ANNUAL REPORT

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

FOR THE FISCAL YEAR
ENDED MARCH 31, 1969

THE DEPARTMENT OF NATIONAL HEALTH AND WELFARE

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OTTAWA

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His Excellency the Right Honourable Roland Michener,
Governor General and Commander-in-Chief of Canada.

MAY IT PLEASE YOUR EXCELLENCY:

The undersigned has the honour to present to Your Excellency the Annual Report of the Department of National Health and Welfare for the fiscal year ended March 31, 1969.

Respectfully submitted,

JOHN MUNRO

Minister of National Health and Welfare

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Honourable John Munro

Minister of National Health and Welfare

Sir:

Activities aimed at extending health and welfare services to which Canadians are entitled were features of the department's work during the fiscal year 1968-69.

Of special importance among the many and varied activities of the Health Insurance and Resources Directorate is the study undertaken to examine costs of health services in Canada. This involved senior officials from all directorates, as well as a few from other departmental branches. The study (now in print) arose from the Federal-Provincial Ministers of Health Conference in November, 1968 and had as a basic objective the determination of positive action that can be taken to contain the increasing health costs in a logical, definitive and practical way.

The public information and public relations program of the Canada Pension Plan was extended during the year. Concentrated efforts have been directed to public contacts and organized community groups heard 1,600 talks by field personnel on various aspects of the plan. This type of contact brings to the public a knowledge of the program which cannot be duplicated in any other way.

During the year, the Health Services Branch gave increasing emphasis to the priority areas of water and air pollution. Plans were made for the organization and resources necessary for an expanded air pollution program to be carried out in co-operation with the provinces. There was continued collaboration in studies for the International Joint Commission of the United States and Canada on air and water pollution problems in boundary areas.

After slightly more than two years of operation, the drug notification program of the Food and Drug Directorate has practically achieved its original objective, i. e., to establish a record of all drugs on the Canadian market and their manufacturers.

In the area of Medical Services, the year was marked by growing development of arrangements with universities, medical specialist associations and others for augmenting delivery of medical care by highly skilled personnel on a rotating system in remoter areas where such personnel could not locate permanently.

Throughout much of the fiscal year the Fitness and Amateur Sport Directorate was involved in planning for the First Canadian Summer Games, which were supported by funds provided by that directorate.

The necessity for continued attention to long-standing problems was highlighted by the opening, on October 8, 1968, of the National Tuberculosi Reference Center in the Department's Laboratory of Hygiene. This center is concerned particularly with investigative and reference work arising from developing resistance to anti-tuberculosis drugs currently in use.

A major project of the Emergency Welfare Services Division was participation in a systematic analysis (Phoenix) conducted by the Canada Emergency Measures Organization designed to update and improve basic civil emergency measures in Canada.

It would be remiss of me, in closing this letter of transmittal, not to express appreciation for the constant support and loyalty given by staff of this department in 1968-69.

Respectfully submitted,

Maurice LeClair, M.D.
Deputy Minister of National Health

Joseph W. Willard
Deputy Minister of National Welfare

MEDICAL SERVICES

The Medical Services Branch has the duty of:

(a) Administering the Quarantine and Leprosy Acts, designed to prevent entry and spread of smallpox, cholera, plague, yellow fever, epidemic typhus, relapsing fever or leprosy within Canadian jurisdiction.

(b) Assessing the physical and mental fitness of intending immigrants and ensuring as far as practicable they do not introduce infectious diseases or become a charge on the state by reason of incapacitating chronic illness.

(c) Implementing Part V of the Canada Shipping Act, which provides for insured medical care to seamen, both foreign and domestic, in respect to the payment of certain dues levied on shipping, an arrangement which basically predates Confederation and is now in some respects obsolete and under revision.

(d) Organising regulatory inspections to ensure hygienic safety in federal premises, public works, shipping, aircraft and other international or interprovincial means of public transport and associated terminals and ports.

(e) Under various Orders-in-Council and under Section V of the Department of National Health and Welfare Act, advising employing federal departments and agencies on the protection and promotion of the health of all government employees and, in particular attempting to ensure that only persons physically and mentally suitable are,

i) recruited to federal employment,
ii) assigned to duties requiring special fitness or aptitude or involving special hazards,
iii) permitted to control or operate civil aircraft or pilot shipping and
iv) assessing and advising on the degrees of hazard involved in certain duties and the working conditions of federal employees in general.

In addition the branch has been charged with arranging for medical care and public health services for indigent or impoverished groups of the indigenous races and, by special agreement with the governments of the two Northern Territories, with providing direction and oversight of public health services in the territories. It also provides a medical service to the Canadian Coast Guard.

The primary duty laid on Medical Services is not so much to provide the required services directly as to see that they are provided. Consequently the branch attempts wherever possible to enlist the services of any available practitioner, hospital, health unit or other locally available facility. Physicians' and dentists' and other paramedical practitioners' services

are extensively hired on a fee-for-service basis. Hospitals receive special additional construction grants-in-aid or subsidies in respect of making provision for large numbers of Indians or Eskimos. Provincial health units accept a variety of arrangements, some a partial payment others a sharing of staff and facilities. Regulatory public health inspection services are frequently arranged with municipal health departments or provincial health departments by special negotiation. The indigenous peoples are strongly urged and frequently assisted financially to enlist themselves under provincial medical care insurance. All are now included under hospital insurance plans. The object of this policy is to attempt to ensure that whatever services are locally available to the general population are equally available to sick mariners, Indians and Eskimos regardless of their ability to pay.

Only where local facilities are lacking, unable or unwilling to co-operate, does the branch provide direct services. This now applies mainly in the remoter sparsely populated areas, particularly in the Arctic territories and in respect of certain specific functions such as the health advisory services for public servants. Under these circumstances, health centres, nursing stations, clinics and hospitals are constructed, staffed and directly administered. In the past more had to be provided than are now required and, as provincial health services have developed, it has become increasingly possible to phase out more and more federal institutions. This has sometimes been represented as a "reduction of services". Properly understood it has always been a replacement of obsolescent facilities by more efficient services. During 1968 negotiations were started to phase out or convert to other use three more now unnecessary Indian hospitals. One, the Lady Willingdon Hospital, was given to the local Indian Band to administer either as a home for the elderly or a nursing home as they finally decide themselves. Similar arrangements for the transfer of other federal hospitals to other administration is contemplated.

In 1968, Medical Services operated 14 hospitals, 30 clinics, 47 nursing stations, 93 health centres, 54 health stations (facilities not permanently staffed provided for visiting staff for clinical purposes) and 35 public service health units. While the trend in the South is to reduce, in the high Arctic the demand to improve services continues to increase and plans have been made to upgrade several health stations into permanently staffed nursing stations. Six new nursing stations were expected to be opened in the early summer of 1969.

Getting specialist services for residents of remote areas has always posed peculiar problems. Medical Services attempts to meet this need by arranging with specialists' associations for visiting services and some associations, notably the paediatrics and ophthalmologists have responded generously. Some provincial health departments have made the services of their peripatetic specialists available on a routine basis. More recently efforts have been made to interest university schools of medicine in the training and experience opportunities afforded by the federal work in the

remoter areas and they are increasingly availing themselves of them. The current state of affairs can be summarised as follows:

1. Dalhousie University

   In co-operation with the governments of Newfoundland and Canada, Dalhousie University has developed a School of Frontier Nursing. The purpose is to train graduate nurses to meet the special requirements of nursing in isolated and relatively primitive areas. This is a two year course, the first of which is intramural and the second an internship in the field.

2. Montreal University

   Senior members of the Department of Paediatrics visit remote Indian and Eskimo communities in Quebec to perform surveys, provide consultations, and in general promote the health of the young native population.

3. McGill University (Montreal Sick Children's Hospital)

   A rotating paediatric resident, and a medical resident become part of Frobisher Bay Hospital staff at the beginning of each month. Periodic consultant visits to Frobisher Bay are made by other resident specialists. The university is involved in research projects on health conditions in the North. A medical preceptorship program for students is underway.

4. Queen's University

   The Faculty of Paediatrics assigns a full-time assistant professor to Moose Factory Hospital. Faculty members from all branches make periodic visits to Moose Factory accompanied by residents, interns and students. The Department of Preventive Medicine has adopted the nearby Tyendinaga Indian Reserve, where it conducts the school and preschool health programs. One or two third-year medical students are usually engaged at Moose Factory for the summer months - selected and supervised by the university faculty. A medical preceptorship program for students is underway.

5. University of Western Ontario (Children's Memorial Hospital)

   The Department of Paediatrics has adopted the nearby Muncey Reserve by declaring it an extension of the outpatient department of the hospital. Paediatric residents make regular visits and hold clinics. Extension of the university's interests is contemplated in other branches of medicine, dentistry and nursing.

6. McMaster University

   The Department of Family Practice supplies residents to the Six Nations Reserve, Brantford.

7. University of Toronto (Sick Children's Hospital)

Has adopted the Sioux Lookout Hospital as an extension. A program is developing in paediatrics, the behavioural sciences, hospital administration and nursing. A medical preceptorship program for students is underway.

8. University of Manitoba

Negotiations in the past have resulted in consultant work in the Keewatin area.

9. University of Saskatchewan

Has done special projects and made sociological studies at Rankin Inlet.

10. University of Alberta

Negotiations continue on the feasibility of affiliating the Charles Camsell Hospital with the university as a teaching hospital. Consultants travel to Inuvik.

11. University of British Columbia.

The university is looking into the feasibility of taking over the responsibility for the provision of health services to certain northern unserviced portions of the Province of British Columbia. Indians are to be included. Negotiations are current with the Department of Ophthalmology.

Dental services have often been difficult to arrange more often because of a paucity of dentists than unwillingness to co-operate. The decentralization policy within Medical Services Branch has given regional directors greater responsibility as regards their budget and requires them to allocate their funds according to the need within each region and the available dollars. This decentralization has to some extent reduced the branch's demand for assistance from Dental Health Division. Medical Services is, however, indebted to Dental Health Division, for its continued provision of consultative services on dental matters and for other assistance such as the post-auditing of accounts for dental services authorized by Medical Services Branch and provided by private dental practitioners on a fee for service basis.

QUARANTINE SERVICE

The Quarantine Service is operated under the authority of the Quarantine Act and Quarantine Regulations and in accordance with the International Sanitary Regulations of the World Health Organization to which Canada subscribes without reservation since their entry into force in 1952. Its primary objective is to reduce to a minimum the hazard of entry into Canada through international traffic of the major quarantinable diseases and infectious disease in general.

INDIAN HEALTH

There exists no specific legal obligation to provide health services to Indians. However, the federal government has over the years felt morally obliged to do so. This would not necessarily involve providing services directly but would involve seeing to it that Indians did have ready access to health care services. On this basis, over the past forty years, funds have been voted by Parliament annually to assist Indians to get necessary care who lacked alternative resources and would otherwise have been deprived of it. Indians who could obtain care from their own resources have always been expected to do so and, indeed, some bands have always contributed towards hiring a physician's services for their own people from their own communal funds. Currently the Medical Services Branch spends over thirty million dollars annually on medical services to Indians in the provinces, that is for a population that barely numbers 230,000.

TABLE 13

INDIAN VITAL STATISTICS BY PROVINCES
1967

Province or Territory	Birth rate per 1000 pop.	Infant mortality per 1000 live births	Crude death rate per 1000 pop.	Vital Index	Natural Increase per cent of pop.	Indian pop. per cent provincial pop.
P.E.I.	27.1	*90.9	12.3	2.2	1.5	0.4
N.S.	30.3	+85.3	9.6	3.1	2.1	0.6
N.B.	32.6	15.4	6.3	5.2	2.6	0.6
Que.	30.0	29.9	6.5	4.7	2.4	0.4
Ont.	28.0	36.7	7.9	3.5	2.0	0.7
Eastern	28.9	36.4	7.5	3.8	2.1	0.6
Man.	46.3	53.5	8.4	5.5	3.8	3.4
Sask.	48.4	67.4	8.9	5.4	3.9	3.4
Alta.	45.3	48.4	7.4	6.1	3.8	1.8
Prairie	46.8	57.2	8.3	5.7	3.9	2.7
B.C.	33.6	75.0	10.7	3.2	2.3	2.3
Yukon	52.5	31.5	5.8	9.1	4.7	?
West Coast	34.5	71.7	10.4	3.3	2.4	
N.W.T.	37.6	45.5	5.8	6.5	3.2	?
Canada	37.3	53.6	8.4	4.5	2.9	1.1

* Only 1 death involved out of 11 born.
\+ Only 11 deaths involved out of 129 born.

Registered Indians comprise 19.2% of the combined population of the Yukon and N.W.T.

Note the marked differences between prairie Indians, West Coast Indians and Indians in Eastern Canada.

Indian vital rates in the eastern provinces do not greatly exceed provincial rates nor do Indians in those provinces pose any major problems in respect of their numbers in relation to the total population of the provinces. The situation in other provinces differs considerably.

The Indian health profile has been steadily improving.

Infant mortality is still more than twice the national rate and occurs mainly among prairie Indians and West Coast Indians.

The main causes of death among Indians continue to be accidents (automobile, drowning and fires chiefly), respiratory diseases among both adults and children and gastro-enteritis among children. Cardiovascular diseases and cancers continue to show only half the mortality rates shown in the population as a whole.

The registered Indian population is very "young" with a mean age of around 20 years, 57% of the population being under 20 years of age. The age span, however, extends well over 100 years and the expectation of life at birth for both sexes is only a little over ten years less than for any Canadian. The heaviest mortality is in the earlier years of life and any Indian who survives to be 35 years of age may expect to live as long as anyone else of the same age unless they happen to be Indian women living on the prairies or in British Columbia in particular among whom mortality continues to be abnormally excessive until age 60 years.

Much stress is laid on education and preventive medicine in working with Indians. Preventive immunisation in early childhood has apparently eradicated diphtheria and poliomyelitis among Indians and reduced the incidence of tuberculosis. In 1968 early immunisation against measles has been extensively increased, using attenuated live vaccine. Although influenza vaccines are recognised of doubtful value, because influenza can be a serious disease among northern Indians in particular, immunisation campaigns are carried out. The incidence of new cases of tuberculosis, which has been showing a disturbing upward trend in recent years among northern Indians, appears to have been brought under control.

In health education stress is laid on getting the Indians themselves to recognise the situation and decide the course of action to take. Indian liaison officers are now being appointed by the Indians to co-operate with Regional Office personnel in deciding action and the training of Indian Community Health Workers, also selected by the Indians, continues.

Nutrition Education

The Charles Camsell Hospital co-operates with the Northern Alberta Institute of Technology in Edmonton by giving the dietary aide students six months practical, supervised experience in their dietary department.

At Whitehorse a similar arrangement has been worked out between the departmental hospital and the local vocational school. The ward-aide trainees spend some weeks in the hospital and part of this time is spent in

the main kitchen and in preparation of therapeutic diets under the direction of the food service supervisor.

The regional nutritionists carry on a continuing service to the Indian Affairs Branch by their visits to the Indian residential schools. Reports on the food service at the schools and hostels are sent to the school principals and to I. A. B. officers concerned with the schools.

The nutritionists work closely with the public health nurses in presenting nutrition education talks and demonstrations on request.

In 1963 a version of "Good Food - Good Health" with some line-drawings was designed for the Eskimos. The booklet was out of print by 1968 and it was decided that a professional designer be asked to submit some suitable illustrations for a new edition. The new illustrations were so successful that, when information officers of the department showed this booklet, along with their other current publications, at the June 1968 meeting of the Canadian Public Relations Society it won two awards of excellence.

For some time there has been a need for a simple reliable recipe book to be used in helping the Indian homemaker to provide good meals for her family. The authors of "Recipes for You" considered the foods available and the equipment available in most homes in selection of recipes. The book is a joint effort by the Medical Services' nutritionist in Manitoba and Saskatchewan Zones and the staff of the Nutrition Division, Saskatchewan Department of Health. Some help was also provided by the Manitoba Department of Health.

NORTHERN HEALTH

Medical Services of the Department of National Health and Welfare function in respect of the two northern governments as the department of health until such time as either or both governments can establish such a department on a territorial basis. The services administered thus include all residents. Eskimos do not inhabit the Yukon but in the Northwest Territories they comprise about 36% of the population and Indians about 20%. These races thus influence northern vital statistics to a much greater extent than in the provinces. In addition it must be noted that, in the Northwest Territories in particular, about 70% of the population fall into the low income group. In all countries, when this socio-economic group is isolated from the rest of the population, even in affluent nations, they always show vital statistical rates double or triple that of the general population. Add to this the severity of environmental conditions, difficulties in communication and vast distances. In spite of all these very adverse factors, the general health profile presented is actually better than might well be expected.

Infant mortality rates tend to be rather high, for Eskimos between 8 to 9% of all live births, for Indians over 5% in 1968 and for others almost 3%. The crude death rate has consistently been below the national death rate in recent years but this neglects to take into account the age composition

of the population and the somewhat "self selecting" characteristics of the people who live in those regions who tend to be young and vigorous. Only the hardy are likely to survive or remain permanently. Birth rates tend to be high, particularly Eskimo birth rates. In 1968 the Eskimo birth rate was 53, the Indian, 42 and for "others" the rate was 32 per 1000 of estimated population. There have been no maternal deaths for two years, the last recorded being one Eskimo woman in 1966. Despite the 9% infant mortality rate, the Eskimo population is still increasing annually at over 4.5%, the highest rate of natural increase now being recorded anywhere. In 1968, 90.6% of all births took place in medical institutions under professional supervision. Illegitimate births are extremely common, particularly in the Yukon where it is more the rule than the exception. About one fifth of births in the Northwest Territories in 1968 were illegitimate. That these births all result from casual liaisons must not be inferred, however. The facts, indeed, seem to indicate that marriage rites are increasingly being regarded as of secondary importance but the informal unions being formed appear, in most cases, to be as stable as most legal marriages and the offspring have the benefits of a normal home and both parents.

An intriguing observation made in the Northwest Territories has been the steady reduction in the birth of male Eskimos. Each year in Canada for every 1000 females born some 1050 or more males are born and the ratio rarely varies to any significant degree from around this figure. The ratios in the Northwest Territories present an interesting contrast.

TABLE 14

MALE BIRTHS PER 1000 FEMALE BIRTHS IN NORTHWEST TERRITORIES

Year	Indians	Eskimos	Others
1965	1030	1270	1188
1966	1069	1004	1089
1967	1141	1011	1106
1968	1237	926	1033

While the ratio of males among Indian births appears to have been steadily rising, among Eskimo and "other" births it has been dropping and, in 1968, was strikingly low. As females generally survive the hazards of life better than males, if present trends continue the Eskimo population will show a marked excess of females and the Indians, possibly, an excess of males. An apparent deficit in the ratio of Eskimo males being born was noted prior to 1965 but the data were unreliable. The matter has been carefully observed since.

Some 46% of all deaths occured among children under five years of age, 56% of Eskimo deaths, 35% of Indian deaths and 30% of "other" deaths.

Accidental deaths are on the increase.

It is frequently argued that Indians and Eskimos require excessive terms of hospitalisation.

If Indians and Eskimos did use rather more than their fair share of patient days, the excessive use was trivial and not statistically significant. The majority of "others" who take up residence in the North are largely selected on the basis that their state of health is such that a minimum of hospital care can be expected. Indians and particularly Eskimos comprise the bulk of the really permanent residents.

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