spring 1918, a novel influenza frequently called "Spanish Flu" arrived in Canada. Most authorities took little action because of its shared symptoms with seasonal influenza and its low mortality. However, six months later the influenza had mutated and its second—and most deadly—wave crashed down. Landing first in the Maritimes, Quebec, and Ontario via American travelers from New England and Canadian soldiers returning from Europe, influenza rapidly spread westward with railroad traffic to the Prairies and British Columbia. Of the estimated 50 million global deaths as a result of influenza, about 55 000 were Canadian (Fahrni & Jones 2012, 4).

Historical context is key to understanding the devastation of this influenza crisis. Despite an expansion in size and mandate, the Canadian state was unprepared for the pandemic. By fall 1918, the federal government was leading Canada's involvement in World War I, and most of the country's human and physical resources were geared to the war effort. Additionally, constitutional arrangements meant that responsibility for the services necessary to manage the pandemic was split across orders of government. Canada's public health infrastructure was also immature: it lacked a coordinating body, depended on individual payment for services, and varied tremendously by region (Humphries 2008; Jenkins 2007; McDougall 2007).

Early responses to control the pandemic operated through measures of exclusion. Mounties prevented Indigenous persons from leaving reserves (Lux 1997), and at least one Nova Scotia hospital refused admission to Indigenous persons on the grounds that they were considered "wards of the Dominion" (Maple 2019, 21). Attempting to prevent sick travelers from spreading the disease, Alberta placed inspectors on its borders and Yukon requested the sick be prevented from boarding trains traveling from Alaska to Whitehorse. These interventions failed to contain the virus: the disease had already infected residents within the borders, and there was little focus on preventing the spread of the epidemic already underway (Humphries 2008). For example, many did not have access to paid sick leave, resulting in people working while sick, and there was little to no compensation for employment income lost as a result of quarantine measures (Jones 2006; Lux 1997).

Many provinces had legislation that granted powers to municipal health officers in case of emergency. For example, Manitoba officers held the power to inspect, quarantine, placard, and fumigate private homes (Jones 2005). Alberta went the furthest of any province, quarantining entire municipalities (Humphries 2008) and requiring all residents to wear masks outside the home (Dickin McGinnis 1976). Debates raged over the legality and effectiveness of such orders, with many public health officials expressing concerns that mirror those raised today.

Public gathering spaces were transformed during influenza. Most provinces issued province-wide closures of schools, theatres, and some businesses. Schools and universities were often converted to emergency centres to house patients. Montreal initially exempted churches and businesses, but pushback by physicians changed that. Vociferous debate broke out about the morality of closing churches, the efficacy of closing schools (often seen as safer because nursing staff could monitor children), and the economic impact of closing businesses.

In some cases, social policies compounded the impact of influenza on certain populations. Cities with large immigrant populations, like Winnipeg, suffered as governments were not prepared to extend access to supports beyond middle- and upper-class Euro-Canadians. Language barriers limited access to doctors, the number of orphaned children increased dramatically, and access to maternal benefits required proof of heterosexual marriage before childbirth between a woman and her Canadian husband (Lux 1997).

The public health and economic devastation as a result of influenza gave significant weight to the Canadian Public Health Association's argument that Canada needed a federal department of health—and that department was established on June 6th, 1919 (Marble 2019, 26). The groundswell of support for this decision paved the way for greater investment in Canada's health systems.

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Despite the well-meaning phrase "we're all in this together," history shows us that pandemics are not democratic. The influenza pandemic affected people differently based on race and ethnicity, class and occupation, and gender. Indigenous people, workers, and men died more often as a result of influenza due to the impact of settler-colonialism, pro-business policies, and occupation; women were expected to volunteer in addition to working and caring for their own families (Fahrni 2004; Herring 1993; Kelm 1999).

We are seeing parallel—although distinct—impacts on marginalized communities today. Women, youth, and those employed precariously have taken the biggest hit in terms of pandemic-related job losses. At the same time, much of front-line and essential work has fallen on women and minorities, in many cases without any recompense being offered for the increased hazard. Many of these jobs are low-paying ones. Public policies, both during crisis as well as in recovery, must account for this.

The low wages and dangerous employment conditions workers faced in 1918 contributed to a sense that Canada's economic system was fundamentally unjust, and culminated in the Winnipeg General Strike in spring 1919. Today, though policy makers have intervened with policies to compensate for the loss of wages due to illnesses, caregiving, and job loss, we must also recognize the importance of protecting "essential workers" from heightened health risks by implementing risk premiums retroactive to the start of stay-at-home orders.

Not only must we navigate the pandemic, we must also manage the economic recovery from it. Early indications suggest that infrastructure projects may be prime targets for public investment. This recession, however, is not affecting male-dominated construction and related sectors in the same way as female-dominated education and service sectors (Alon et al. 2020). In addition, women continue to shoulder the largest share of caring duties while earning less than men. Officials should develop re-entry policies that acknowledge and correct the gendered effects of the pandemic recession. This includes adopting recruitment and promotion policies that consider the unwaged time and labour associated with childrearing, as well as expanding subsidized childcare spaces.

The influenza pandemic of 1918-20 placed an unequal burden on Canadians and exacerbated existing inequalities; the coronavirus pandemic has significant potential to do the same—but we can choose a different path.

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