Annual Report 1979-1980

1.) CANADA
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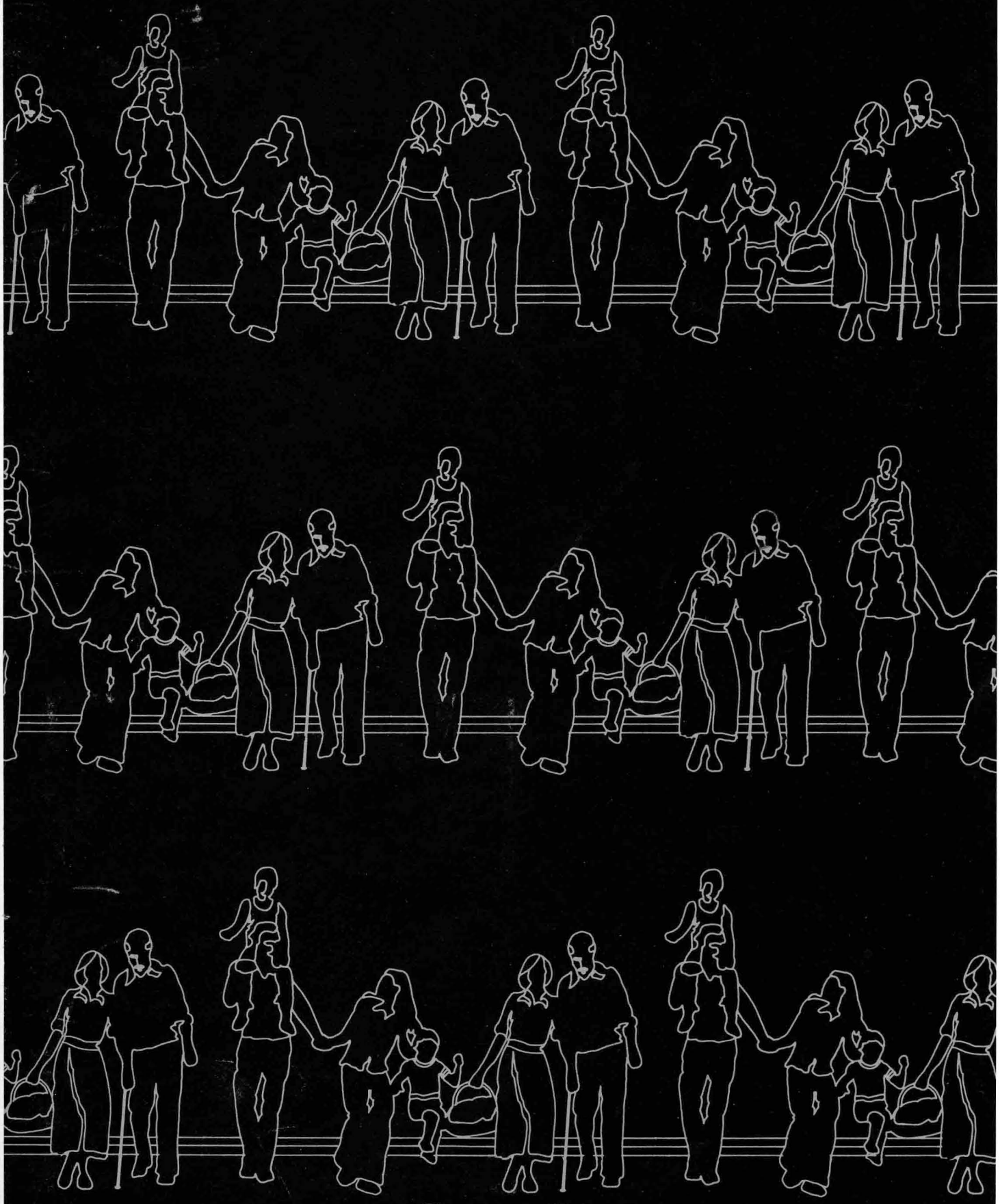
Health and Welfare Canada

Santé et Bien-être social Canada



Canada

Annual Report 1979-1980

His Excellency the Right Honourable Edward Schreyer,
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 ending March 31, 1980.

Respectfully submitted,

Monique Bégin
Minister of National Health and Welfare

Cat. No. H 1-3/1980
ISBN 0-662-50974-9

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Medical Services Branch

By legislation or custom, Medical Services Branch provides a variety of health services to a number of client groups. These clients include registered Indians and Inuit, all residents of the Yukon and Northwest Territories, immigrants and temporary residents, international travellers, federal public servants, civil aviation personnel, the physically handicapped and disaster victims. The programs under which services are provided to these clients are Indian Health Services, Northern Health Services, Immigration Medicine, Quarantine and Regulatory, Public Service Health, Civil Aviation Medicine, Prosthetic Services and Emergency Services.

The objectives of Medical Services are to promote, preserve, and improve the health of those whom it serves. Meeting such comprehensive objectives requires expertise in virtually every area of health care – community health, medical testing and screening, laboratory analysis, aero-space medicine, health education and others.

Indian and Northern Health

Native Involvement

Although closer native involvement in all aspects of planning and delivering health services has been a Medical Services Branch priority for many years, the events of 1979 gave increased emphasis to this thrust area. The new Indian Health Policy, announced in September, clearly stated that only Indian communities themselves, with the support of the federal government and the larger Canadian community, can change the root causes of their poor health status. The Policy states that an increased level of health must be generated and maintained by Indian communities themselves. When announcing this new policy, the government also announced that it was making money available for increased consultation between Indian people and Medical Services Branch at all levels.

In 1979 Medical Services Branch also presented its Indian Health Discussion Paper – a draft document exploring new frameworks that will give Indian Health policy and programs the flexibility to evolve that will meet changing requirements. This document strongly endorses native involvement and the broader government policy of self-determination for Indian and Inuit people.

The above events deal with broad policy issues that have given added impetus to the ongoing implementation of native involvement. Medical Services Branch also continued to support and encourage native participation at the community level. Health committees grew in number and scope. In many parts of the country, the Community Health Representative program became increasingly controlled and operated by Indian people; for example, Indian Bands themselves employ a large percentage of their Community Health Representatives, and Indian colleges, where possible, are taking on responsibility for training of these health workers. Tribal Councils and other groupings of Indian people have begun negotiations with the Department to assume responsibility for a range of health services, including the administration of hospitals, patient referral services, transportation services, nursing services, and dental services. In some parts of the country, Indian Bands have been responsible for some of these services for several years, and they are now in the process of assuming responsibility for more services as they feel ready.

Transfer of Health Services

Representatives of the Government of Canada and the Yukon have agreed that no further discussions will take place on the subject of transferring the health services organization to the territory until such time as the land claims negotiations have been concluded with Yukon Indians.

With respect to a possible transfer to the health administration in the Northwest Territories, no action will be taken by Canada until positive indications are received from the enlarged N.W.T. Council that they wish to proceed with negotiations.

Negotiations with the Alberta Government and native associations to transfer the Charles Camsell Hospital to provincial jurisdiction have been conducted over several years and are continuing. This 400-bed hospital was originally built to care for large numbers of Indians and Inuit who were ill with tuberculosis. However, new methods of tuberculosis control, such as drug therapy, have made the hospital unnecessary for that purpose. It has, instead, become a conventional acute care hospital and no longer has native health as its primary orientation.

National Native Alcohol Abuse Program

In recognition of the extensive health and social problems created by alcohol abuse among Native people, the National Native Alcohol Abuse Program was established jointly in 1975 by the Department of National Health and Welfare and the Department of Indian and Northern Affairs. The primary thrusts of the program are to involve native people in combatting alcohol abuse and to encourage the development by Native people of a variety of approaches to the problem. During the year there were approximately 120 alcohol abuse projects funded by the program, employing more than 300 Indian and Inuit people in all provinces and territories. Projects were developed and operated by Native people and involved a variety of activities, such as counselling and referrals, detoxification, rehabilitation, alcohol abuse awareness education, curriculum development and training of alcohol workers.

As it is estimated that more than one-third of all Indian and Inuit deaths from accidents and violence were associated with alcohol abuse, the National Native Alcohol Abuse Program is considered one of the Branch's high priority programs. In order to meet requirements for continued funding, in 1979 an operational evaluation and review of the program's organizational structure was undertaken. Recommendations were submitted to the two sponsoring departments, and plans for further evaluations are being developed to strengthen and enrich what is considered to be a very worthwhile endeavour.

Environmental Contaminants

Environmental contamination has become a major concern of society, but it is often not recognized that Indian and Inuit people when living some distance from urban communities may be more exposed to the health hazards of environmental contaminants than the average Canadian, as their traditional way of life is closely related to the natural environment. The aim of the Environmental Contaminants Program is to identify, assess and prevent adverse effects of environmental contaminants on the health of Indian and Inuit people.

During 1979-80, the across-Canada survey for mercury levels in Indian and northern people continued, as did the survey program for PCB levels in Indian residents of the southern part of Ontario. Work was also carried out in relationship to health dangers posed by hydrogen sulphide, radiation and fluoride. Steps were taken to expedite a study on multiple contaminants on the health of residents of St. Regis Reserve, Ontario. A detailed study of effects of methylmercury and the sources of methylmercury in the Inuit of northern Quebec, particularly in the community of Sugluk, was begun and developed, and the final phases of the epidemiology survey on the effects of mercury on the health of northern Quebec Cree were completed. The latter study was carried out by McGill University, with funding from the Department of National Health and Welfare, Ministère des Affaires sociales du Québec and the Donner Canadian Foundation. A report "Methylmercury in Canada: Exposure of Indian and Inuit Residents to Methylmercury in the Canadian Environment" was prepared and released. This document reviews the mercury program findings to December 31, 1978, assesses the present and future policy and program approaches, and makes recommendations for future research. It is hoped that this report, together with the Epidemiology Study Report, will allow a balanced assessment of the health hazards due to environmental mercury in the unique exposure pattern seen in the Canadian native people.

Infant Health

Infant mortality rates remain twice that of the overall Canadian experience, and the rate of decline has been relatively slow, particularly for Indian infants, over the past five years. At present, rates of death from congenital malformations, sudden unexpected deaths in infancy, respiratory infections and disorders of prematurity and low birthweight remain considerably higher than national figures. Underlying causes are multi-factorial and interrelated. Poverty, inadequate housing, high rates of social disruption, teenage pregnancies and alcohol abuse by parents have a compounding, detrimental impact on care of the infant at home. The well-recognized relationship between these factors and infant mortality, particularly in the post-neonatal period, indicates that improvement in environment and lifestyle are crucial before infant health in Indian and Inuit children can be expected to approach Canadian expectations.

However, in the areas of newborn problems and respiratory and digestive tract disorders, there has been a reduction in the rates of death. As well, communicable diseases such as measles, diptheria, whooping cough, and poliomyelitis occur less frequently than in the past. These improvements in infant health can be related to the work of Community Health Nurses and Community Health Representatives, who carry out programs which emphasize antenatal care, infant feeding practices, immunization and home visiting. High risk maternal and pediatric registers also have been established in many field units, enabling health personnel to give more effective care and follow-up. Education and counselling appear to be playing a significant role in reducing some of the health problems experienced by this age group.

Tuberculosis
Despite a dramatic lowering of tuberculosis rates among Indian and Inuit populations over the past two decades, the frequency of this infection is 10 times higher in native Canadians than for the rest of the population. Most cases occur sporadically, although outbreaks in communities are still being seen on occasion, most recently in northwestern Canada.

The emphasis of the tuberculosis program has shifted from routine mass surveys to contact tracing and surveying of high incidence areas. As well, health workers have introduced educational programs to create an awareness of the dangers of tuberculosis, especially among young people, who have never experienced tuberculosis epidemics and tend to be somewhat complacent. In particular, emphasis is placed on preventive measures that can be taken by the client population, such as the observance of basic sanitary precautions.

Dental Health Services
The Department operates a dental health care program on behalf of the registered Indian and Inuit populations in Canada. It arranges for private dentists to provide services on a contract or fee-for-service basis in private dental offices or in field dental clinics, and it provides dental services directly through its own dentists, who are generally employed in northern areas where private practitioners are not available. As well, the Department employs dental therapists as dental auxiliary personnel to provide emergency and basic dental treatment services in isolated areas. Under the supervision of a dentist, the therapists also provide an extensive preventive dental program and conduct dental health education programs in reserve schools.

The concept of the dental therapist is a new approach to the delivery of dental health care services in Canada. It was developed to meet the need for dental services among the Indian and Inuit population in isolated areas. Dental therapists are educated at the School of Dental Therapy in Fort Smith, N.W.T., a joint operation by the Department and the Faculty of Dentistry, University of Toronto.

In addition to the dental therapists, there are other types of dental auxiliaries, some with lesser training and qualifications than dental therapists, now employed by the Department. These include dental hygienists, assistants and receptionists, who provide assistance to the dentist in a variety of ways.

This past year approximately 1000 private practising dentists provided services at a cost of $5 491 000. The Department itself employed 17 full-time dentists and 38 dental therapists. An additional 12 dental therapists will graduate from the School in Fort Smith in the coming year.

Health Education
The goal of health education in Medical Services Branch is to provide and support the education and promotion components of Branch health activities, with particular emphasis on the needs of the Native community.

All members of the health team have a responsibility to carry out health education as part of their activities and programs. One of the main purposes of the health education program is to provide active support and encouragement to health care staff in their efforts to provide a better balance between preventive medicine on one hand and crisis intervention and treatment on the other.

Professional health educators have the responsibility to determine community needs and problems and develop activities to deal with these, to coordinate the development and management of the Community Health Representative program, to coordinate the development of health education and information materials, and to provide other members of the health team with the knowledge and skills to carry out effective community education programs.

The main thrust of health education this year was at the community level to support the efforts of Native Community Health Representatives by providing audio-visual aids, arranging for training and refresher courses and giving overall guidance in running the program. Health educators were also very involved in planning and supporting Youth Job Corps projects undertaken by native youth across the country. In many areas of the country, health educators were also involved in developing cross-cultural orientation programs for use by departmental personnel.

Public Service Health

The year 1979 was a difficult one for the Public Service Health activity, as economies announced during the previous year came into effect, resulting in a loss of 20 per cent of manpower. There was an inevitable reduction in the level of service provided, but care was taken to ensure that service was maintained for those employees whose occupations exposed them to the more serious hazards to health. These same restrictions, however, prevented any new initiatives in the occupational health field. The Employee Assistance Program, established by Treasury Board in 1977, continued but was unable to grow significantly due to financial restraints.