ANNUAL REPORT

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

FOR THE FISCAL YEAR
ENDED MARCH 31, 1970

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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, 1970.

Respectfully submitted,

JOHN MUNRO

Minister of National Health and Welfare

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Honourable John Munro

Minister of National Health and Welfare

Sir:

We have the honour to submit the Annual Report for the Department of National Health and Welfare for the fiscal year 1969-70.

Respectfully submitted,

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

Joseph W. Willard,
Deputy Minister of National Welfare

MEDICAL SERVICES BRANCH

Much as the activities developed in the department for co-operation with other agencies have been grouped into the Health Services so those activities offering services primarily to persons as individuals have been grouped as a branch of the department designated Medical Services.

In 1969, Medical Services, as defined above, comprised;

(1) Quarantine control of persons crossing Canadian borders to ensure they did not introduce dangerous infectious diseases,

(2) Medical assessment of intending immigrants to Canada to gauge their physical and mental fitness for life in Canada,

(3) Insured medical care for seamen taken ill or injured on visiting foreign ships,

(4) Medical assessment of applicants for licences to operate or control private or commercial civil aircraft,

(5) Medical assessment of applicants for appointment to the public service at home or abroad or in government sponsored aid or development programmes,

(6) Counselling on health problems and emergency treatment services for public servants at home and abroad,

(7) Inspection of hygiene and sanitation on federal properties in the interest of the health, comfort and well-being of federal employees,

(8) Care and promotion of the health of the indigenous races,

(9) Care and promotion of the health of all residents in the arctic territories,

(10) Control of hygiene in common carriers, depots, ports and national parks in the interest of the health, comfort and well-being of the travelling public and vacationing visitors.

Again, as with the Health Services, all activities fall under the co-ordination and control of a Director General reporting to the Deputy Minister of National Health and assisted by a Deputy Director General and staff of advisers, each specialised in and representing one or more of the major services listed. Unlike Health Services, however, which can concentrate much of their major activities in Ottawa, the nature of Medical Services' activities demands decentralisation and regional administration. They serve persons spread over not only all Canada but the entire surface of the globe. Thus, where Health Services readily divide and subdivide organisationally along lines of specialised function, Medical Services divide and subdivide along geographical lines. The chief of a division in

the Health Services can become a highly specialised scientist, well versed in one particular field of knowledge but any director in Medical Services, even of the smaller field units, must have expertise in the administration of public services generally.

As not all Medical Services programmes have equal applicability in all regions, considerable administrative latitude must be allowed regional directors at the decentralised centres of control. The Regional Director of the new Overseas Region for example has a major concern for immigrants and an important role for Canadians serving overseas in various official capacities but none at all in regard to Indians, Eskimos, sick mariners or even quarantine control. On the other hand, the Regional Directors of the Atlantic, Pacific, Quebec and Ontario Regions have a major concern with quarantine control, sick seamen and everything else in differing emphasis. On the prairies, Indian health problems form the principal concern, other programmes tending to take lower priority while in the two northern territories, by special arrangement, Medical Services function as the territorial health department for each territorial government, implementing the full range of health services normally provided by a provincial health department.

Organisational changes in 1969-70 brought the new Overseas Region into being and some revision of head office duties. Medical control of immigrants overseas had been supervised from a regional office in London, Britain. This developed originally because most immigrants came from Europe but, of recent years, immigration from Asia, Africa and, especially the Caribbean has rapidly expanded. The whole policy of medical control came under review. Most Canadian medical officers posted overseas in Europe have now been withdrawn and medical inspection largely entrusted to local European physicians under the revised arrangements while general control can now best be exercised from Ottawa. The former Regional Office in London now functions as a Zone Office for a zone which includes a substantial part of Europe.

Another organisational adjustment saw the Public Service Health activities and Civil Aviation Medical Control activities separately represented at headquarters by two specialisng advisers. Rapid expansion of these activities has begun. They had been controlled and co-ordinated hitherto by the Director of the Ottawa Bureau, within which the major facilities had been concentrated, the original health services to public servants having been restricted to the concentration of civil servants found in Ottawa. Though now assuming a role more akin to that of a region, Ottawa Bureau still has a unique relation to these activities because of its special facilities, expertise and experience; an advisory role and final "court of appeal" in dubious or contentious cases. In that it manages all Medical Services activities within the National Capital area, including quarantine control at the airport, the Ottawa Bureau might well be renamed the National Capital Region except that it does obviously deviate from the more usual concept of a region in other respects and performs a unique function.

Other developments involved the closing of two more obsolete and redundant federal hospitals for Indians, reducing the number still in operation from 15 to 13. In one case the Indian community the hospital had served took over the building to operate it as a home for the aged and infirm while the future use of the other building remained under vigorous debate. Some legal technicalities complicate matters. Direct participation of Indians in discussing and deciding matters affecting their health or health services constituted another advance in 1969. Indian bands can now employ, with some financial assistance from the federal government, Indians as liaison officers to represent them in discussions with Medical Services personnel and participate in planning.

The number of nursing stations increased from 48 to 57 and health centres from 86 to 91 while several existing stations were enlarged and their staffs augmented to improve services. Some health units for public servants outside of Ottawa also had additional staff posted and four new units opened, increasing the number of units outside of the National Capital region from 17 to 21. While deliberately contracting the scope of services given directly to Indians in the south and, instead, hiring or otherwise arranging to substitute other equivalent locally available services, Medical Services plan major developments in the services they administer in the northern parts of the provinces and far north where other health services if they exist at all remain minimal. Provision of new facilities, staff and services planned for systematic development to improve delivery of services in the north, mid-north and for public servants outside of Ottawa has already received parliamentary approval in principle and an adequate allocation of funds for immediate needs.

TABLE 6

ANALYSIS OF EXPENDITURES OF MEDICAL SERVICES BRANCH

FISCAL YEARS 1965/66, 1966/67, 1967/68, 1968/69, 1969/70

(000's)

	1965/66	1966/67	1967/68	1968/69	1969/70	% Increase (Decrease) 1969/70 vs 1965/66
Administration	1,907	2,604	2,743	2,719	2,994	57.0
Civil Aviation Medical Assessment	153	140	133	157	181	18.3
Public Service Health	638	697	793	863	1,276	100.0
Indian Health Service	21,469	22,802	25,219	27,682	29,353	32.0
Northern Health Service	9,678	8,173	9,012	8,541	11,059	14.2
Immigration Medical	1,834	2,032	2,742	2,195	2,281	24.3
Quarantine Services	488	654	688	757	765	56.7
Sick Mariners Service	1,274	1,349	1,472	1,175	1,195	(6.2)
Public Health Sanitation Service *	65	46	-	-	-	-
TOTAL	37,506	38,497	42,802	44,089	49,104	37.0

* Northern Health Service and Public Health Sanitation Service were included in Indian Health Service During 1965/66. During 1967/68 Public Health Sanitation Service was dropped as a separate activity and split into Indian Health Service (65%), Public Service Health (20%) and Quarantine Service (15%).

The above figures list the actual expenditures by Medical Services Branch during the last five fiscal years. The Government fiscal year ends March 31.

During the five year period in the table expenditures have increased by $11,598,000 or 37% above the 1965/66 fiscal year level.

Indian Health which accounted for an expenditure of $29,353,000 during 1969/70 is the major activity representing 67.2% of the Medical Services Branch total during 1969/70.

Northern Health, a growing activity, represents 29.0% of Medical Services Branch expenditures during 1969/70.

INDIAN HEALTH

The highlight in 1969 in relation to health services for Indians was the hiring of a firm of consultants to make a special study of the delivery of health care services in the northern parts of the provinces. These areas still remain largely undeveloped and difficult to access. The sparse population and inadequate facilities for rapid communication and transport pose peculiar problems for anyone attempting to deliver health services.

The recommendations submitted by the consultants with a view to improving the existing services included:

- building additional nursing Stations, a form of health unit they considered especially appropriate.

- increasing the numbers of nursing and other paramedical personnel employed.

- increasing the number of visits made by peripatetic professional and consultant specialist personnel.

- improving the technical capabilities of the systems of communication between base hospitals and satellite field health units.

- involving Indians more deeply and directly in planning and administering services designed to serve their needs.

Extensive progress has been made already towards implementing most of these recommendations in 1970. In the southern areas where provincial health services have been well developed, activities of both federal and provincial services have been closely co-ordinated. Representatives of both services meet regularly to eliminate duplication of effort and, even more important, any hiatus. Health facilities available to non-Indians now serve Indians on an equal basis. Further phasing out of obsolete federal facilities has become possible as provincial facilities assume the work load. Coqualeetza Indian Hospital closed towards the end of 1969 in this way. The department continues to facilitate provision of provincial services by financing the Indian share of the expenses.

In the more northerly areas new health stations were developed at Kasatchewan, Gull Bay, Winneway, Deschambault and One Arrow, nursing stations at Round Lake and Osnaburgh. Several additional new centres have been planned for 1970 and major improvements in many existing facilities, including increasing the resident staff in several cases. Training courses for community health workers have been further developed and the possibilities of appointing Indians as liaison officers between their own people and federal services extensively explored. One such official started work. Meetings were held with Indian leaders to discuss plans for developing closer working co-operation with Indians.

Despite popular misconception of the situation and vigorous assertions to the contrary, neither the federal nor any other government has any formal obligation to provide Indians or anyone else with free medical services. All governments, however, have a moral obligation to care for those within their jurisdiction who cannot care for themselves. On this basis, the federal government spent $29.4 million on supplying health care services to Indians in 1969. For 1970-71, to improve services as planned, the funds requested amount to $35 million.

Medical problems among Indians do not differ significantly from medical problems elsewhere save that infectious diseases associated with defective domestic hygiene and inferior nutrition tend to be rather more prevalent. Certain congenital defects have attracted attention and are under research. Invasive amoebiasis has become a problem in Saskatchewan and also the subject of much intensive research. Accidents remain the leading cause of death except on the east coast and in Quebec where heart disease has recently taken first place. In this and in most other respects, Indians in the Atlantic provinces and Quebec reflect almost the same health picture presented by all residents of the province. Indians in other provinces present some interesting differences from both their provincial neighbours and Indians in the eastern provinces. In 1969, neonatal and infant mortality rates fell in all regions, suggesting a general improvement in the standard of living.

The average age at death for Indian males has risen from 34 in 1964 to 40 and, for Indian females, from 37 to 41. The expectation of life for an Indian male at birth has increased to over 60 years and for females to over 66 years. During the same period, the average age at death for Canadians as a whole rose from 61 to 62 years for males and from 64 to 66 for females while no significant increase in expectation of life has, as yet, been estimated. Expectation of life for Indians appears to fall short of the expectation of Canadians as a whole by some eight years. The gap used to exceed ten years and has significantly closed during the past decade. Improvement has resulted from a dramatic drop in infant mortality from a rate of 64 per 1000 live births in 1964 to 49 in 1968. This rate, however, still more than doubles the national rate.

The number of persons legally registered as "Indian" continues to increase annually at a rate of 3% per annum contrasting sharply with the comparable rate of increase for the Canadian population as a whole of just over 1% per annum. In all provinces except British Columbia Indians comprise an ever increasing percentage of the total provincial population, particularly in the prairie provinces where the rate of Indian population growth exceeds 4% per annum. Registered Indians now comprise 1.12% of all Canadians and have slowly but steadily been increasing their relative representation indicating that the rate of Indian natural increase somewhat exceeds the rate of growth of the Canadian population as a whole by both natural increase and immigration combined. Although both the national and Indian birth rates appear to be dropping at about the same rate of decline, Indian women still show more than double the fertility rate shown by Canadian women as a whole. That, out of every 1000

Canadians, 11 are Indian, has interest but that out of every 1000 Canadians under ten years of age, not 11 but 17 are Indians and, out of every 1000 Canadians over seventy years of age, only 6, has even greater significance.

Of recent years Indians have increasingly tended to migrate from the reserves to the cities. More than one fifth of all registered Indians now live off the reserves, in Ontario about one third.

NORTHERN HEALTH

Federal Medical Services function in a dual capacity in the two northern territories. By mutual understanding with the two territorial governments, in addition to their role as a federal agency, they fill the roles of territorial health departments. The respective co-operating governments share the costs. Both territorial governments have introduced comprehensive hospital insurance schemes and planned comprehensive medical care insurance for early implementations. The Yukon Government has moved towards asserting more direct control over health matters but still cannot achieve financial independence.

Implementation of the five years plans for developing health services in the Yukon and Northwest Territories advanced on schedule in 1969. All posts for medical officers were filled, coverage in the Keewatin improved by stationing a second doctor at Churchill and a psychiatrist posted to the Yukon improved mental health care in that territory. Improved financial compensation for hardship posts helped improve staffing problems. In addition agreements were signed with two universities to provide comprehensive consultant and treatment services at Inuvik and along the western arctic coast (University of Albert) and in Baffin (McGill University).

During the year, hospital requirements came under review by a team from the Hospital Insurance and Diagnostic Services Division. These psychiatrists and a psychologist surveyed the mental health situation and the Yukon school dental hygiene pilot project made noteworthy improvement in the dental conditions of Yukon children. Construction began on four new nursing stations all expected to be completed by April 1970. Other stations were enlarged and improved and additional nursing personnel posted.

Accidents, pneumonia and diseases of early infancy remain the chief causes of death. By comparison, deaths attributed to other causes appear almost insignificant. Tuberculosis however, though under control again, still remains a source of worry while abuse of alcohol and venereal disease continue to require increasing attention. Botulism made a reappearance in 1969, taking three lives but six other victims recovered after treatment with trivalent antitoxin.

Plans for 1970 envision special financial and study leave arrangements to encourage professional health personnel to consider northern service, expanding the training of indigenous residents so that they may assume increasing responsibilities in health promotion services, further expansion of nursing stations and nursing services, improved staff orientation programs and improved communications, even air strips.