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Health Statistics

Statistics are an essential tool in all phases of research in the health sciences, medical and dental research as well as operations research. We single out health statistics for separate discussion for several reasons:

(1) the relative neglect of the field of health statistics in recent years in Canada,

(2) the resultant scarcity of data which time and again hampered our own investigations and the lack of organization and co-ordination of existing statistics,

(3) the need for statistical information in the future to evaluate health progress and the effectiveness of the recommended Health Services Programmes.

EXISTING SITUATION

The sources of health statistics in Canada are as numerous and varied as the agencies engaged in the provision and administration of health services and in health research. Statistics are found in scientific papers and reports on special studies, but most of the data are obtained as a by-product of programmes administered by public or private agencies. Thus, there are statistics from prepayment plans, voluntary organizations, municipal and provincial health departments, and hospital insurance agencies. Welfare programmes associated with health problems, such as the allowances for the disabled and the blind, also yield health statistics as do the registration of births, marriages, and deaths which serve as the source of vital statistics. Physicians, public health and industrial nurses also collect records which means that practitioners, hospitals, clinics, schools, industrial establishments, medical and hospital insurance programmes and government health departments all possess statistics relating to health in one aspect or another.

Despite the volume of health statistics collected we have found serious shortcomings. There are gaps. On the other hand there is a duplica-

tion of effort in such fields as hospital statistics (including statistics on hospital morbidity) and the reporting of notifiable diseases. Moreover, there is evidence that the analysis of health statistics, from the point of view of assessing the needs of the community and the success with which health services and programmes meet these needs, has lagged substantially behind the collection of data.

The lack of adequate statistics is evident in all major areas of the health field, i.e., the identification and measurement of health problems, the assessment of the supply of health personnel and facilities as well as their activities, and the study of health economics. If we note many shortcomings in this area, it should not be allowed to obscure the fact that many organizations do first-rate work in some of these areas. Some provinces contributed greatly to our knowledge of the problems that faced us through the use of their statistics which were timely and accurate.[1] The same can be said about some of the medical prepayment plans[2] and the Department of National Health and Welfare and the Dominion Bureau of Statistics.

But as we were concerned with the health problems of the Canadian people as a whole, our main need was for national statistics and for data showing significant variations among provinces and regions. These were difficult and sometimes impossible to obtain. In addition it was not possible, in many cases, to obtain data that would permit an evaluation of the effects of health programmes in any meaningful way.

In Volume I of our Report we noted the delays in the publication of some statistical series.[3] This was largely an administrative problem but one which limited the usefulness of the data. We cited the example of our national hospital statistics where some series were three or four years old by the time they were published.

The Canadian Sickness Survey 1950-51 is another example of administrative inadequacy limiting the benefits of a major project. This was the one—and it also has remained the only—attempt in Canada to conduct a comprehensive statistical evaluation of the country's health status. The collection of data was completed in 1951, the departments concerned required 11 years to complete a final report, and even then much of the material collected remained unused because resources were not available to process

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[1] For example in Volume I data from the Manitoba Cancer Treatment and Research Foundation were used to illustrate the relationship between incidence and mortality from cancer; the Department of Health Services and Hospital Insurance of British Columbia provided data on the causes of disabilities of adults and the incidence of carious permanent teeth per child in that province; and the Saskatchewan Hospital Services Plan yielded data on the rate of hospitalization from various diseases.

[2] The Commission appreciates greatly the co-operation received from Physicians' Services Incorporated, Manitoba Medical Services, and Medical Services Incorporated in making available their records.

[3] *See* Volume I, Chapter 8, p. 329.

it. Nor were the methods used in the survey adequately evaluated. Although this was an undertaking of nation-wide importance and of great interest to other countries, an insufficient effort was made to provide the necessary resources of personnel and mechanical equipment to derive the greatest possible return from the original investment in the ten provincial surveys that made up the project.

There are other instances of surveys where extensive data were collected but never processed nor results published.[1] Some current series have been discontinued rather than improved. For example, statistics of home nursing which could have been adapted to a comprehensive study of home care services were discontinued at a time when this Commission, and probably other organizations, were badly in need of data for the evaluation of home care services.

Similarly, the Dominion Bureau of Statistics discontinued a statistical series on illness in the Civil Service.[2] While this study was subject to certain limitations[3]—some of which could probably have been removed—it was the only study of general illness for a group of some 140,000 people. The experience of this group is of considerable importance in developing policies particularly in industrial health, i.e., the health of the working population. It offered a unique opportunity to study differences in morbidity among various groups of people such as age groups, the sexes, people doing different types of work (physically active, sedentary, monotonous, etc.). Since there are major groups of federal civil servants in all regions of Canada, regional differences also could be studied (e.g., the course of epidemics). Nevertheless, the series was discontinued because the motivation, or the resources to improve it, or both, were lacking. If this is the policy of an agency whose statutory obligation it is to produce adequate health statistics, one cannot blame hospital insurance and medical care programmes and other insurance agencies generally for using available records only for analysis directly related to their day-to-day operations.

We have already referred to mortality statistics, based on the medical certificates of death, as the most reliable single indicator of health conditions and particularly of historical trends.[4] Nevertheless, these statistics require more appropriate analysis to provide an adequate assessment of health problems. They must take into account that among older persons and those with chronic disease, there may be more than one condition contributing to

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[1] For instance, a survey of maternity cases in Manitoba, the East York Health Survey (a pilot study for the Canadian Sickness Survey), and a height and weight study of Toronto school children.

[2] Discontinued with the issue of the 1962 report.

[3] It covers a selected population and is limited to certified sick leave (i.e., generally of over three days' duration).

[4] *See* Volume I, Chapter 5, p. 141.

the death, and not one "underlying cause" which is sometimes selected by rather arbitrary criteria. Mental health statistics, despite some improvements, continue to be inadequate to provide "sufficient reliable information for research, evaluation or planning".[1] Tuberculosis statistics could benefit from the addition of prevalence data since mortality, admissions to institutions, and even the incidence of new cases no longer tell the whole story adequately. Finally, historical manpower statistics were so limited in their value that major policy questions relating to the expansion of medical, dental, nursing and other health education facilities could only be resolved after the Commission itself had arranged for extensive studies in this area.

There has been an improvement in certain statistical series in recent years. The quality of hospital statistics has been enhanced since the implementation of the hospital insurance programme, largely due to the activities of the Advisory Committee on Hospital Insurance and Diagnostic Services as well as through experimentation by the Dominion Bureau of Statistics with computer calculated hospital indicators. Some national or near national hospital morbidity data have been released but here there is still a considerable lack of co-ordination and comparability between different sets of data. Despite the general concern over the growing cost of hospitalization and possible control measures, we have no adequate information indicating whether there is over-use or perhaps under-use of hospital facilities. Only very limited statistics are available on such newly emerging but increasingly important patterns of health care as medical group practice, home care programmes or rehabilitation services.

The statistical needs in the health field have not always received the low priority that they appear to have received over the past decade. When the development of modern public health services called for the guidance of statistical information on the incidence of certain diseases, the logical steps were taken: a list of the diseases in question was drawn up and through an agreement among provincial and federal health departments, and with the co-operation of the medical profession, a reporting system instituted. The list of these diseases was revised on several occasions to keep pace with changing needs. When venereal diseases began to present a major health problem during and after World War II, a special reporting system was set up to aid in the treatment, follow-up, and case-finding as well as in the statistical study of trends. No corresponding effort has as yet been made to cope in a similar way with the newly emerging health problems such as chronic disease, including mental disorders, accidents, physical and mental handicaps both congenital and acquired, dental disorders, and others. Much is said of the need for increased emphasis on positive health, fitness, and the

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[1] Richman, A., *Psychiatric Care in Canada: Extent and Results,* a study prepared for the Royal Commission on Health Services, Chapter 2, Ottawa: Queen's Printer (*in press*).

prevention of illness but little effort has been made to define and quantify the positive state of health rather than the negative state manifested by illness.

Some, if not all, of the existing statistical projects and series are inadequate because there is no effective machinery for their evaluation. The records collected by various professional personnel and health agencies have not been fully used for the study of health problems in the community. Data have not always been obtained with a view to making effective use of modern recording and data-processing equipment. Partly, this has been the consequence of the federal structure of Canada which leads to programmes and private and government organizations being organized on provincial lines. Partly it has been the consequence of what can only be described as a jurisdictional dispute between the two federal agencies responsible for health statistics, the Department of National Health and Welfare and the Dominion Bureau of Statistics, a situation which was noted by the Royal Commission on Government Organization.[1] This situation, which is discussed in detail later in this chapter, appears to have prevented the Federal Government from doing all that it could do in this area.

IMPROVEMENT OF HEALTH STATISTICS

If the system of health statistics is to meet the needs of Canadians it must be improved. Deficiencies must be made good, overlapping must be reduced as far as possible, statistics that are collected must be analysed, the results published promptly, and obsolete statistical series abandoned.[2] Such a development can only come about through a thorough reappraisal of what is presently being done and the establishment of some body charged with the responsibility of ensuring that improvement takes place in the future. We, therefore, examine two specific areas in the future system of health statistics: first, the types of statistics that need to be collected and the analysis they require and second, the organizational structure required.

Future Statistical Requirements

Basic to the design of a system of health statistics as well as to its component parts must be the recognition that health problems have become

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[1] *The Royal Commission on Government Organization,* Volume 3, Chapter 3, Ottawa: Queen's Printer, 1963, pp. 48-51.

[2] Before discarding statistical projects which in their present form are no longer useful, an investigation should be made to see if they could not be improved, thus making use of established procedures for recording and data collection. To establish new recording or reporting procedures is often very difficult and time consuming especially where various jurisdictions are involved.

much more complex than they were in the days when most of the existing statistical series originated. When the acute and sometimes epidemic communicable diseases constituted the main health problems, statistics on the number of cases and their distribution supplied much of the data needed for the study and control of these diseases. It is different with many of the major health hazards of today. Chronic diseases are subtle and insidious in their onset, of long duration, and often uncertain as to their outcome.

The new environmental hazards that man himself creates are also complex and largely unknown in regard to their effects on health. Radiation, air pollution, carcinogenic substances usually require a long time, sometimes generations before their ill effects become manifest. While we arbitrarily assume that old age starts at age 60 or 65, this is a gross over-simplification which tends to obscure the fact that many chronic conditions characteristic of an older age group may have their onset many years before old age, as defined above, sets in. To study the etiology and epidemiology of these diseases and of the environmental factors, we need not only counts of cases but also longitudinal studies.

Case registers should be studied in this connection with a view to their wider application. Such registers are already in use for the case-finding, treatment, and follow-up in tuberculosis, cancer, mental disease, and physical or mental handicaps. The consolidation of existing registers and their expansion will not only aid in the treatment of these conditions but also provide useful statistical data on the incidence, prevalence, and the course of the disease covered.

Another area in which data are limited and where new work could usefully be initiated is at the individual and family level in order to determine not only unmet health needs but the extent to which individuals and families receive various services. The latter can only be measured adequately at the point where such services are actually received. Here, household interview surveys can provide such data as well as the social, demographic and economic characteristics of the individuals involved. In the United States this type of survey is carried out on a continuing basis but nothing has been done in Canada since the Sickness Survey of 1951.

With the development of universal Health Services Programmes such a large-scale programme may not be needed although small-scale programmes will continue to serve specific purposes. With the removal of financial barriers to health services, the records of the various programmes would come much closer to reflecting the health problems of the general population than has been the case when services were available only to selected groups of the population. From the records of physicians' services, as well as hospitals, morbidity data will become available reflecting general morbidity much more completely than hospital records alone now provide. Besides, these data will be based on a medical diagnosis instead of relying

on the individual's diagnosis as in the case of household surveys. Modern means of data processing can greatly facilitate such analysis, if the source records are appropriately designed.[1] The use of social security or birth registration numbers can enhance the possibility of linking health records with those of other social insurance programmes and the Census.

Although an alternative for mass surveys such as the Canadian Sickness Survey or the United States Health Interview Survey would exist within Health Services Programmes, sample surveys of households, families, or individuals would certainly not altogether disappear from health statistical programmes of the future because for certain items of information—such as attitudes, social characteristics, etc.—they will remain the only source. Sampling will no doubt be used more extensively in routine statistical analysis but particularly in an increasing number of individual studies.

Sampling procedures provide the means of efficiently dealing with a great mass of existing data such as will result from the operation of the Health Services Programmes. They also form the basis for the scientific selection of samples from a large universe from which representative data on certain subject matters may be obtained. The universe may consist of individuals or families whose habits or characteristics should be obtained. We know little, for instance, of such health-related matters as the nutrition status of Canadians, their smoking and drinking habits, their recreational activities related to both physical and mental health, their symptomatic and asymptomatic health defects which do not come to the attention of a physician, to mention but a few. Existing sample designs, such as that used in the Labour Force Survey, may be used to advantage as a basis for the selection of other population samples.

Sampling techniques are already employed in the observation of certain aspects of the environment, such as in studies of radiation and of air- or water-pollution. A host of statistics on other environmental factors will gradually be collected by sampling techniques.

In deciding what data to collect in the health field, whether they are existing or new series, the purpose they are designed to serve must be borne in mind as well as their place in an integrated framework. The purpose may be medical or dental research; it may involve the evaluation of the health status of the Canadian people and the identification of health problems and their trends; or it may concern the administration, planning and evaluation of health services. Moreover, to the extent that it is possible, data collected for one

[1] Reference is made to the work being done in Canada by H. B. Newcombe in collaboration with the Biology Branch of Atomic Energy of Canada, Ltd.; the Vital Statistics Section, Dominion Bureau of Statistics; and the Division of Vital Statistics, Department of Health Services and Hospital Insurance, British Columbia.

purpose should be in a form that makes them useful for other purposes. For example, statistics of hospital patient-days are necessary for the administration of a particular hospital. They should also be in a form to permit the evaluation of the effectiveness of hospital care.

It is for this reason that statistics must be collected within a system that permits comparison between institutions, regions and even countries; they must be collected on the basis of commonly accepted principles of terminology, concepts and classifications. To compare hospital A with hospital B, their statistics must be based on comparable records and methods. To compare patients treated in hospitals with those treated for the same condition outside the hospital, a common classification of diseases must be used, as well as common classifications regarding the social and demographic characteristics of patients.

Similarly, if health problems are to be identified, statistics must permit comparability over space and time. A disease becomes a problem if mortality or incidence are higher now than they were in some period in the past, if they are higher among one age group than another, higher in one part of a country than in another, or higher than the mortality or incidence of other diseases. Of equal importance is comparability of Canadian statistics with those of other countries: differences in the incidence of diseases in different countries can provide valuable information for the study of the epidemiology and etiology of diseases; they illustrate the position of our country in relation to others; and data from other countries can be used sometimes to fill gaps in our own statistics. For all these reasons, the work of international organizations, particularly the World Health Organization, is important in the development of uniform standards, definitions, classifications, and terminology. Nor is its significance confined to international comparisons. The work of the expert committees of the World Health Organization has become widely accepted by national agencies. Canada has made considerable contributions to this work in the past.

It must also be recognized that if health professionals and institutions that collect health statistics are to provide the appropriate data, and that if statistical and other agencies are to collect, process, analyse and publish these data in a time period short enough to make them useful, there must be sufficient resources, both financial and personnel, to complete the tasks. We have provided for the costs of such operations in the administrative costs of the various health funds and for the development of trained personnel through professional training grants and the activities of the Health Sciences Research Council.

The difficulties that have arisen in the preparation of hospital statistics illustrate some of these problems, particularly that of the delay in the publication of data:

(a) It takes time for the collecting agencies to obtain returns from some 1,200 hospitals in all parts of Canada. The smaller hospitals with a limited administrative staff encounter difficulties in completing the required returns; some institutions, like many business firms cannot see the need or the urgency for reporting. One possible solution would be the tightening of the administrative procedures. But it should also be established whether the routine returns required under the Hospital Insurance and Diagnostic Services Act can reasonably be completed by small hospitals. Perhaps administrative arrangements for groups of small hospitals could be pooled more efficiently, or the collecting agency, in the course of following up delayed returns, may be able to assist institutions in the completion of the returns.

(b) The processing of the data involves clerical and mechanical procedures. The former requires an adequate number of qualified personnel. The machine operations also need personnel as well as the necessary equipment and facilities. Both types of resources must be adequate to accommodate, without delay, the routine analysis of statistics as well as any special projects undertaken from time to time.

(c) At the subsequent stage of compilation and analysis the requirements for personnel stated above also apply.

(d) Delays in producing statistics occur in the service operations such as typing, translating, editing, proof reading and printing. These services are often understaffed and as a result health statistical projects have to compete with numerous others for priorities. Here again it is a matter of providing an establishment adequate to accommodate all reasonable demands. If statistics are worth collecting—and about this one must be sure—they must be processed and published as expeditiously as possible.

In summary, major improvements are needed in the present health statistics. Important new statistical series will have to be introduced to fill the gaps that have arisen, partly as a consequence of the greater complexity of modern health problems and health services. Existing health statistics require careful evaluation. Data from various sources must lend themselves to comparisons and co-ordination, and therefore be based on uniform standards, definitions, and terminology. There is a need to expand the resources to provide essential health statistical services in Canada; shortages of funds and qualified personnel must be overcome before any appreciable improvement can be made in the standards of health statistics in Canada. Statistics are a tool, however, and not an end in themselves.

Care must also be taken that the resources devoted to statistics are fully and efficiently utilized. This introduces the organizational aspect of the future health statistics system.

Statistical Organization

In a nation in which the responsibility for health programmes rests with ten provincial governments the data required to assess these services and determine policy at the provincial and national levels must be organized as a co-ordinated system of health statistics.

The original data must come from the individual practitioner, institution, or programme. It is obvious, therefore, that much of the data will be available to the provincial agencies and that, in a number of instances, they will be processed, and statistics produced, by the provinces. And there may be instances when collection of health statistics becomes a joint federal-provincial project. But, whatever form the organization of health statistical compilations takes, the fact remains that it is at the provincial level—particularly for the purposes of the provincial Health Services Commissions and Planning Councils—that an immediate need for regional statistics will exist. Physicians, public health and visiting nurses, and hospitals are, of course, primarily concerned with providing services to their patients. They should not be overburdened with what they might consider as an undue amount of paper work. Modern recording methods, however, can substantially reduce the time spent in keeping records, and a large volume of the resulting data can be processed speedily if modern equipment can be brought to bear in a health statistics system.

The increasing application of electronic techniques to the processing of health statistics opens up vast new possibilities not only for obtaining additional data speedily, but also for the linkage and co-ordination of existing records. It also requires thorough planning to combine the greatest possible output with efficient use of available equipment. Because of their familiarity in matters of record design, data collection and processing, statistical agencies should, whenever possible, anticipate the statistical needs and advise programme administrators of the necessity to build into their operations an effective record system and statistical procedures. Statistical experts should not play a passive role but take the initiative by suggesting new uses of health statistics for analytical and policy purposes.

The ability of a province to collect the necessary statistics will depend upon its resources, and the assistance which it can obtain from the Dominion Bureau of Statistics. If the system of health statistics for Canada were to be based on the data that could be produced by the province with the least resources, the resulting statistics would be inadequate for other provinces and federal agencies. However, with the resources available through the Health Services Programmes plus the assistance of the Dominion Bureau of Statistics in the collection and processing of statistics as well as in the conduct of *ad hoc* studies and sample surveys, all provinces should be able to produce data sufficient for most needs.

In an era of rapid and profound changes in health problems and in the methods of dealing with them, our knowledge of these problems and of the services provided to deal with them must keep pace with these developments. In turn these needs must be reflected in a system of statistics that is at one and the same time comprehensive and flexible. To attempt to prepare a detailed blueprint for such a system of health statistics would be premature. This could only be done by careful and thorough planning. But what we wish to do is to set out in the pages that follow a broad outline of the objectives and possible organization of a health statistical system for Canada.

A HEALTH STATISTICAL SYSTEM FOR CANADA

The provision of health services by a variety of professional personnel and organizations in ten different provinces is bound to result in a multiplicity of record systems. If these are to serve the objectives of medical research and evaluation of the quality of health care, a clearing house and co-ordinating agency such as the Health Sciences Research Council is absolutely necessary.

In establishing and maintaining a system of health statistics, the Health Sciences Research Council must perform an important role. At the provincial level statistical requirements will be determined by local and provincial health planning councils. Through the advice and guidance of the Health Sciences Research Council it will be possible to ensure that in meeting their own requirements, the provincial and local agencies produce data that are comparable with those produced by other provinces. Since the Council's functions include also guidance and consultation with local health planning councils, provincial Health Services Commissions, the Department of National Health, and the Dominion Bureau of Statistics and other departments of the Federal Government, it will be familiar with the statistical needs of all agencies in every province as well as those at the federal level including its own, and therefore will be in a good position to formulate proposals for statistical co-ordination.

In the planning and design of health statistics as a system, account should be taken of the experience gained elsewhere, notably in the United States where the establishment of the National Center for Health Statistics permits the integration of statistics from a variety of organizations whose activities it is intended "to supplement but not supplant".[1] Within the Center,

[1] United States Department of Health, Education, and Welfare, Public Health Services; *Final Report of the Study Group on Mission and Organization of the Public Health Service*, Washington: United States Government Printing Office, 1960, p. 18.

the basis of general[1] health statistics is the National Health Survey which includes as one of its main components a household survey.

Evaluation procedures too must be built into the Health Services Programmes to facilitate a continuing assessment of the quality of care provided and the effectiveness with which this is accomplished. In carrying out its responsibilities at the local, provincial and federal levels the Health Sciences Research Council will be able to offer guidance to the Provincial Health Services Commissions in their evaluation of health services programmes. A co-ordinated system of health statistics is a vital part of any evaluation study. The Council's efforts in establishing and maintaining such a system will enable it to discharge effectively its responsibility for conducting or providing grants for research studies evaluating the effectiveness of the various elements of the Health Services Programmes at the national level.

Before a co-ordinated system of health statistics can operate effectively at the national level the present jurisdictional dispute between the Department of National Health and Welfare and the Dominion Bureau of Statistics must be resolved.[2]

The statistical activities of the Research and Statistics Division of the Department of National Health and Welfare are divided between studies undertaken by the division itself and statistical services and consultation provided to other branches of the Department, to other agencies and to the provinces. It has collected or analysed statistics regarding certain health problems and matters of health economics, as well as government and voluntary health care services. In addition, the Department has been responsible for the collection of data needed for the administration of various health grants, including the grants made under the Hospital Insurance and Diagnostic Services Act.

The principal statistical agency in Canada which is concerned with the collection, processing and publication of health statistics, without being responsible for the operating or administration of a specific health programme is the Health and Welfare Division of the Dominion Bureau of Statistics.[3] The Division routinely produces and publishes for Canada vital statistics, hospital statistics, mental health and tuberculosis statistics, and statistics on notifiable diseases.[4] Besides its publication programme, the Division answers

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[1] These are statistics relating to health and health services generally, without being limited to specific programmes, particular diseases or health problems, or certain population groups.

[2] Other federal agencies responsible for the production of health statistics are the Department of Veterans Affairs and the Department of Labour. The Department of Veterans Affairs produces statistics relating to its health services and the Department of Labour provides statistics relating to vocational rehabilitation and work accidents. The principal statistical agencies are the Department of National Health and Welfare and the Dominion Bureau of Statistics.

[3] With three sections dealing with health statistics: Institutions Section, Public Health Section, and Vital Statistics Section.

[4] For a detailed list of the Bureau's publications *see Current Publications—Dominion Bureau of Statistics 1960*, Ottawa: Queen's Printer, 1960, and supplements.

requests for statistical information. Its work is supplemented by other divisions of the Bureau which produce data on the demographic and social aspects of the Canadian people. In the field of vital statistics the Bureau operates under a formal Federal-Provincial agreement within the Vital Statistics Council, established by Order in Council. In other areas of health statistics, the basis for collaboration with the provinces is limited to personal contact, *ad hoc* committees, and participation in working groups of the Department of National Health and Welfare.

During a period of rapid development in the health sciences and emergence of new patterns of health services, the lack of understanding and co-operation between these two departments has limited the necessary corresponding development of health statistics. Rather than dwell on the reasons for the present unsatisfactory situation, we would like to offer some constructive comments.

The Royal Commission on Government Organization (the Glassco Report) has taken note of the existing jurisdictional problem and recommended that it be settled by the Treasury Board. It recommended generally, in regard to all national statistics, complete integration and co-ordination of the statistical system under the Dominion Bureau of Statistics.[1] At the same time, it stated that "the departments should be free to collect and process certain kinds of statistics themselves,"[2] but this should be confined to relatively small-scale work of experimental nature.[3] The Glassco Report also observed as an obstacle to effective collaboration between the Dominion Bureau of Statistics and other federal departments, that the Bureau has a statutory obligation to collaborate with all departments on statistical matters without a corresponding obligation to collaborate on the part of the other departments.[4] There the matter rests—unresolved.

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[1] *The Royal Commission on Government Organization, Volume 3,* Ottawa: Queen's Printer, 1962, p. 38.

[2] *Ibid.,* p. 41.

[3] *Ibid.*

[4] The Dominion Bureau of Statistics is a federal agency whose sole function is the production of statistics, without any responsibility for formulating policies or administering specific programmes.

The Statistics Act (1948, c. 45, s. 1, as amended), revised Statutes of Canada, 1952, Volume IV, Chapter 257, establishes under the Minister of Trade and Commerce the Dominion Bureau of Statistics whose duties are:

> "to collect, compile, analyse, abstract and publish statistical information relative to the commercial, industrial, financial, social, economic and general activities and condition of the people;
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> "to collaborate with all other departments of the government in the collection, compilation and publication of statistical records of administration according to any regulations;
>
> "to take the census of Canada as provided in this Act; and
>
> "generally to organize a scheme of co-ordinated social and economic statistics pertaining to the whole of Canada and to each of the provinces thereof."

The Act contains strict provisions for the preservation of the confidentiality and secrecy of statistical returns made to the Bureau.

(*Continued on p. 146*)

This unsettled state of affairs manifests itself even in the field of hospital statistics which, on the whole, represent one of the few instances where some progress has been made. In this area, as in others, both federal agencies make diverse claims for jurisdiction, often leading to either conflicting or competing requests to the service agencies, resulting in a good deal of duplication in the work on the one hand and slow progress on the other. The Bureau's position is based on the provisions of the Statistics Act, the Department's claim on its Minister's responsibilities under the Hospital Insurance and Diagnostic Services Act. It appears to us that the basic question here is: should there be a central statistical agency like the Bureau or should each department concerned with some special area, such as the Department of National Health and Welfare, collect its own statistics?

There are pros and cons on either side.[1] The Glassco Commission has reviewed this matter and decided in favour of retaining and strengthening

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[1] A central statistical agency being divorced from policy-making decisions may be more objective and better suited to gear its programme to the statistical needs of all potential consumers, not only those of the federal department concerned; it provides an opportunity of integrating various statistical series (important also in connection with record linkage and sample design) and of generally organizing "a scheme of co-ordinated social and economic statistics pertaining to the whole of Canada and to each of the provinces thereof", as the Statistics Act puts it; it can better implement uniform concepts and classifications; it can more efficiently use resources of personnel and machines required in modern data processing. The subject matter department, on the other hand, has closer contact with the field, may be better aware of statistical needs, and be in a better position to proceed with statistical projects of its own without competing for priorities with statistical projects in other fields. In particular, it may be aware of the need to undertake a specific analysis at a particular moment of time, an awareness that arises from the need to evaluate objectives and formulate new approaches to problems.

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[4] (*Continued from p. 145*)

In addition to the foregoing general description of the duties of the Bureau, the Act specifies the following areas in which the Bureau shall produce statistics:

Census of population and agriculture;
Census of industry, construction, trading and service establishments, etc.;
Carriers and public utilities;
Criminal statistics;

The Act further lists the following matters in particular, on which the Bureau shall "collect, compile, analyse, abstract and publish statistics:

(a) population;
(b) births, deaths, marriages, divorces;
(c) epidemiology, morbidity;
(d) immigration and emigration;
(e) employment, unemployment, payrolls, man-hours;
(f) agriculture, horticulture, dairying, cold storage;
(g) factories, mines and productive industries generally;
(h) education;
(i) public and private finance;
(j) wholesale and retail trade and supplying of services;
(k) hospitals, mental institutions, tuberculosis institutions, charitable and benevolent institutions;
(l) prices and cost of living; and
(m) any other matters prescribed by the Minister or by the Governor in Council."

the Bureau as the agency principally responsible for the collection of data. Accepting this judgment, how can the Bureau's role in the health field be clearly established and defined?

The enumeration of the Bureau's functions in the Statistics Act is bound to be dated by conditions at the time of the promulgation of the Act. It leaves open the responsibility for the collection of other health statistics such as medical care, home care and the social and economic implications of health and ill-health. These obviously cannot be divorced from epidemiology, morbidity, births, deaths, and hospitals. An amendment of the Act referring to health statistics in general rather than selected aspects of such statistics appears necessary. We agree with the Glassco Report that the Department of National Health and Welfare also will have to pursue some statistical activities. The division of labour, however, cannot be achieved by a listing of subjects to be dealt with by each agency because it will often be a question of scope rather than of subject matter. The aforementioned criteria contained in the Glassco Report would seem to be a logical guide but they cannot be more than a guide and they can be workable only if there is understanding and the will to co-operate on both sides.

Such an understanding is necessary because the Bureau cannot hope to produce adequate and useful health statistics without the support of the Department. Nor can the latter economically fill the gap without the Bureau's statistical resources. The Health Services Programmes cannot afford the luxury of duplicating statistical services.

We are fully confident that the department heads can create a climate of collaboration or failing this that they can be directed to do so by Treasury Board. The Bureau must, of course, accept and carry out its full responsibility with regard to health statistics while meeting the requirements of the Department of National Health and Welfare and other agencies. Claiming wide responsibility for health statistics while rejecting requests for statistical assistance on the grounds of lack of resources does not solve the problems Canadians face and with which the operating government departments are called upon to deal. The Bureau's needs for resources in terms of well-qualified professional staff (both in the subject matter field and statistical methodology) technical and clerical staff, modern mechanical equipment, and also the processing services[1] must be established and met if the statistics produced are to be adequate in coverage, quality, and timeliness.[2]

We visualize, however, that two measures may be necessary to enable the Bureau to fulfil its functions. We believe there is some merit in the complaint made by the Department of National Health and Welfare and

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[1] For example, typing, translation, editing, proof-reading and printing.
[2] *See* Volume I, Chapter 2, Recommendation 188, p. 83.

other health agencies that the Bureau with its multi-subject obligations relegates health statistical projects to a lower priority than they would receive otherwise. The Bureau, like any other government agency, has to function within a budget and within its limits has to accommodate demands for statistics from the various government departments and the public at large. When the question of priority between different projects arises, it should not be left to the Bureau to decide which should be carried out and which postponed or curtailed. It strikes us that an agency similar to the Central Commission of Statistics in the Netherlands could be a useful method "to protect government departments, the public and scientific institutions from improper interference with the collection and publication of statistics, and to maintain the objectivity and high scientific standards of the Bureau's work programme".[1]

We have already stated that a second prerequisite for the Bureau's proper function in the health field is some agency to determine the country's health statistical needs including those of the Department of National Health and Welfare as well as of other institutions or agencies. An agency of this type existed in Canada in the form of the Medical Advisory Committee to the Dominion Statistician.[2] This, unfortunately, has been allowed to pass into oblivion leaving the Bureau without effective liaison with the health agencies. We visualize that the Health Sciences Research Council will perform this function in the future. It would not only advise the Dominion Bureau of Statistics on the extent of the need for various types of health statistics, but it would also maintain close liaison with the Bureau to deter-

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[1] *The Netherlands Central Bureau of Statistics: Organization, Functions and Activities,* The Netherlands Government Printing Office, The Hague, 1960, p. 9.

NOTE: The Netherlands has a Central Bureau of Statistics which is attached to the Ministry of Economic Affairs. The above quoted description of its functions also notes that only the Central Bureau of Statistics collects, compiles and publishes statistical information pertaining to all social, economic and cultural activities in the country; and adds that with regard to a number of administrative ("secondary") statistics, the work is performed in co-operation with other government departments. This is the kind of co-operation which should prevail, for instance, in the field of hospital statistics.

In regard to the Central Commission of Statistics in the Netherlands, the statute provides (Art. 2):

> "The Bureau cannot undertake any new statistical enquiries, issue new publications or discontinue existing enquiries and publications without the consent of the Central Commission of Statistics.
>
> "On its own initiative or on the instruction of the Minister of Economic Affairs, the Central Commission of Statistics may instruct the Director of the Central Bureau of Statistics to collect, to process and to publish certain statistical data.
>
> "The Director shall carry out these instructions, except that he has the right to appeal to the Minister with respect to instructions given by the Commission on its own initiative."

In Canada, this could become a function of the Committee of the Privy Council on Scientific and Industrial Research.

[2] With the Deputy Minister of National Health and Welfare as Chairman and the Director of the Bureau's Health and Welfare Division as Secretary.

mine if these needs were being met. If the Bureau failed to meet these needs the Council would ascertain the reasons so that it could make appropriate recommendations to the officials responsible for the Bureau's operations.

CONCLUSION

In Volume I of our Report we have made certain observations and recommendations regarding health statistics in Canada. Because of the importance of statistical information in the field of health research, as well as in the administration of the health services, we have examined this subject in depth in this volume.

The objectives of statistics must guide their collection and processing, lest they degenerate into wasteful paperwork. The sources of health statistics are as varied as the agencies providing health services. There is a great need for co-ordination among these agencies in order to fill existing gaps, to assure comparability, to eliminate duplication, and to provide policy makers and administrators with the necessary basic information to make wise decisions and to carry them out.

This leads us to the recommendation[1] that the Health Sciences Research Council take a positive role "in developing and maintaining a continuing system of health statistics" including a dental health index. Health statistics can achieve maximum usefulness only if the experience of one programme, one area, one practice or institution can be compared with others *or* with some accepted norm which, in turn, may be the average for the universe of programmes, areas, practices or institutions. The linkage of records and statistics assumes increased importance the more complex the health problems and services become. All this requires basic uniformity, comparability, and co-ordination of statistics. Statistical requirements will, therefore, often go beyond the needs of a particular agency in its day-to-day operation.

The health statistical system of the future will have to serve the needs of the operating and financing agencies as well as those of the Health Services Commissions, the Health Planning Councils, and the Health Sciences Research Council.

This will require the co-operation of all the agencies concerned with the production of the source data, the collection, compilation and publication of statistics, and the use of these statistics. Flexibility still will have to be maintained in order to meet the statistical needs at the various levels and to adapt statistical projects to changing needs. At the federal level, the produc-

[1] *See* Volume I, Chapter 2, Recommendation 184, p. 81.

tion of statistics by the Dominion Bureau of Statistics must be reconciled with the needs of the Department of National Health and Welfare and other agencies. In particular, we have recommended closer co-operation between these two main federal agencies concerned with health statistics. Their respective needs are not conflicting and we are confident that they can be resolved in a constructive manner.

In view of the great and continuing advances of scientific knowledge and technology in the field of statistics, it will be of the utmost importance that health statistics be designed to take full advantage of progress in this field. This will render possible many useful projects which in the past would have been unrealistic or too costly. It will provide more adequate and more up-to-date information than could be produced previously. At the same time the use of modern recording methods will ease the task of obtaining source data, and data processing and record linkage will, with the same amount of clerical work, or less, produce more and better statistics.

Thorough and continuing planning is needed to accomplish these objectives and to ensure that health statistics provide the answers to the questions arising in the sciences and to facilitate the planning, formulation, operation, and evaluation of health services. If this is done, the possibility of achieving the best possible health care for Canadians will be much enhanced.

6

Voluntary Health Organizations

INTRODUCTION

The substantial growth of voluntary health organizations in Canada and the support they receive reflects the increased concern of our society for the health of its citizens, and the belief that voluntary organizations can play an effective and responsible part in the provision of good health care. Public participation both financial and personal has increased steadily in organizations engaged in the promotion of health; the prevention of illness; the discovery, treatment and rehabilitation of the victims of disease and disability; the stimulation of scientific research; and the training of health personnel.

In Volume I of this Report we have referred to the significant contributions of voluntary organizations in the provision of health services for Canadians. Here we wish to examine this contribution in more detail, particularly the growth of various voluntary organizations, the services they provide, and the ways in which they are organized and financed as a prerequisite to an examination of their future role in the Health Services Programmes. In essence, we are presenting in this chapter an assessment of the past, present, and probable future roles of voluntary health organizations in Canada.

In our discussion we have dealt with the major activities of voluntary organizations but we have excluded voluntary hospitals and charitable foundations. It must be emphasized, however, that limitations of the available data prevent us from developing a detailed analysis of every organization. However, more information on individual voluntary organizations appears in the study prepared for the Commission on which this chapter is based.[1]

We have not specifically analysed the services of voluntary organizations according to whether these are provided free of charge to the patient

[1] Govan, E. S. L., *Voluntary Health Organizations in Canada*, a study prepared for the Royal Commission on Health Services. Ottawa: Queen's Printer (*in press*).

or at a price. A shift of emphasis is taking place in that these organizations no longer provide services solely for the indigent but tend to provide them for all those needing such services, regardless of their income or means. With the implementation of the Health Services Programmes the role of the voluntary organizations should remain essentially unchanged though personal health services provided under the programmes will be paid for from their funds.

DEVELOPMENT OF VOLUNTARY ACTIVITIES

The establishment of voluntary organizations to provide health services for Canadians began before Confederation. Community nursing, one of the earliest functions of voluntary organizations, was begun more than a century ago by religious orders in Quebec,[1] and the Nazareth Institute for the Blind was founded in Montreal in 1861. Schools for the blind were established in Halifax in 1870 and in Ontario in 1872 but the major impetus to the growth of voluntary agencies did not come until the end of the nineteenth century when the first national voluntary health organizations were established in Canada. These organizations began as outgrowths of organizations which had developed in the United Kingdom. Thus the Canadian Red Cross Society was first organized in 1896 as an overseas branch of the British Red Cross Society to provide aid to the sick and wounded in war,[2] the Victorian Order of Nurses was founded in 1897 with maternal and infant welfare as its primary objective, while branches of the St. John Ambulance Association were organized in various provinces to provide first-aid courses with a national organization being established in 1910. In 1896, the National Sanitarium Association was established by physicians and laymen to provide services for residents of Ontario. The medical profes-

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[1] Even before the middle of the nineteenth century voluntary organizations had implemented some of the principles of care in the community, continuing care, and rehabilitation. They were mostly conceived as welfare organizations and operated on a local basis. The following are but a few examples of such early agencies in Quebec. In 1843, the Azile de la Providence was founded in Montreal with home visits to the needy sick as one of its objectives. The same is true of the Convent Bethléem, founded in 1868. The Institution des Sourds-Muets, founded in 1848, provided instruction to the deaf-mutes in Montreal. Both the aforementioned Azile de la Providence and the Father Dowd Memorial Home, the latter founded in 1868, provided homes for the aged. Commencing in 1848, illegitimate children born at the Hôpital de la Miséricorde were taken care of by the Crèche de la Miséricorde.

[2] Porter, McKenzie, *To All Men—The Story of the Canadian Red Cross*, Toronto: McClelland and Stewart, 1960. In 1885, at the Battle of Batoche during the Saskatchewan rebellion, Dr. G. S. Ryerson, surgeon of the Tenth Royals, improvised the Red Cross insignia which he used on the battlefield while caring for the wounded. This was the first Red Cross flag flown in Canada. Dr. Ryerson was later instrumental in the establishment of the Canadian Red Cross Society. In 1896, the Canadian Branch of the British Red Cross Society was established at a meeting held in Toronto under the chairmanship of Dr. Ryerson and attended by Sir Frederick Borden, Sir Charles Hibbert Tupper and Colonel J. B. Maclean.

sion took a leading role in developing a national organization for the control of tuberculosis, and in 1900 the Canadian Tuberculosis Association was established.[1] In 1908, Catholic women established the St. Elizabeth Visiting Nurses' Association in Toronto. All these were responses to health problems which were outstanding at the time.

The First World War provided a further impetus to the growth of voluntary agencies. In 1917, the Canadian National Institute for the Blind was organized under the inspired leadership of Col. E. A. Baker, a blinded war veteran who had undergone some rehabilitation at St. Dunston's Hospital in England and who had joined the Braille Library in Toronto on his return. Through his ability to interest influential citizens he was able to obtain a national charter and remained as general secretary of the organization which promoted a national network of services for the blind and to some extent provided a model of comprehensive services to a group of the handicapped.

During and immediately after World War I the medical profession and laymen established an agency designed to combat the spread of venereal disease. Later this organization became the Health League of Canada with the primary function of disseminating health information and stimulating government action in the field of health. In 1918, the Canadian National Committee for Mental Health was established by businessmen to arouse widespread public support for the more humane care of the mentally ill in Canada; eventually this became the Canadian Mental Health Association.

In the inter-war period there was a slow but steady growth of the work of established organizations as well as the development of new voluntary agencies to deal with new health problems. In this development, the health professions and the general public and governments all played a part. The Canadian Red Cross pioneered the development of nursing services in many of the provinces and provided funds for many other voluntary agencies, while urging and assisting in the establishment of local health units. For example, when a public health nursing course was established at Dalhousie University

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[1] The Canadian Tuberculosis Association indicates that the founding dates of the provincial branches of the Canadian Tuberculosis Association were as follows:

British Columbia Tuberculosis Society	1904
New Brunswick Tuberculosis Association	1909
Saskatchewan Anti-Tuberculosis League	1910
Sanatorium Board of Manitoba	1929
Prince Edward Island Tuberculosis League	1936
Quebec Provincial Committee for the Prevention of Tuberculosis	1937
Alberta Tuberculosis Association	1940
Newfoundland Tuberculosis Association	1944
Ontario Tuberculosis Association	1945
Nova Scotia Tuberculosis Association	1946

These dates are those on which the associations were set up in their present form. Most of them, however, had been in being since the very early nineteen hundreds, usually on the basis of separate city associations.

in 1919, the Canadian Red Cross Society provided scholarships and $25,000 to maintain several nurses in the field for a year. In addition to assisting this and other universities to provide professional training for the public health field, the Society undertook in 1923 to establish training courses in home nursing for the maintenance of family health by teaching household hygiene, health habits and principles of nutrition. As early as 1925 the Toronto branch of the Red Cross Society had begun to develop homemaker services through the establishment of a planning committee with representatives of the medical, nursing, social work and home economist professions. In 1930, the Health League of Canada established its Immunization Committee to inform the public concerning the use of diphtheria toxoid, while the Victorian Order of Nurses began to shift its operations to the provision of nursing care in the home for the chronically ill and those discharged from hospital. The Canadian Tuberculosis Association meanwhile began to include public education as a major aspect of its work.

Among the new organizations established at this time were those interested in the needs of crippled children. Between 1916 and 1922, a number of service clubs in Ontario, mainly Rotary, developed services for crippled children as their community service project, while in 1922 representatives of these clubs established the Ontario Society for Crippled Children to spread this work throughout the province. The Quebec Society of Crippled Children developed in a similar fashion. From these provincial organizations a national organization was established in 1938 with a federal charter under the name of the Canadian Council for Crippled Children. Another new organization, Alcoholics Anonymous, was established in 1935. This organization was founded on the belief that an alcoholic may be aided in his recovery by association with a former alcoholic and that the group reinforces the rehabilitation efforts of the individual. Consequently the organization of A.A. assumed the form of a number of independent groups in different communities.

The representations by voluntary health organizations led to the establishment in 1919 of the federal Department of Health. By giving a number of financial grants to the nationally organized, voluntary health promoting agencies, the Department established and recognized their place in the public health field. At the same time provincial departments of health were giving increasing help and recognition to the voluntary organizations. In this way, over the years, Canada developed patterns of co-operation between voluntary organizations, governments and the public. A leader in this development was the Canadian Red Cross Society. Having to re-orient itself to a peace-time role after World War I, the Red Cross Society, acting as an auxiliary to the federal Department of Soldiers Civil Re-establishment, first took on the task of helping veterans readjust to peace.

Organizations of health professionals in this period continued to stimulate the establishment of voluntary health organizations. In 1938, the Canadian Medical Association undertook to set up within its own organization a department of cancer control and to organize a citizen group, the Canadian Society for the Control of Cancer. From this development came the Canadian Cancer Society with action committees in all provinces.

With the outbreak of World War II there was an increased concern with the need to mobilize the entire labour force, including the disabled, and voluntary organizations began to extend their activities in this direction. In 1940, the Canadian Hearing Society was established primarily as a placement agency for the deaf and the hard of hearing.

During the war, voluntary associations that had formerly concentrated on meeting the needs of handicapped children began to turn their attention to the rehabilitation needs of the adult population. This process was continued after the war as voluntary associations recognizing that facilities, treatment procedures and needs of all handicapped had many common elements (particularly as their own patients and wards grew older) established organizations with broader terms of reference. The national organization dealing with crippled children removed its age limit on services and changed its name in 1954 to The National Council for Crippled Children and Adults. A number of provincial societies similarly followed suit, while some provincial societies made arrangements to transfer the care of the handicapped after age 18 to the Canadian Foundation for Poliomyelitis (established in 1948) which, with the diminished threat of polio, had expanded to serve other handicapped groups.

As we observed in Volume I of our Report the public interest in health has been enlarged in scope and given new force since the end of World War II.[1] Nowhere has the public interest been more manifest than in the growth of the voluntary health agencies. Urged on by a greater appreciation of need and an even greater optimism as to what medical science and skill could accomplish, more organized attacks on health problems were launched than in any earlier period of our history.

In their identification of new health needs and their search for solutions to such needs, voluntary agencies have continued to receive strong support from governments. Since 1948, the National Health Grants Programme has assisted voluntary organizations concerned with rehabilitation. In that year, a grant was made to the Canadian Arthritis and Rheumatism Society for its initial organization and assistance was provided to six provincial branches to equip and staff clinics. In 1953, the Medical and Rehabilitation Grant was created as one of the National Health Grants. Under

[1] *See* Volume I, Chapter 1, p. 5.

this grant funds were made available which could be used for the establishment of voluntarily operated rehabilitation clinics. Such clinics as the G. F. Strong Rehabilitation Centre in Vancouver, the Rehabilitation Institute in Montreal, the Nova Scotia Rehabilitation Centre in Halifax, and others have received grants under this programme. Provincial governments also extended their support of voluntary agencies in this period increasing both the number and the amount of grants to provincial voluntary health organizations as well as by purchasing services provided by such organizations. The introduction of the Hospital Insurance and Diagnostic Services Act in 1957, coupled with later amendments relating to out-patient services, led to the transfer of certain responsibilities of voluntary organizations to the publicly financed hospital programme. This was, of course, in keeping with the role of voluntary organizations as the sponsors of health programmes designed to meet newly identified needs in the community which later could be met best on a more universal basis.

The medical profession too continued to provide an impetus to the establishment of voluntary agencies concerned with specific diseases. Medical practitioners and other professionals specially interested in the prevention and control of cardio-vascular disease were active in developing provincial foundations for research in this area. From these developed the Canadian Heart Foundation established in 1956.

One significant development in the post-war period has been the number of voluntary organizations, established by patients or the parents of afflicted children, which ultimately became national in scope. "Patient-member" organizations had existed previously such as, for example, the Canadian Council of the Blind (affiliated with the Canadian National Institute of the Blind), the Canadian Federation of the Blind, operating mainly in Quebec and Saskatchewan, and the Canadian Federation for the Hard of Hearing. In 1945, a group of paraplegic war casualties under the leadership of J. G. Counsell founded the Canadian Paraplegic Association to supplement the treatment services of the Department of Veterans Affairs and extend these services to civilians.

In 1948, the Multiple Sclerosis Society of Canada was incorporated as an organization of patients and friends dedicated to the support of research. Still another organization, the Muscular Dystrophy Association of Canada was founded by parents and friends who felt that because of the low incidence and non-infectious character of the disease this problem was being largely ignored. Other associations that began as "patient-member" organizations in this period include the Canadian Hemophilia Society, the Canadian Cystic Fibrosis Association, the Canadian Association for Retarded Children. Also in 1948, the Canadian Arthritis and Rheumatism Society was founded out of the combined concern of patients, experts and governments. At the urging of the Canadian Rheumatism Society, the Minister of National Health and

Welfare convened a conference of experts to discuss the "Control of Rheumatic Diseases in Canada". At a second conference attended by representatives of the provincial departments of health, university medical schools, professional organizations and the Red Cross Society, the voluntary organization was born.

Membership does not reflect the degree of public support enjoyed by voluntary organizations because much community support comes in the form of individual contributions to Community Chest or United Fund Appeals which then allocate funds to the various voluntary agencies. It is evident however, that a substantial number of Canadians actively participate in voluntary activities by maintaining membership, by actually providing services, and by participating in the administration of voluntary organizations. Table 6-1 summarizes the organization and structure of 28 national voluntary organizations.

It should be noted that membership figures shown in Table 6-1 have a different meaning for different organizations; the Canadian Cancer Society counts as members all persons donating one dollar or more, while St. John Ambulance lists only uniformed and trained members; the Canadian Heart Foundation includes individuals and organizations, while the Canadian Red Cross Society maintains enrolment numbers for the Junior Red Cross only. "Patient-member" organizations, on the other hand, draw their membership from those affected by, or concerned with, certain diseases or handicaps, nor is there always a clear distinction made. Some organizations do not indicate the extent of their membership. On the other hand, vast constellations of volunteers are organized in service clubs, auxiliaries, church and other groups which provide services in health areas.

Elsewhere in our Report[1] we have distinguished between the legal functions of the Colleges of Physicians and Surgeons and the Canadian Medical Association which, together with its sister organization l'Association des Médecins de Langue Française du Canada, and its provincial divisions, constitute the voluntary organizations of the members of the profession. In a similar way, the professional organizations of other health professions fulfil to a varying extent a dual role by licensing or registering qualified members and promoting the interest of their members. In both capacities, professional organizations have contributed greatly to the advancement of knowledge in their respective fields and to raising the professional standards of their members and thus the quality of service provided to the public. Our efforts to establish the conditions necessary for the best possible health care for all Canadians have been greatly helped not only by the evidence submitted by the health professional organizations but also by their active co-operation in our own studies. Representatives of the

[1] *See* Volume I, Chapter 2, p. 31.

TABLE 6-1 ORGANIZATION AND STRUCTURE OF NATIONAL VOLUNTARY HEALTH ORGANIZATIONS, CANADA

(1962 or nearest year)

Organization	Date Founded	Number of Provinces*	Branches Operating	National Headquarters	Reported Membership	United Fund Participation	Federal Grants	Provincial Grants†
Canadian Red Cross Society	1896	10	1,152	Toronto	—	x	x	x
Victorian Order of Nurses	1897	10	119	Ottawa	0	x	x	x
Canadian Tuberculosis Association‡	1900	10	175	Ottawa	—	x	x	x
St. Elizabeth Visiting Nurses Association	1908	1	2	Toronto	1,200	—	x	x
St. John Ambulance[a]	1910	10	389	Ottawa	10,000	x	x	x
Canadian National Institute for the Blind	1917	10	48	Toronto	—	x	x	x
Canadian Mental Health Association[b]	1918	9	91	Toronto	137,000	x	x	x
Health League of Canada[c]	1919	1	2	Toronto	—	x	x	x
Canadian Federation of the Blind	1928	—	8	—	—	x	—	—
Canadian Mothercraft Society	1931	1	2	Toronto	0	—	—	x
Alcoholics Anonymous	1935	10	1,075	—	15,410	—	—	x
Canadian Cancer Society	1938	10	—	Toronto	—	x	—	x
Canadian Council for Crippled Children	1938	10	—	Toronto	—	x	—	x
Canadian Hearing Society	1940	1	3	Toronto	0	—	—	x
Canadian Council of the Blind	1944	—	—	Montreal	—	—	—	—
Canadian Paraplegic Association	1945	9	4	Toronto	2,000	—	x	—
Canadian Arthritis and Rheumatism Society	1947	8	80	Toronto	2,000	x	x	x
National Cancer Institute	1947	—	—	Toronto	—	—	—	x
Canadian Association for Retarded Children[d]	1947	9	—	Toronto	14,000	x	x	x
Canadian Foundation for Poliomyelitis	1948	10	32	Montreal	0	x	—	—
Multiple Sclerosis Society of Canada	1948	8	30	Montreal	9,600	—	—	x
Muscular Dystrophy Association of Canada	1950	7	—	Toronto	3,500	—	—	—
Canadian Heart Foundation	1952	9	—	Toronto	—	—	—	—
Canadian Diabetic Association	1953	—	30	Toronto	3,500	—	—	—
Canadian Hemophilia Society	1953	4	1	Toronto	300	—	—	—
Canadian Council on Alcoholism	1959	—	—	—	—	—	—	—
Cystic Fibrosis Foundation	1960	—	—	Toronto	1,120	—	—	—
Cerebral Palsy Association[e]	—	—	—	—	—	x	—	x

* Depending on the structure of the voluntary organization, the provincial groups are either branches of the national organization (e.g., Victorian Order of Nurses) or autonomous organizations (e.g., Alcoholics Anonymous).

† Based on briefs submitted to the Royal Commission on Health Services; data are not available for those organizations that did not submit briefs.

‡ Originally National Sanatorium Board, 1896.

[a] Originally Priory of the Most Venerable Order of the Hospital of St. John of Jerusalem.

[b] Originally Committee on Mental Health, later Canadian Council on Mental Health, adopted its present name federally incorporated in 1950.

[c] Originally Canadian Council for Combatting Venereal Disease, later Canadian Social Hygiene Council.

[d] Federally incorporated in 1956.

[e] Several provincial associations joined administratively with the Canadian Rehabilitation Council for the Disabled in 1962.

NOTE: Dashes indicate incomplete data available.

SOURCE: Reports, pamphlets, and briefs submitted to the Royal Commission on Health Services.

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professional organizations serve in many agencies in executive or advisory capacities. The journals published by these organizations serve both to disseminate technical information and to encourage research among their members.

The Canadian Medical Association, the professional organization of physicians in Canada, provides an example of the contributions these organizations make towards the improvement of health. Among the objects of the Canadian Medical Association is the promotion of "the medical and related arts and sciences".[1] The Act establishing the Association specifies among its objectives such matters as these:

> "to aid in the furtherance of measures designed to improve the public health and to prevent disease and disability;
>
> "to promote the improvement of medical services however rendered;
>
> "to assist in the promotion of measures designed to improve standards of hospital and medical services;"[2]

This work is conducted by continuing or *ad hoc* committees such as those on maternal welfare, the medical aspects of traffic accidents, child health, cancer, nutrition, rehabilitation, aging, physical education and recreation. The Association was instrumental in the establishment of the Associate Committee on Medical Research of the National Research Council, the forerunner of the Medical Research Council, and in fact in the appointment of this Royal Commission on Health Services. It conducts studies into specific health problems and is making outstanding contributions to the quality of health services through the physician-supported Canadian Council on Hospital Accreditation and the Committee on Approval of Hospitals for the Training of Junior Interns, and in the training of nurses. We have already mentioned the work of the various committees of medical hospital staffs[3] and also the experience gained in the administration of medical care insurance by the profession-sponsored prepayment plans.[4] Committees of the Canadian Medical Association undertake to assess and approve Canadian Schools for Laboratory Technologists, Schools for Radiological Technicians and Schools for Occupational and Physical Therapists.

Dentists, nurses, pharmacists and other health professions have been rendering in their own fields valuable contributions to the improvement of health and health services. This is one of the main reasons why we are anxious to preserve free and self-governing professions[5] and, if anything, strengthen their capacity to improve the health services to the people of Canada.

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[1] Section 2(*a*) of the Act respecting the Canadian Medical Association.
[2] *Ibid.*, Sections 2(*b*), (*c*), and (*e*).
[3] *See* Volume I, Chapter 14, pp. 606 and 608.
[4] *Ibid.*, Chapter 2, pp. 29 and 30.
[5] *Ibid.*, Chapter 1, p. 12.

CURRENT PROGRAMMES OF VOLUNTARY ORGANIZATIONS

Having traced the development of voluntary organizations we now turn to the examination of the activities of voluntary organizations at the present time with particular reference to emerging trends.

Broadly defined, the activities of voluntary health organizations continue to be the provision of services to patients, the health education of the public, the provision of funds for the education of health personnel, support of medical research, and action to obtain the expansion of government support in specific fields of health. Practically all voluntary organizations engage in the provision of services for patients, most engage in public health education and a few are substantially interested in the provision of funds for health research.

Direct Services to Patients

The direct services given to patients by voluntary health organizations vary from province to province, and even within regions of provinces. In examining briefly the major fields where voluntary organizations operate, we pay particular attention to those areas that would be affected by our recommendations. These areas include case-finding, diagnosis, treatment and rehabilitation services; community nursing; homemaker services; blood transfusion services; the provision of sick-room supplies, home care equipment, appliances, transportation services, hostels and sheltered workshops.

CASE-FINDING, DIAGNOSIS, TREATMENT AND REHABILITATION SERVICES

Although public funds are now available to finance some of the activities carried out by voluntary organizations and in some cases emerging public institutions provide services formerly provided under voluntary auspices, the voluntary agencies continue to concern themselves with the early detection of diseases or case-finding. They are involved in diagnostic assessment and in the total evaluation of disabled persons to determine what services the organization should provide, or to refer the patient to other professional or public services. They may operate clinics for treatment or provide other means to achieve rehabilitation.

Case-finding, diagnosis, and the treatment of tuberculous patients continue to be a major field for voluntary effort. Diagnosis and case-finding remain a major concern of organizations dealing with the blind.

Alcoholics Anonymous co-operates with personnel in medicine, public health and correction agencies in achieving its goals. This organization has

a unique procedure to help those alcoholics that turn to it for help; it is based on five steps: (1) admission of alcoholism, (2) personality analysis and catharsis, (3) adjustment of personal relations, (4) working with other alcoholics, (5) dependence upon some higher power. Table 6-2 indicates the scope and distribution of the activities of Alcoholics Anonymous.

TABLE 6-2 ALCOHOLICS ANONYMOUS, GROUP CONTRIBUTIONS TO GENERAL SERVICE OFFICE, CANADA AND PROVINCES, 1963

Province	Number of Groups Reported	Number of Groups Contributing	Amount of Contribution	Membership	Contributions per Capita
			$		$
Newfoundland	10	7	256	139	1.84
Prince Edward Island	11	5	316	198	1.60
Nova Scotia	47	25	1,028	532	1.93
New Brunswick	30	17	528	484	1.09
Quebec	210	71	1,669	3,730	.45
Ontario	346	196	8,572	4,931	1.74
Manitoba	57	31	1,826	1,155	1.58
Saskatchewan	88	53	2,311	1,020	2.26
Alberta	109	59	3,424	1,066	3.21
British Columbia	161	81	4,943	2,121	2.33
Yukon	3	1	59	24	2.46
Northwest Territories	3	2	36	10	3.56
CANADA	1,075	548	24,968	15,410	1.62

SOURCE: Based on *Conference Digest, 1964*, Fourteenth Annual General Service Conference of A.A., New York City, April 21–26, 1964.

For those health problems where medicine has as yet found only limited or no means of effective treatment or cure, or where there remain residual disabilities, health programmes must be directed towards utilizing available techniques to teach the disabled to live within the limits of their disabilities, but to the fullest possible extent of their capabilities. Among these areas are the diseases of the heart and the circulatory system, arthritis and rheumatism, cerebral palsy, multiple sclerosis and other crippling diseases. It is the concepts and techniques of rehabilitation which are brought to bear particularly in these fields.

As we have indicated earlier, voluntary organizations have a long history of meeting the needs of Canadians in this area and continue to do so. Despite the expansion of government rehabilitation programmes for disabled Canadians, voluntary organizations participate in the provision of

services of one form or another. They concentrate on the treatment of certain categories of patients and on the development of services for them. Voluntary organizations operate rehabilitation clinics in major cities. Although general hospitals have now assumed the operating responsibility for 25 clinics established by the Canadian Arthritis and Rheumatism Society, the Society continues to operate stationary and mobile clinics in many parts of the country. The development of travelling clinics reflects the specific concern of voluntary organizations with the provision of services for patients remote from other rehabilitation services. For example, the provincial societies for the Care of Crippled Children and Adults conduct special medical and diagnostic review clinics in areas outside metropolitan centres. The capital costs of rehabilitation centres established throughout Canada also continue to be met, in part, through the voluntary organizations.

In addition to providing these services, voluntary organizations pay medical, surgical and prosthetic expenses on behalf of sponsored patients in all provinces. Where government has assumed the cost of treatment, auxiliary services such as transportation, the provision of hostels for patients undergoing protracted treatment in out-patient clinics or at distant medical centres continue to be mainly the responsibility of voluntary organizations.

Finally, these organizations have, in certain instances, assumed quasi-official status, as the organization responsible for the operation and development of rehabilitation services. The Manitoba Society for Crippled Children and Adults carries out all such activities (except rehabilitation services for the tuberculous, the blind, persons covered under the Workmen's Compensation Act and Treaty Indians) and finances its activities through the government medical rehabilitation grant made under the National Health Grants, and with funds from the Vocational Training Grant as well as the proceeds from the voluntary Easter Seal and March-of-Dime campaigns.

COMMUNITY NURSING

Voluntary health organizations supply a substantial portion of home nursing services by providing families, industry and governments with the services of a visiting nurse as needed. Foremost in this activity is the Victorian Order of Nurses that provides home nursing services in all the provinces, except in Prince Edward Island. The Order operates in areas that include 51 per cent of the Canadian population, the proportion of covered population ranging from 25 in Newfoundland to 54 in Manitoba. Although most branches are situated in urban areas, steps have been taken to extend the service to outlying areas. Other associations which provide home nursing care are also concentrated in urban areas. They include The St. Elizabeth Visiting Nurses' Association of Toronto and Hamilton, and the Société des Infirmières Visiteuses in Quebec. This last organization operates in Montreal

and in three other areas and serves an area with a population of nearly 1,500,000.

Nurses of the Victorian Order provide bedside nursing to the sick in their homes and to convalescents following hospitalization; antenatal, individual and group instruction; as well as postnatal health supervision for mothers and babies; school health nursing, and part-time occupational nursing in small industries. Nurses may also be found in Children's Aid Societies, Crippled Children's Clinics and Y.M.C.A. Camps. The nature and extent of their work has adapted itself to the changing needs of society and to the role of the nurse in the official agency. In 1963, maternity and newborn care represented 54 per cent of the total case load of the organization but accounted for only 18 per cent of nursing visits; medical and surgical cases, on the other hand, accounted for 46 per cent of all cases but for 79 per cent of all visits.

Through hospital referral programmes, the Victorian Order of Nurses has demonstrated that the presence in hospitals of a nurse familiar with services and facilities available in the community, promotes continuity of care for patients discharged to their homes. Thirty-six branches of the Victorian Order now operate hospital referral programmes while in some communities, notably in Toronto, Winnipeg, Moose Jaw, Saskatoon, and Ottawa, the hospital referral system dovetails with organized home care programmes in which the Order provides the nursing service and in some instances is the co-ordinating and administering agency of community-based home care plans.

HOMEMAKER SERVICES

Homemaker services are not a health service, but they perform a vital function in the support of health services by making it possible for the home to function when otherwise it would be interrupted by the illness of a member of the family. Thus, support for an ailing or disabled housewife may prevent the social and emotional breakdown of the family. Similarly, the care of the mentally retarded child in the home is made easier through the temporary relief of the parents. In many communities voluntary organizations other than those primarily interested in health sponsor such services. Family service agencies or child welfare agencies operate in this area since not only illness, but old age or desertion may deprive the home of the normal homemaker skills. In Toronto, Hamilton and Ottawa there now are independent visiting homemaker associations. In 35 communities the Red Cross offers the service. In Alberta and British Columbia the Canadian Cancer Society maintains a housekeeper service. The Poliomyelitis Foundation in Alberta also employs housekeepers. Government recognition of the importance of homemaker service may be seen in the Ontario Act to provide for the Services of Homemakers and Nurses which came into effect in August 1958.

RED CROSS BLOOD TRANSFUSION SERVICES

The Blood Transfusion Service represents a giant national co-operative partnership between governments, universities, hospitals and a national voluntary body, the Canadian Red Cross Society. With the opening of the Quebec City depot in November 1961, the Blood Transfusion Service became completely national in scope.

This programme, endorsed by the Canadian Medical Association in 1949, is so organized that the provincial governments provide and maintain the premises, the Society supplies the technical staff and equipment, the Connaught Medical Research Laboratories at the University of Toronto receive and process into plasma blood not used 10-14 days after collection. The blood donated by Canadians in all walks of life is administered to patients in Canadian hospitals. The operation of the service involves: (1) the establishment of provincial blood transfusion depots, (2) the recruitment and screening of volunteer blood donors and collection of blood, (3) the supply of blood and fresh blood to hospitals, (4) blood products and blood protein fractions, (5) free Rh antenatal testing service with detailed serological investigations, (6) making available to federal and provincial departments of health gamma globulin for control of infectious diseases, particularly infectious hepatitis, (7) services to Armed Forces, (8) services to Civil Defence Programmes, (9) research, and (10) an agreement with the American National Red Cross, enabling American tourists in Canada to receive blood free of charge while reciprocally Canadian residents receive blood free of charge in American hospitals.

The extent to which a voluntary organization can call on the resources of citizens is evident from the following data. In the calendar year 1962, 4,491 clinics were held, which 795,226 donors attended. As indicated in Table 6-3, in 1962, almost three-quarter of a million bottles of blood were collected. There has also been an increase in the use of blood fractionation products. From 1961 to 1962, the use of these products by hospitals, with the issue of gamma globulin, practically doubled, from 4,481 vials to 8,302 vials.

TABLE 6-3 BLOOD DONOR CLINICS: BOTTLES COLLECTED AND TRANSFUSIONS, CANADA, 1960–1962

Year	Bottles	Transfusions (Patients)
1960	668,684	227,997
1961	679,319	242,484
1962	744,006	271,686

SOURCE: Based on Canadian Red Cross Society, *Annual Report, 1962*, Toronto: The Society, Table I, pp. 56 and 57.

SICK-ROOM SUPPLIES, HOME CARE EQUIPMENT, APPLIANCES

With improved techniques for the care and rehabilitation of the chronically ill, and the increasing trend towards home care, the range of patient-aids is rapidly expanding. Patients in the home may require hospital beds, wheel-chairs, crutches, walkers, hoyer lifts, weight apparatus, bathroom aid equipment and a host of other items.

The voluntary agencies have taken the main responsibility for the provision of such equipment to patients. In the past, government participation generally has been limited to public welfare assistance to indigents but more recently aid has been made available to persons who qualify for assistance under the Vocational Rehabilitation of Disabled Persons Act of 1962 and to the victims of thalidomide. In the Act there is provision for making available those articles which will restore disabled persons to economic usefulness but the Act does not apply to children, the aged or those with progressive diseases. For persons in these categories the voluntary agencies have been a major source of assistance.

The Red Cross Sickroom Supply Loan Service, originally modelled after the British Red Cross Society's Loan Cupboard, provides, on an emergency basis and with a limit of three months, sick-room supplies such as hospital beds, crutches, wheel-chairs and other items. These articles are available without charge to patients otherwise unable to obtain them and they are loaned on the recommendation of a physician or a visiting nurse. This is an emergency service only, and while helpful for as long as it is provided, has often posed a problem for chronic patients and the doctors, nurses, social workers and physiotherapists attending them, as there has been no standard community resource in Canada for sick-room supplies for those patients who can or must be cared for at home. The Cancer Society frequently directs patients to this Service and consequently assumes responsibility for patients requiring the equipment for longer periods. In some communities the Canadian Cancer Society stocks such equipment.

From funds raised locally, the Multiple Sclerosis Society provides crutches, wheel-chairs, invalid lifts, hospital beds and other items on permanent loan to patients and also undertakes to repair patient-aids. The Canadian Paraplegic Association through supporting organizations such as the Canadian Legion, The Red Cross, Kiwanis, Rotary and Kinsmen Clubs, provides wheel-chairs and other patient-aids. The patient services of the Muscular Dystrophy Association include provision for purchase and repair of wheel-chairs, mechanical aids, lifters and orthopaedic braces. In some regions the provincial office of the Association attempts to serve patients in areas where there is no local chapter, sometimes working through the public health authorities.

The Cystic Fibrosis Foundation procures for its members at considerably reduced cost inhalation therapy tents and inhalation masks. The tents are sold by the national office to the provincial groups and to two organizations active in this field but not affiliated with the national body. The Foundation has succeeded in obtaining remission of customs duties and sales taxes, and assumes responsibility for transportation, repair and maintenance. Depending on their ability, the parents pay a portion of the cost, and the balance is made up by "sponsoring groups or individuals". Since the parents of afflicted children are faced with long-term outlay for costly antibiotic drugs, the benefit derived from participation in the organization is self-evident.

By sending physiotherapists to the home, the Canadian Arthritis and Rheumatism Society has been able to adapt patient-aids to individual requirements. Mindful of the needs of the handicapped in the activities of daily living and of the often prohibitive costs of commercially prepared items such as ramps, splints, and raised toilet seats, the Society helps to measure and advise on construction of these items which may be built or improvised at little cost.

TRANSPORTATION SERVICES, HOSTELS, AND SHELTERED WORKSHOPS

There are other services, though not directly related to health, on which in many cases the efficient provision of health services nevertheless depends. Among these are the patient's transportation (either provided in kind or paid for), hostels, and sheltered workshops, in all of which voluntary organizations play a vital part.

We have already referred briefly to the provision of transportation services and hostels. Here we wish to draw attention to the extent to which those afflictions requiring periodic treatment call forth a substantial effort on the part of voluntary health organizations. For example, in the treatment of cancer, many patients are unable to bear the costs of staying for extended periods at distant centres for radiation therapy, while a transportation problem may exist even if the patient lives in the same area. The Canadian Cancer Society and the various provincial member organizations of the Canadian Council for Crippled Children and Adults provide transportation for the groups they serve. The St. John Ambulance in New Brunswick operates a service known as the "Invalid Transport Programme". While this programme was originally devised to meet needs in rural areas not served by commercial ambulance companies, there have been requests for this service from the three larger cities and some smaller communities. One pilot project has been set up in a community of 1,500 population. In other organizations throughout the country, volunteer workers continue to provide transportation for the people they serve, although not on such a formal basis. The cost of transporting patients from outlying areas is sometimes met by voluntary organizations where this is not borne by government programmes.

If those patients who have travelled a long distance for treatment are not to use scarce active treatment beds, some type of accommodation must be provided. The Cancer Society has developed such hostels, specializing in building and equipping temporary living quarters for ambulatory cancer patients undergoing radiation therapy. Hostels have been built in Vancouver, Toronto, Hamilton, and London with the operating costs being met by patient fees or by subsidies from local governments or voluntary organizations for those who cannot afford to pay. Similarly the Canadian Mental Health Association and the Canadian Association for Retarded Children, as well as other voluntary organizations, have encouraged the development of, and in some cases have built close to urban treatment centres, small self-contained residences for the mentally ill or the disabled.

The need for a "half-way house" when moving back into regular economic activity along with the inability of many persons to lead a normal

TABLE 6-4 SHELTERED WORKSHOPS UNDER VOLUNTARY AUSPICES, BY CATEGORY, CANADA AND PROVINCES, FISCAL YEAR ENDING MARCH 31, 1963

Province	Business Enterprises	General and Community	Blind	Mentally Retarded	Total
Newfoundland	—	—	1	—	1
Prince Edward Island	—	—	—	1	1
Nova Scotia	11	—	—	1	12
New Brunswick	—	—	1	—	1
Quebec	1	11*	11†	5	28
Ontario	—	17‡	15	30[a]	62
Manitoba[b]	—	4[c]	3	2	9
Saskatchewan	—	4[d]	2	5	11[e]
Alberta	—	3	2	2	7
British Columbia	—	2[f]	5	2	9
CANADA	12	41	40	48	141

* Mostly in Montreal.

† Two sponsored by the Canadian National Institute for the Blind, one by Montreal Association for the Blind, one by Association Canadienne Française des Aveugles, one by Institution des Aveugles.

‡ Ten clinics sponsored by March of Dimes.

[a] One Canadian Association for Retarded Children workshop offers service to all handicapped.

[b] In Manitoba there is an inter-agency Workshop Coordinating Committee.

[c] Society of Crippled Children and Adults.

[d] Salvation Army, Council for Crippled Children and Adults.

[e] In Saskatchewan the Canadian Association for Retarded Children and Council for Crippled Children and Adults have one joint workshop.

[f] One by British Columbia Foundation for Poliomyelitis and Rehabilitation.

SOURCE: Based on "Preliminary List of Sheltered Employment Facilities in Canada", prepared by Department of Labour, made available by the Department of National Health and Welfare.

working life has led to the establishment of institutions to supplement both special schools and vocational training institutes, that is, sheltered workshops which are operated almost exclusively by voluntary organizations. In 1963, almost 200 such institutions were operated in Canada. The services they perform may be sub-contracting of clerical and light assembly work, refinishing of discarded household articles for resale, and the manufacture of small articles. Some workshops provide services for work assessment and work-conditioning for pre-employment adjustment to work habits. They also frequently provide terminal sheltered employment for those who are so physically or mentally disabled that they can never be expected to obtain normal employment. The sheltered workshops in many instances were developed for retarded or otherwise handicapped youths and young adults who could no longer benefit from special schools. Table 6-4 shows the distribution of sheltered workshops in Canada by category and province according to the latest data available. The rapid rate of growth of these organizations is evident since the 141 workshops listed in 1963 compare with an estimated 60 in 1960. The most significant and most rapid gain has been made by the Canadian Association for Retarded Children which now has more workshops listed than either those for the blind or those in the general and community category.

Some indication of the contribution made by voluntary organizations in assisting the totally disabled to become productive members of society within the limits of their disability can be seen from Tables 6-4 and 6-5.

TABLE 6-5 NUMBER OF PEOPLE EMPLOYED AND TOTAL SALES, CATERING DEPARTMENT, THE CANADIAN NATIONAL INSTITUTE FOR THE BLIND, CANADA AND PROVINCES, FISCAL YEAR ENDING MARCH 31, 1963

Division	Total Stands	Registered Blind Employees	Total Sales $'000
Newfoundland	17	29	501
Maritimes	55	73	1,027
Quebec	39	54	1,720
Ontario	190	228	7,014
Manitoba	35	43	878
Saskatchewan	21	36	442
Alberta	38	64	958
British Columbia	56	77	1,309
CANADA	451	604	13,849*

* Earnings of part-time and full-time registered blind employees amounted to $1.1 million.

SOURCE: Based on "Preliminary List of Sheltered Employment Facilities in Canada", prepared by the Department of Labour, made available by the Department of National Health and Welfare.

These agencies represent only a few of the organizations active in this area but they indicate the growing interest of the Canadian public in this valuable operation.

Research and the Education of Health Personnel

One area in which voluntary organizations have rapidly expanded their activities in recent years is that of the support of medical research and the training of research personnel. These activities, along with our recommendations in this area, are discussed in Chapter 4. Here we wish to make a brief reference to research and to the work of voluntary organizations as it relates to the education of professional personnel in the health field.

RESEARCH

The major purpose of several voluntary organizations is the support of medical research. In 1961, the Canadian Heart Foundation allocated $998,107 to its fellowship and grants-in-aid programme; the Muscular Dystrophy Association provided $279,822 and in 1963 supported 44 projects at a cost of $325,687; the Multiple Sclerosis Society expended $70,023; the Canadian Cancer Society, in 1960, allocated $2,053,000 or 47.2 per cent of its total budget to research.

Moreover, organizations that formerly devoted their efforts mainly to patient care, rehabilitation, or to education are now including the support of research as part of their activities. Thus, the C. A. Baker Foundation of the Canadian National Institute for the Blind allocated $75,000 to research in 1963. The Canadian Mental Health Association which launched five major research projects in the period 1959-1963 now maintains a research fund director to supervise the programme. Its expenditure for research in 1963 was $26,299. The Canadian Tuberculosis Association is now formulating a long-term programme of research with suggestions to the provincial divisions to allocate up to 5 per cent of Christmas Seals revenue for this purpose. In 1963, the Canadian Cystic Fibrosis Association undertook a $10,000 campaign for research funds to support genetic studies. The newly formed Rehabilitation Foundation for the Disabled, Ontario Branch, devoted $10,000 out of its regular funds for research and obtained an additional $45,000 from the Atkinson Foundation to investigate a method of pre-vocational training for severely handicapped children. The Canadian Hemophilia Society participates in clinical research and has also sponsored studies of the relationship between capillary fragility and bleeding.

EDUCATION OF HEALTH PERSONNEL

We have outlined also in Chapter 4 the assistance available from various voluntary sources for the training of health scientists entering a career in health research. In addition to sponsoring the training of research

personnel, the voluntary organizations have developed a wide-spread programme for the training of other health personnel.

The Canadian Cancer Society, the Canadian Arthritis and Rheumatism Society, and the Canadian Diabetic Society are among organizations that have provided financial assistance to physicians seeking special training in areas of interest to the specific organization, while La Ligue d'Hygiène Dentaire, with government assistance, has sponsored post-graduate training in dental hygiene for practising dentists. The Canadian Cancer Society and the Canadian Arthritis and Rheumatism Society have also financed the education of physiotherapists and technicians. The Poliomyelitis Foundation in Quebec and British Columbia has made grants to university schools of rehabilitation and physiotherapy.

The Victorian Order of Nurses awards about 50 bursaries annually with the recipients committed to work for one year in a position determined by the national office. Grants for advanced work have been given for administration, supervision and rehabilitation nursing. In 1961, 47 per cent of the organization's staff with specialized training had been recipients of the Victorian Order of Nurses' bursaries. The bursary programme of the Order undoubtedly explains, in part, its good staffing position. In 1960, the amount awarded was $46,748 and in 1961 the amount was increased to $49,138. In 1960, the St. John Ambulance Association established the Countess Mountbatten Bursary Fund for assistance to student nurses for post-graduate study or for some special field of nursing. At the end of 1962 the receipts for this fund were $23,730, and $4,556 had been disbursed. The Margaret MacLaren Memorial Fund is a national organization established to make awards to students of Nursing. Priority is given to those who have participated in the work of St. John Ambulance but others are also eligible. Four bursaries were awarded in 1964.

The Canadian Tuberculosis Association's support of professional education includes distribution of books, periodicals, and abstracts, as well as financial support of the Canadian Thoracic Society. The Canadian Mental Health Association has contributed to professional education in many different ways. A sub-committee of the Scientific Planning Council of the Association prepared a number of draft reports on psychiatric services in recent years.[1] The final report was published under the title *More for the Mind.* The Canadian Institute on Mental Health Services sponsored by the Canadian Psychiatric Association, and financed partly by Mental Health Grants, convened a committee of 150 delegates to consider these draft reports. The report of this committee stimulated a lively professional dialogue and paved the way for the national conference in March 1964,

[1] Tyhurst, *et. al., More for the Mind, A Study of Psychiatric Services in Canada,* Canadian Mental Health Association, Toronto: the Association, 1963.

sponsored jointly by the Canadian Mental Health Association, the Canadian Psychiatric Association, and the Canadian Medical Association, and dealt with the integration of psychiatry into all fields of medical practice.

The concern of the Canadian Association for Retarded Children in the appropriate training for specialists dealing with retardates has stimulated such institutions as the Children's Psychiatric Research Centre in London, Ontario. The Montreal Association for Retarded Children has launched as its centennial project a $300,000 Education, Research and Staff Training Centre. The Saskatchewan Division has decided to sponsor a professorship in mental retardation at the University of Saskatchewan, associated with the chromosome research unit. In Nova Scotia, the Association has planned an Atlantic Centennial Research Centre for Mental Retardation, stressing the biochemical and genetic aspects. Other provincial divisions have undertaken model community programmes. Other ways in which the Association contributes to professional development in this field are through a continuing programme of professional staff recruitment and development. In December 1963, the Association convened a national conference of scientific and professional leaders in the field of mental retardation to guide future projects.

The Canadian Council on Alcoholism[1] recognizes the need for communicating up to date information on the latest developments in treatment for the training of physicians, social workers, psychologists, lawyers, clergy, and nurses, if these are to be adequately prepared for their responsibility in this field. The Alcoholism Research Foundation of Ontario has provided a manual of scientific information for professional speakers, and, at the request of the Ontario Department of Education a booklet, designed mainly for teachers of physical and health education in secondary schools.

Public Information, Health Education, and First Aid

Health education, in its broadest sense, has always been a component of personal medical services. The physician, the dentist, and the nurse have always given medical advice or instruction to patients in carrying out preventive and treatment procedures. In the public health field, to a great extent in the past, public health officers enforced public health measures arising out of their knowledge of what was good for the people, "with reliance upon legal force whenever necessary".[2] This was possible in an era when

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[1] The Canadian Council on Alcoholism represents the Alcoholism Foundation of British Columbia, Alcoholism Foundation of Alberta, Bureau on Alcoholism, Department of Social Welfare and Rehabilitation, Saskatchewan, Alcoholism Foundation of Manitoba, Alcoholism and Drug Addiction Research Foundation of Ontario, Fédération des Maisons Domremy, Quebec, and the Nova Scotia Alcoholism Research Commission.

[2] Hanlon, John J., *Principles of Public Health Administration*, 3 ed. St. Louis: C. V. Mosby Company, 1960, p. 402.

individuals were regarded only as potential impediments to the implementation of wholesale preventive measures for the health of the community. Today, it is widely recognized that measures for attaining good health cannot be forced upon people, but when they are educated to their value, individuals will work to secure these benefits for themselves, their family, and their community. How this education is to be attained becomes a challenge for each community, and voluntary health organizations have moved to meet it. The activities of voluntary organizations in these areas continue to be the teaching of first aid, home nursing and child care, the development of educational programmes directed to the general public and to professional groups for the prevention of disease, and the dissemination of knowledge about good health practices and safety.

The responsibility for teaching home nursing and first aid for national preparedness is now shared by the Canadian Red Cross Society and the St. John Ambulance Association. The Association provides courses in senior home nursing, junior home nursing, senior child care, and junior child care, with these courses increasingly emphasizing the positive aspects of health education, accident prevention and home safety as well as simple basic skills for the care of the injured and the sick.[1] The Association is also responsible for all first-aid training for national preparedness in Canada, except Prince Edward Island and parts of Ontario where the Canadian Red Cross Society has provided this service since 1951. About 3,000 instructors conduct courses in first-aid, home nursing and child care. In addition, the St. John Ambulance also provides first-aid services at 174 first-aid posts maintained in five provinces, namely British Columbia, Saskatchewan, Manitoba, Newfoundland, and Ontario, one independently and three in co-operation with provincial motor leagues. The St. John Ambulance Brigade establishes, equips and staffs first-aid posts at fairs, exhibitions, organized sports events, and ski resorts. Thirty-three first-aid posts are maintained by the Society. A water safety programme is conducted by the Red Cross Society which trains instructors to set up and carry out programmes in communities across the country with volunteers assisting regular instructors at swimming pools, recreation centres and pools for the handicapped.

Accidents constitute only one of the major health problems. But while most others have to rely on medical science for a solution, the prevention of accidents is largely a matter of law enforcement, individual responsibility, and knowledge of safety measures. It is in this area, therefore, that voluntary effort can be expected to have a more immediate impact than in most other fields. The Canadian Highway Safety Council[2] has as its

[1] In 1961, the Red Cross had 8,442 persons and the St. John Ambulance Association about 8,300 persons attending classes in home nursing.

[2] Continuing the activities of the National Highway Safety Conference, first convened in 1955.

objective the reduction of motor vehicle accidents.[1] It promotes legislation, education of the public, safety measures such as the use of seat belts, design of safe vehicles and roads, and highway accident prevention generally. The Council supports financially the National Safety League of Canada and the Traffic Injury Research Foundation.

The National Safety League carries out some of its functions in conjunction with the Canadian Highway Safety Council mainly in the fields of home, farm, child, and recreational safety. In the area of industrial safety, provincial health departments and workmen's compensation boards are assisted by the Industrial Accident Prevention Association, the Canadian Industrial Safety Association, and several province- or industry-wide organizations. The Red Cross Society and the St. John Ambulance also provide instruction in safety measures and in first-aid.

The Canadian National Institute for the Blind has an active programme for blindness prevention including dissemination of information through mass media education and the Wise Owl clubs now existing in 432 Canadian companies.[2] The Health League of Canada is concerned with industrial safety through its publications in the area of industrial health.

Having recognized accidents as a major cause of injury, death, and demand for health services,[3] it is important that the agencies concerned with their prevention, like the other voluntary health organizations, participate in the work of the Planning Councils we discuss in Chapters 7 and 8.

The Commission recommends:

223. That agencies concerned with the prevention of accidents participate in the work of the Health Planning Councils at the various levels and in particular with regard to measures to prevent highway accidents.

Other voluntary organizations also conduct extensive campaigns in the field of health education. The parental guidance and counselling service of the Canadian Association of Retarded Children is one example of health education. Hand in hand with this, a programme, making available pamphlets, films and speakers, has enlisted community support by increasing understanding of the nature and the extent of the problem. The Canadian Arthritis and Rheumatism Society, in describing its public information service, states that it is designed to stimulate public interest and understanding in both

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[1] Between 1961 and 1963, the number of fatalities from motor vehicle accidents in Canada has increased by 562 to a total of 4,444; the rate per 100,000 population climbed from 21.3 in 1961 to 23.6 in 1963. We have estimated the cost of health services due to all accidents as close to $75 million in 1961. *See* Volume I, Chapter 5, p. 216.

[2] The Wise Owl clubs were established in co-operation with Industrial Safety Council in 1961. Membership is given as an award to a person who averted eye injury by taking precautions.

[3] *See* Volume I, Chapter 5.

arthritis and the work of the Society, using a variety of media, with emphasis on the warning signs to encourage early diagnosis and treatment. The literature and films are aimed at different audiences, namely members and friends, patients, the general public, and family physicians and specialists in rheumatology or physiatry to whom it also distributes pathological and clinical slides.

The Muscular Dystrophy Association publishes a quarterly newspaper, the Muscular Dystrophy Reporter. The 47 home teachers of the Canadian National Institute for the Blind provide a service in health education to the partially sighted and newly blinded as well as to their families.

Health education is high on the list of activities of the Canadian Diabetic Association. Included in this category are diet counselling, summer camps which seek to establish appropriate regimes, patient clubs, manuals, educational meetings, a quarterly newsletter as well as a school for diabetics which has been sponsored in Moncton, New Brunswick. The approach taken by the Canadian Paraplegic Association is to demonstrate the ability of the paraplegic to compensate for disability by use of intelligence and development of residual skills. Thus athletic teams have been an element in public education of the potential of the handicapped. The Canadian Mental Health Association has done a very competent job of fostering principles of mental health and removing some of the stigma attached to mental illness. This has been accomplished to some degree by mass media but more effectively through mental health workshops and study groups and through the involvement of volunteers in communities who are daily removing the barriers between the mental hospital and the community.

In its cancer prevention programme, the objective of the Canadian Cancer Society has been to acquaint the public with symptoms that may be significant and to lead physicians to undertake routine cytological examinations of women patients. The success of its education programme can be judged by the findings of public opinion polls which indicated that the proportion of women interviewed who know that cancer is not necessarily incurable rose from 63 to 71 per cent over the period 1954-1960, while in the same period the proportion that recognize the need for early treatment rose from 80 to 87 per cent. Currently, the Society is attempting to educate people about the hazards of cigarette smoking. Health education programmes in this area require careful co-ordination and planning between health and education authorities as well as the enlistment of voluntary agencies to reach the young persons vulnerable to the hazards of smoking. It is precisely in the area of motivating persons to change their behaviour that more refined techniques of education must be learned and applied.

The Canadian Hemophilia Society publishes a news bulletin entitled "Hemophilia Today" which combines organization news with development in the field. In 1963, the Society agreed with the Canadian Rehabilitation

Council for the Disabled that certain phases such as information and channelling research projects would be undertaken in the near future by the Council. The Canadian Heart Foundation makes available non-technical information for the general public through "Pulse", a monthly news bulletin, as well as through speakers, pamphlets, radio and television announcements, and literature distributed through the provincial health and welfare departments. There is no direct service to patients; consequently, no direct health education programme aimed at them.

La Ligue d'Hygiène Dentaire de la Province de Québec, established in 1942 as a committee of the Quebec College of Dental Surgeons, aims its education programme at the promotion of dental hygiene and the prevention of dental disease. It concentrates on those persons who are thought to have the greatest responsibility for the health of young children: nurses, mothers, and teachers.

While most voluntary health organizations employ persons for publicity or public relations purposes, very few have made it a practice to employ health education specialists. The Canadian Tuberculosis Association has had a health education consultant on its staff since 1943. The Ontario Tuberculosis Association, the Canadian Mental Health Association, the British Columbia Alcoholism Foundation and the Canadian Junior Red Cross have employed health education specialists as executive directors or programme directors.

The Health League of Canada continues to emphasize its primary aim of disseminating health information and popular health education in the field of prevention. Its main publication "Health" is published bi-monthly, partly in French, and reaches a paid circulation of approximately 35,000 which includes about 12,000 medical practitioners. The Canadian Life Insurance Officers Association has undertaken to supply complimentary subscriptions to all general medical practitioners across the country.

The League whose role is primarily educational has consistently campaigned for improved legislation in health matters. It has urged the passage of laws making pasteurization of milk universal in Canada, and taken a determined stand on the issue of fluoridation and dental health.

SOURCES AND DISTRIBUTION OF FUNDS

An analysis of the financial structure of voluntary health organizations can only be done in a limited fashion. Financial data were not available for many provincial organizations or available only in summary form for many others. As a consequence, the data relating to sources and distributions of funds of voluntary organizations which we present here are incomplete.

However, they do include the major voluntary health organizations in Canada and, therefore, are indicative of the magnitude of support that Canadians provide for these activities. It must be emphasized that most voluntary organizations do not follow a standardized accounting procedure and the various reporting systems they use make comparisons of institutions a difficult task. However, we believe that the data we present provide a reasonable picture of how voluntary organizations distributed their funds in 1963.

Sources of Funds

Voluntary organizations derive their income from a variety of sources: donations made by the public directly or through federated funds,[1] payment by governments for services rendered, grants from governments, payments by the public for health services, interest on investments and other minor sources.

Grants by the Federal Government are made to support the activities of a number of voluntary organizations. As Table 6-6 shows, 16 organizations received grants in 1963 varying in amount from $1,400 to $55,000. Federal Government support to voluntary health organizations is contingent upon recommendation by the Department of National Health and Welfare. This provides the organization with recognition of the usefulness of its endeavours. It qualifies the organization for the receipt of a federal grant and also is helpful in campaigns for public support. Thus, apart from their monetary value, these grants have the effect of enhancing the status of the organization. Once established, the grants are continued subject to a review of the organizations' annual reports. Some organizations such as the Canadian Heart Foundation and the National Cancer Institute do not receive grants under this category but may receive support from the Federal Government directly or indirectly as, for instance, through research grants.[2]

Since they purchase a large amount of health services from voluntary organizations, provincial governments are a substantial source of government support to the voluntary organizations. In addition, they too may allocate grants in recognition of the functions of a particular association. The same policy is followed by some municipalities.

Table 6-7 summarizes grants and payments received by voluntary agencies from governments at all levels. Of the 12 organizations for which data are available, 3 show no direct government financial support in 1963

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[1] A federated fund is a community appeal which is made jointly by a group of voluntary organizations, usually from both the health and welfare fields, and which is centrally administered. The receipts of the fund are distributed among members on the basis of an agreed formula.

[2] The Canadian Red Cross Blood Transfusion Service receives financial support from the provincial governments under their Hospital Insurance plans equal to approximately 50 per cent of the technical cost of the service (i.e., excluding the cost of donor procurement).

while the remainder received grants which varied between .7 per cent of total income (Canadian Cancer Society) and 29.8 per cent (Canadian Paraplegic Association), with the average for the 12 organizations being 14.1 per cent of total income. A comparison of Table 6-6, Federal Grants to Voluntary Health Organizations, 1963, with the "Government Grants" column of Table 6-7, indicates the level of support by federal and provincial governments. For example, the Victorian Order of Nurses received $833,000 in government grants of which $20,000 was from the Federal Government, the Canadian Paraplegic Association received $78,000, of which $15,000 was from the Federal Government, and the Canadian National Institute for the Blind received $380,000 of which $55,000 was from the Federal Government. It is possible that, apart from the grants shown in Table 6-6, other government assistance was received but it cannot be identified.

TABLE 6-6 FEDERAL GRANTS TO VOLUNTARY HEALTH ORGANIZATIONS, CANADA, 1963

Organization	Amount of Grant
	$
Canadian Mental Health Association	15,000
Health League of Canada	15,000
Canadian Public Health Association	7,500
Canadian National Institute for the Blind	55,000
L'Association Canadienne Française des Aveugles	6,000
L'Institut Nazareth de Montréal	4,050
Montreal Association for the Blind	4,050
Canadian Tuberculosis Association	20,250
Victorian Order of Nurses	20,000
St. John Ambulance	15,000
Canadian Red Cross Society	10,000
Canadian Paraplegic Association	15,000
Canadian Association for Retarded Children	5,000
Commonwealth Council for Royal Life Saving Society	1,400
Canadian Highway Safety Council	25,000
Canadian Rehabilitation Council	7,000
TOTAL	225,250

SOURCE: Data supplied by the Department of National Health and Welfare.

The voluntary health organizations derive most of their income from public donations. These gifts are made in various forms: direct donations to the agency by an individual or corporation, bequests, payments for memberships and contributions to federated funds. Table 6-7 shows that the organizations listed obtained about 70 per cent of their total income from these sources.

TABLE 6-7 INCOME AND EXPENDITURE: SELECTED NATIONAL VOLUNTARY ORGANIZATIONS, CANADA, 1963

Organization		Income					
		Government Grants	Federated Funds	Interest from Securities Investments	Donations, Memberships and Bequests	Other	Total Income
Canadian Arthritis & Rheumatism Society	$	167,000	600,000	30,000	290,000	135,000	1,222,000
	%	13.7	49.1	2.4	23.8	11.0	100
Canadian Cancer Society	$	30,000	69,000	65,000	4,170,000	—	4,334,000
	%	.7	1.6	1.5	96.2	—	100
Canadian Diabetic Association	$	—	—	—	72,000	23,000[d]	95,000
	%	—	—	—	75.7	24.3	100
Canadian Heart Foundation	$	—	47,000	69,000	1,197,000[e]	412,000	1,725,000
	%	—	2.7	4.0	69.4	23.9	100
Canadian Mothercraft Society	$	11,000	—	36,000	6,000	40,000	93,000
	%	12.2	—	38.4	6.8	42.6	100
Canadian National Institute for the Blind	$	380,000	1,129,000	138,000	959,000	—	2,606,000
	%	14.6	43.3	5.3	36.8	—	100
Canadian Paraplegic Association	$	78,000	—	6,000	106,000	72,000[l]	262,000
	%	29.8	—	2.1	40.5	27.6	100
Canadian Red Cross Society	$	1,987,000[n]	2,703,000	145,000	3,426,000	1,643,000	9,904,000
	%	20.0	27.3	1.5	34.6	16.6	100
Health League of Canada	$	23,000	78,000[q]	2,000	24,000	27,000[r]	154,000
	%	14.8	51.0	1.2	15.5	17.5	100
Multiple Sclerosis Society	$	5,000	29,000[u]	200	85,000	—	119,200[s]
	%	4.2	24.5	.2	71.1	—	100
Muscular Dystrophy Association	$	—	115,000	21,000	312,000	—	448,000
	%	—	25.6	4.6	69.8	—	100
Victorian Order of Nurses	$	833,000	1,579,000[u]	98,000	220,000	1,309,000[v]	4,039,000
	%	20.6	39.1	2.4	5.4	32.5	100
TOTAL	$	3,514,000	6,349,000	610,200	10,867,000	3,661,000	25,001,200
	%	14.1	25.4	2.4	43.5	14.6	100

TABLE 6-7 INCOME AND EXPENDITURE: SELECTED NATIONAL VOLUNTARY ORGANIZATIONS, CANADA, 1963— (*Concluded*)

Organization		Expenditure						Surplus or Deficit
		Patient Services	Research	Public Education	Administration	Other	Total Expenditure	(+ or −)
Canadian Arthritis & Rheumatism Society	$	765,000	232,000	63,000	190,000	41,000[a]	1,291,000	−69,000
	%	59.2	18.0	4.9	14.7	3.2	100	
Canadian Cancer Society	$	624,000	2,032,000	770,000	538,000[b]	175,000[c]	4,139,000	+195,000
	%	15.1	49.1	18.6	13.0	4.2	100	
Canadian Diabetic Association	$	24.000	21.000	10.000[e]	33,000	9,000	97,000	− 2,000
	%	24.8	22.1	10.3	33.6	9.2	100	
Canadian Heart Foundation	$	—	1,180,000	183,000[g]	245,000[h]	—	1,608,000	+117,000
	%	—	73.4	11.4	15.2	—	100	
Canadian Mothercraft Society	$	16,000	—	1,000[i]	82,000	—	99,000	− 6,000
	%	16.0	—	.8	83.2	—	100	
Canadian National Institute for the Blind	$	2,547,000[j]	—	—	382,000	125,000[k]	3,054,000	−448,000
	%	83.4	—	—	12.5	4.1	100	
Canadian Paraplegic Association	$	200,000[m]	—	—	97,000	—	297,000	− 35,000
	%	67.3	—	—	32.7	—	100	
Canadian Red Cross Society	$	7,385,000	—	1,296,000	889,000[o]	279,000[p]	9,849,000	+ 55,000
	%	75.0	—	13.2	9.0	2.8	100	
Health League of Canada	$	—	—	58,000	51,000	37,000[r]	146,000	+ 8,000
	%	—	—	39.6	35.3	25.1	100	
Multiple Sclerosis Society	$	4,000	71,000	6,000	23,000	—	104,000	+ 15,200
	%	4.2	68.4	5.7	21.7	—	100	
Muscular Dystrophy Association	$	26,000	326,000	19,000[t]	85,000	—	456,000	− 8,000
	%	5.8	71.4	4.2	18.6	—	100	
Victorian Order of Nurses	$	3,399,000	—	4,000	708,000	48,000[w]	4,159,000	−120,000
	%	81.7	—	0.1	17.0	1.2	100	
TOTAL	$	14,990,000	3,862,000	2,410,000	3,323,000	714,000	25,299,000	297,800
	%	59.3	15.3	9.5	13.1	2.8	100	

SOURCE: Annual Reports of the Selected Agencies, 1963. National Agency Review Committee (NARC) reports, 1964, for fiscal year 1963. Canadian Welfare Council, Allocations to National Organizations by Canadian Community Funds, 1963.

[a] Professional information service.
[b] Includes cost of fund raising—$239,000.
[c] Grants to provincial cancer foundation.
[d] Includes $5,000 from sale of publications and $5,000 from research.
[e] Agency titles this "education and publicity".
[f] Canadian Heart Fund 1963 campaign receipts.
[g] Agency titles this "professional and public education".
[h] Includes cost of fund raising—$125,000.
[i] Agency titles this "advertising and publicity".
[j] Includes $829,000 for salaries for field workers and blind field secretaries.
[k] Operation of a braille and recorded book library.
[l] Revenue from the sale of wheelchairs and prosthetic devices, and revenue from patients.
[m] Includes salaries of rehabilitation staff.
[n] Most of these grants are the government's share of the technical cost of the blood transfusions service—$1,971,000.
[o] Includes campaign expenses and supplies—$433,000.
[p] International work.
[q] Received from Greater Toronto United Appeal.
[r] Revenue and expenditure on Health magazine.
[s] Chapters retain $4,000 for patient services.
[t] Agency titles this "public and professional information".
[u] These are the figures as supplied by the national organization.
[v] Nursing fees—$1,271,000.
[w] Expenditure on bursaries—$40,000.

Table 6-7 indicates that those organizations which join federated funds derive a significant proportion of their income from this source. Of the 12 organizations which are full participants, the range varied from 27.3 per cent (Canadian Red Cross Society) to 51.0 per cent (Health League of Canada) of their total income.[1] The Canadian Heart Foundation and the Canadian Cancer Society are members in a few communities only and therefore derive only 2.7 per cent and 1.6 per cent of their respective incomes from this source. In 1963, there were 115 federated funds operating in Canada. Chart 6-1 and Chart 6-2 indicate that of the $25.4 million collected in 1963 by the funds for all purposes, almost $8 million was allocated to health organizations. The smaller organizations have benefited especially by this method of fund raising as they have been able to avoid mounting their own financial campaigns. The large organizations increasingly have joined these common drives because of the growing use of the payroll deduction method of voluntary giving to federated fund appeals in various communities.

The largest single source of income for voluntary health organizations is the donations of individuals and corporations. Organizations which are not members of federated funds depend on this source more heavily than member organizations. From the data available, it was not possible to separate the amount given by corporations from the total donations for each organization.[2] The importance of combined corporate and individual donations for those organizations not extensively members of federated funds may be seen in Table 6-7. For example, the Canadian Cancer Society in 1963 derived 96.2 per cent of its income from private and corporate donations (including membership fees and bequests), and the Canadian Heart Foundation derived 93.3 per cent from these sources. However, even where the organization is a member of federated funds, donations in various forms by the public or corporations still constitute a large part of its income. Table 6-7 shows that for the 12 organizations the average proportion of income from this source was 43.5 per cent. The Victorian Order of Nurses is an exception to the general rule in that it received only 5.4 per cent of its income from direct public donations. The explanation is that in view of the services it renders the Order receives some payment for its services either from patients or from governments on their behalf.

The final major category of income used in Table 6-7 is the category "other", which includes miscellaneous income and income derived from

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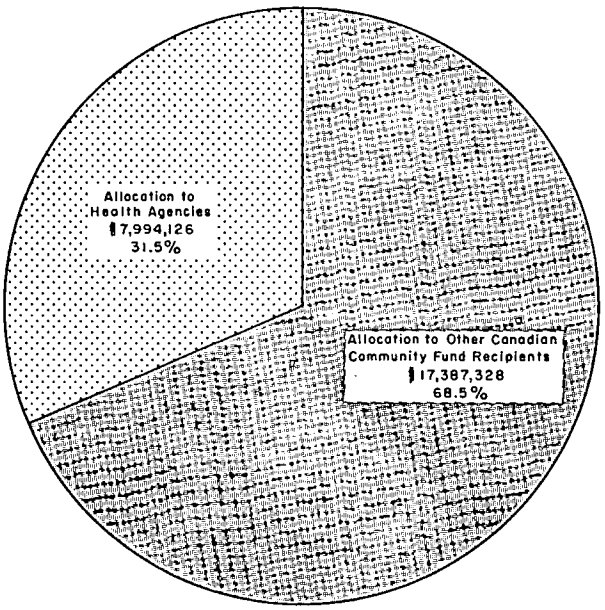
[1] The Canadian Diabetic Association, Canadian Hemophilia Society, the Canadian Hearing Society, the Canadian Mothercraft Society, the Canadian Cystic Fibrosis Foundation and the Canadian Paraplegic Association do not participate. The Canadian Heart Foundation and the Canadian Cancer Society are members in only a few communities.

[2] From 1950 to 1959 corporate charitable donations (to health and welfare) rose from $23.7 million to $42.4 million. In the same period individual donations rose from $100 million to $380 million. *See* Watson, J. H., Douglas, M., *Company Contribution in Canada,* National Industrial Conference Board, Montreal, 1963.

CHART 6-1

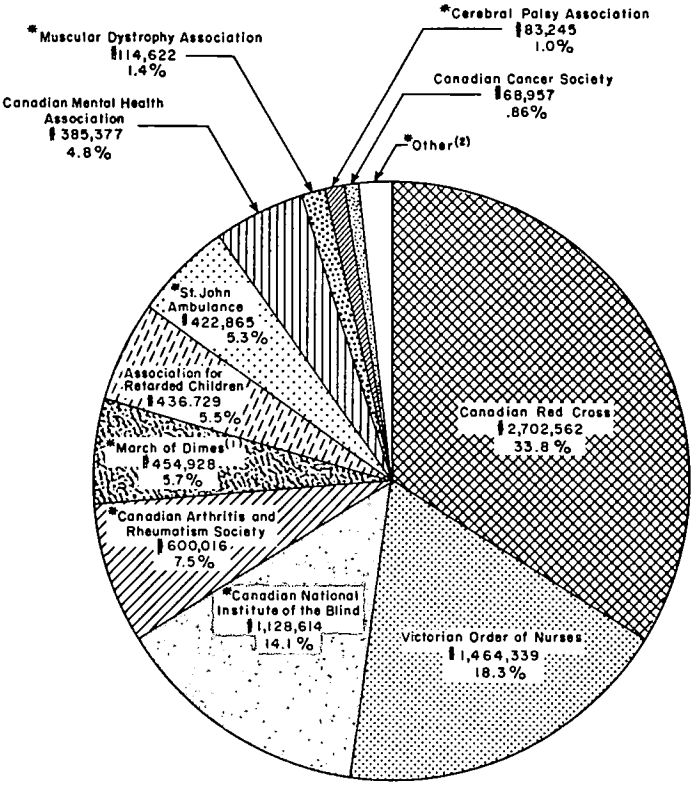
PROPORTION OF TOTAL CANADIAN COMMUNITY FUNDS GIVEN TO HEALTH AGENCIES: 1963



Source: Allocations to National Organizations by Canadian Community Funds, Community Funds and Councils Division, the Canadian Welfare Council, July 1963.

CHART 6-2

ALLOCATIONS BY AGENCIES OF TOTAL GIVEN TO NATIONAL HEALTH ORGANIZATIONS - 1963



(1) Rehabilitation Foundation for Poliomyelitis and Orthopaedically Disabled

(2) Canadian Heart Foundation:.....$46,985, .6%
Canadian Tuberculosis Association: $2,115, .03%
Crippled Children and Adults:..... $24,487, .3%
Multiple Sclerosis Society:.....$57,815, .7%
Federation of the Blind: ..... $500, .006%
Total...$131,902, 1.7%

*Allocations to National Organizations by Canadian Community Funds

Source: Community Funds and Councils Division,— The Canadian Welfare Council, July 1963.

sources specific to an individual organization. For example, the Canadian Diabetic Association obtains money earmarked for research from the sale of publications; the Mothercraft Society and the Victorian Order of Nurses receive money from patients for services performed; the Canadian Paraplegic Association derives an income from the sale of wheel-chairs, prosthetic devices and from services to patients; and the Red Cross Society derives an income from services rendered in clinics and hospitals, instructional programmes, homemaker services, veterans' services and the Junior Red Cross. In 1963 the 12 organizations in Table 6-7 derived 14.6 per cent of their total income from these "other" sources.

Distribution of Funds

Voluntary health organizations have developed either to provide services or to finance research. Consequently the largest portion of each organization's funds is spent on patient services or on research, depending on the organization's orientation. This is borne out by Table 6-7. The Canadian Arthritis and Rheumatism Society, the Canadian National Institute for the Blind, the Canadian Paraplegic Association, the Red Cross Society, and the Victorian Order of Nurses all spend most of their income on patient services. The Canadian Cancer Society, the Canadian Heart Foundation, the Multiple Sclerosis Society, and the Muscular Dystrophy Association, on the other hand, all spend most heavily on research projects. For the 12 organizations listed, 59 per cent of the expenditure was allocated to patient services, and 15 per cent to research. However, 6 organizations spent nothing on research.

Voluntary organizations depend upon support from private citizens and corporations, and they have to keep the public aware of their role in the health field. Many organizations do this at the same time as they are trying to educate the public with respect to a specific disease and preventive health measures. If the agency spends its funds solely for advertising, that is, to gain financial or other support from the public, then it is not a public education cost. However, in most cases the organizations combine education and advertising costs in their financial reports and it is impossible to separate them. In Table 6-7 where they appear combined, they have been placed in the public education category and footnoted accordingly. Advertising costs alone were regarded as a fund-raising cost and included in the administrative cost category.

Two of the organizations included in Table 6-7, namely the Canadian National Institute for the Blind and the Canadian Paraplegic Association, are listed as having no expenditure on public education in 1963. The remaining 10 spent from 0.1 per cent (the Victorian Order of Nurses) to 39.6 per cent (Health League of Canada) of total expenditure in 1963. The average

proportion of total expenditure allocated to this area by the 12 organizations was 9.5 per cent.

The final expenditure common to all voluntary organizations is for administration. As the data available for the compilation of Table 6-7 were not homogeneous due to the disparate methods of financial reporting, the administrative category is necessarily a broad one. The general definition used was that any expenditure that was not directly related to patient services, research or public education, but did relate to the machinery for the provision of these services, was an administrative cost. In this fashion, the cost of fund-raising was included in the administrative category.

In Table 6-7, administrative expenditures formed, with one exception a quite regular proportion of total expenditure. The average expenditure for administration in 1963 by the 12 organizations was 13.1 per cent of total expenditure. The Canadian Mothercraft Society spent the highest proportion on administration. However, this is the consequence of a reporting system that did not separate the salaries of staff responsible for operating the society's hospital from those of the administrative staff. Considering the other 11 organizations, it may be seen that, generally, the larger the organization the smaller the proportion of total expenditure spent on administration. In other words, there seem to be economies of scale in the voluntary field. However, any comparison of administrative costs must bear in mind that the different organizations have different administrative structures and different reporting procedures.

These differences may also account for the residual expenditure category used in Table 6-7, which includes as "other" all those expenses that did not fit in the other four categories. The average expenditure in 1963 on this category was 2.8 per cent.

ORGANIZATION

Although health and welfare in Canada are matters that are largely under provincial jurisdiction, there is also federal legislation that permits voluntary organizations to obtain national incorporation. In consequence, voluntary organizations may be incorporated nationally, provincially or both. In some cases, local chapters may be incorporated as well, so that any organization may have national, provincial and local chapters all with some degree of autonomy and with powers and responsibilities varying between organization levels.

In the development of voluntary organizations the movement has gone two ways, either from the national level to the provinces and regions or from the local or provincial society to the national level. Such movements have,

of course, called for considerable adaptation at all levels, not only in the structure of the organization, but in the functions to be carried out and the priorities to be established. For example, the Canadian Mental Health Association, originally founded as a national organization, had as its main purpose public education for an enlightened approach toward treatment of mental illness, as well as the promotion of mental health. However, some local chapters and provincial divisions developed out of older societies which had already built up programmes of voluntary visiting to mental hospitals, recreational programmes for the psychiatric patients and social action of a purely local (e.g., SHARE in Manitoba) or provincial (Nova Scotia) nature.

In contrast, the Canadian Association for Retarded Children underwent considerable evolution on a local and provincial level before 1955 when seven provincial associations joined to form the Canadian Association for Retarded Children. Another three years were to pass before the national organization received its Letters Patent. Staffing and financing a national office came even later, in 1959, as local priorities for the establishment of facilities for the trainable retarded consumed the time, energy and finances of the determined parents. As local and provincial governments began to assume increasing responsibility for the trainable, as well as the educable and custodial categories of the mentally retarded, the Association moved to achieve effective liaison with the federal and other governments on a national basis.

Other organizations with varying distribution of responsibility for the implementation of broad national policy are: the Canadian Foundation for Poliomyelitis, the Canadian Society for Crippled Children and Adults,[1] the Canadian Cystic Fibrosis Foundation, the Canadian Hemophilia Society, the Multiple Sclerosis Society of Canada and the Muscular Dystrophy Association. The national office assumes responsibility for the provision of educational materials and administers research programmes while the local associations negotiate methods of fund-raising and devise programmes of patient-aid. The Canadian Arthritis and Rheumatism Society provides an example of what appears to be a balance of powers with regard to decisions concerning programming and distribution of staff. Like most of the organizations discussed above there is a National Board of Directors advised by a National Medical Advisory Board. There is a structure at the provincial divisional level, with most divisions being administered by medical directors, full- or part-time. Conforming with the usual pattern, the research and professional education programme is administered nationally, and there is a central mailing list. Tabulation and analysis of treatment statistics are done at the national level.

[1] These two organizations joined nationally in 1962 to form the new Rehabilitation Council for the Disabled. Each agency retained its own national charter. While most provincial and local societies have followed the example set by the national organization, some have not.

This is possible when there are professionals in the health field at the local level who provide the data.

Other distributions of functions exist, however. For example, provincial divisions have only been developed since 1953 in the Victorian Order of Nurses; the local chapters have the responsibility for raising sufficient funds to operate on a financially self-sufficient basis. The national office maintains statistics, determines policies and standards and is responsible for the hiring and allocation of staff. The national office also assists in establishing new branches and new services.

In the St. John Ambulance, the national headquarters provides general direction and supervision of instruction and voluntary services including the preparation of instructional material and maintenance of central purchasing and stores. The Canadian Cancer Society is affiliated with the National Cancer Institute but incorporated separately, with the latter being the research branch of the Society. The president of each is appointed as officer to the board of the other, and there is a joint executive director and treasurer. The Canadian Red Cross has a Central Council consisting of approximately 60 members which is the governing body of the Society. Twenty national standing committees co-ordinate the provincial and local efforts in their area of concern and provide continuity in policy.

VOLUNTARY HEALTH ORGANIZATIONS IN SELECTED COUNTRIES WITH COMPREHENSIVE HEALTH SCHEMES

Some concern has been expressed to us that the advent of a comprehensive health care programme may seriously affect individual initiative and voluntary effort, which have played such a significant role in the development of health services in Canada. In fact, however, the broader the concept of health care and the more extensive the provision for it, the greater is the responsibility of every citizen and every group for the promotion of community health. This is evident from a summary of activities in countries with comprehensive health programmes, illustrating the way in which voluntary organizations are supplementing the statutory agencies in the development and elaboration of existing services, and are leading the way in the exploration of new ones. In fact, the analysis of the experiences of other countries with the comprehensive health schemes has confirmed our own conviction that there is an expanding and even more useful place for voluntary organizations in Canada. They can be of even greater service to the Canadian people within the framework of an all-inclusive health service programme.

In considering the voluntary organizations in other countries, it is noteworthy that there is a growing tendency for Canadian voluntary organizations to be associated with them in international bodies. In some instances, Canadians have taken an active lead in the development of international standards, for example, in rehabilitation, mental retardation and tuberculosis, in the management and control of disease, as well as in the implementation of those preventive measures which will contribute to the well-being of mankind. We review below developments in the following countries: United Kingdom, Denmark, Sweden, Norway, New Zealand, and Israel.

United Kingdom

It might be thought that under the British National Health Service the role of the voluntary organization would have diminished. This however has not been the result. "Voluntary bodies have proved to have a role to play, working in co-operation with State agencies, not in competition with them, and voluntary workers are active not only in the service of voluntary bodies, but also of official ones and in the conduct of public affairs."[1] As the traditional areas of responsibility, particularly the financial support of existing services, have gradually been replaced by the expansion of public social services, the energies of voluntary groups have been directed to the development of new services. "In exploring new or better ways to help people in various kinds of distress, the voluntary bodies have a freedom to innovate and experiment which is not open to bodies limited by the terms of their statutory powers and accountable to the public as a whole for the way they spend their funds."[2] They bring to their work a devoted enthusiasm and an independence in approach which militate against the rigidity or remoteness which can occur in undilutedly expert and official systems.[3]

Among the areas where voluntary organizations have continued to operate is the provision of supporting services for those who are ill or handicapped and are not in hospital. The Women's Voluntary Service is the leading British voluntary organization in the area of provision of services to the handicapped. Through its 1,500 W.V.S. centres it lends a hand in the practical difficulties of the handicapped, visiting the sick, bringing "meals on wheels" to the home-bound, minding children, and carrying out relief work for the victims of fire and flood.

Another area of service where voluntary organizations continue to make a contribution is the provision of ambulance services. Local authorities

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[1] British Information Services; *Voluntary Service to the Community in Great Britain*, No. R5089, August 1961, p. 1.
[2] *Ibid.*, p. 3.
[3] *Ibid.*, p. 1.

who bear the responsibility for providing ambulance services in some cases have entered into agreements with the Order of St. John and the British Red Cross Society to provide all or part of the service. The Hospital Car Service is an area where the role of voluntary organizations in ambulance service may expand, organized by the British Red Cross, the St. John's Ambulance Brigade, and the Women's Voluntary Service, it relieves pressure on the National Health Service ambulance service by providing free transportation in private cars.

Voluntary organizations provide valuable services in helping the mentally disordered. The largest voluntary association aiding the mentally disordered is the National Association for Mental Health. Others include the National Society of Mentally Handicapped Children, the Mental Health Research Fund, and the Mental After Care Association. The League of Friends provides volunteer visitors to many mental hospitals. The National Association for Mental Health alone, or in partnership with local authorities and other organizations, operates hostels for the retarded or the mentally ill. The Association stimulates progress in mental health by sponsoring public and professional education and by carrying out pilot projects on new services.

Finally, voluntary organizations are represented on the Regional Hospital Boards. All members of these Boards serve without remuneration on honorary appointments.[1]

Denmark

Despite extensive public participation in health care in Denmark, the voluntary organizations continue to have a significant role in the Danish health programme. As a recent report pointed out there are "a number of fields, e.g. of an experimental character, where private effort has its special merits".[2]

In many cases it was private initiative which originally provided a service for the handicapped. When public support became necessary, many of the voluntary agencies continued to provide services financed by public funds while special services for the handicapped were provided exclusively by voluntary organizations who received State grants.

In addition, there are institutions which attend to special categories of disabled persons: the Association for Spastic Children, the National Association for the Prevention of Multiple Sclerosis, the I.R.P. (assisting the group suffering from polio-induced respiratory paralysis), the Association

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[1] *Health Services in Great Britain*, Central Office of Information, Reference Pamphlet No. 20, London: Her Majesty's Stationery Office, 1960, p. 11.

[2] *Rehabilitation and Care of the Handicapped in Denmark*, International Relations Division, Ministries of Labor and Social Affairs, Copenhagen: 1963, p. 10.

for the Establishment and Running of Children's Institutions for Spastic and other Handicapped Children, the Danish National Association for Infantile Paralysis, the Sanatorium Association of the Co-operative Societies (for rheumatic diseases), and the National Association for the Prevention of Rheumatic Diseases all operate institutions for their special groups. The Cripples Fund, a voluntary fund-raising agency, carries out comprehensive projects for the benefit of the crippled.

Although epileptic patients receive treatment in general hospitals, the main responsibility for epileptics in Denmark lies with the State-approved private institution, the Filadelfia Colony. The operating expenses of this organization are paid mainly from public funds but the administration is under voluntary auspices. The National Association for Epilepsy is a patient-member organization of epileptics.

Basic medical, educational and vocational services for the blind and partially sighted are provided by the State, under a joint administrative sponsorship with voluntary organizations. This government service provides institutes, printing, a library for the blind, a clinic dedicated to fighting hereditary blindness, a registration system, and educational and employment opportunities for both young and old. Within this government framework the voluntary agencies have a small but significant role. The Danish Society for the Blind and other voluntary organizations and institutions run State-approved nursing homes and apartments; and a counselling service to give the blind help and guidance is run co-operatively by the State and the Danish Society for the Blind. Finally, there is one private industry that, in close co-operation with the government, employs blind personnel almost exclusively.

As with the blind, care of the deaf is largely carried out by the State. However, again the general programme is supervised by a joint board representing both government and voluntary bodies interested in the care of the deaf. With respect to the voluntary organizations, the Danish National Association for the Deaf represents the interests of the deaf. The hard of hearing are represented by the National Association for the Promotion of Better Hearing.

The care of those suffering from speech defects is provided free of charge and is concentrated in two regional State institutions. These institutions also treat some cases of word-blindness but the most severe cases are referred to voluntary-organized institutes for the word-blind, of which the largest is the Institute for the Word-blind near Copenhagen.

Responsibility for the mentally handicapped also rests with the State. Danish legislation recognized that it was better to keep handicapped children within the family if possible, and therefore it provided that day schools established by private initiative or local authorities could receive State subsidies. This legislation applies to both the physically and mentally defective.

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Hospitals for the mentally ill are mainly State-operated but there is also an auxiliary programme where institutional care is supplemented by supervised family care.[1]

Sweden

As in the other northern European countries, in Sweden the first steps in most areas of health care were the result of private initiative. The fight against cancer, tuberculosis, mental illness and other diseases was begun by the efforts of voluntary organizations. However, to a very large extent, these functions have been undertaken by the State and the voluntary groups are mainly concerned with the public information aspects of the campaign against the diseases, especially tuberculosis and cancer. Services for crippled children are operated by volunteer agencies and generously supported by the public.[2]

Norway

With very few exceptions, health insurance now covers every resident in Norway. Three Norwegian voluntary health organizations work primarily with problems arising from cancer. The largest of these is the National Cancer Society and it finances a great deal of research and helps with the social problems of cancer patients. These voluntary organizations, and the other Norwegian organizations, like their counterparts in other Scandinavian countries, play a role which supports that of the government service.

In Norway a large proportion of mental patients are attended in private homes. With respect to maladjusted children, a children's psychiatric institute has been opened in Oslo under private initiative. This institute not only provides care, but also performs a training function. Enlargement and improvement of treatment for the mentally retarded is being carried out through the close co-operation of the State and wide private initiative.[3]

New Zealand

Although New Zealand has a comprehensive health services programme, there is a notable list of voluntary agencies performing many essential services. As a recent report points out, "... a feature of the health services in New Zealand is the manner in which official and voluntary efforts are integrated". In many cases the voluntary agencies are "encouraged and

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[1] Halck, N., *Social Welfare in Denmark,* Ministries of Labor and Social Affairs, Copenhagen: 1961, p. 51.

[2] Nelson, G. R., *Freedom and Welfare,* Social Patterns in the Northern Countries of Europe, Ministries of Social Affairs of Denmark, Finland, Iceland, Norway, Sweden, 1953, p. 374.

[3] Evang, Karl, *Health Services in Norway,* E. K. B. Boktrykeri. Oslo: 1960.

assisted" in their work by grants from public funds.[1] The most significant of the voluntary organizations are: the Plunket Society, the King George the Fifth Memorial Children's Health Camps Federation, St. John Ambulance (N.Z.), the New Zealand Red Cross Society, the Crippled Children's Society and the New Zealand Federation of Tuberculosis Associations.

The Plunket Society operates six Karitane hospitals for babies needing special care and for the training of "Plunket nurses". These nurses instruct mothers, visit the homes of nearly all newborn babies, and staff clinics where children are examined regularly. In rural areas where there is no Plunket clinic, public health nurses do infant welfare work. The Plunket Society and the Government co-operate to ensure that each child receives five medical examinations before his twelfth year, and all the necessary inoculations and vaccinations. The Society, which provides its services free, receives subsidies from the Government and also receives strong financial support from all sections of the public. In this respect the Society is quite similar to our own Victorian Order of Nurses.

The King George the Fifth Memorial Children's Health Camps Federation maintains a chain of permanent health camps for delicate and undernourished children. Like the other voluntary organizations, the Federation works in close co-operation with the Department of Health to ensure that the available resources are utilized to the best advantage, and it retains its voluntary character. The financing for the Federation's activities is derived from two sources: public donations and from a government subsidy derived from postal surcharges on specially designed health stamps.

The St. John Ambulance (N.Z.) has divisions throughout the country carrying out free ambulance work and instruction in first aid and home nursing. This organization, like ours, provides first aid to participants and spectators at sports events. The New Zealand Red Cross Society gives training in first aid, home nursing, hygiene and sanitation, and emergency transportation of the injured. Graduates of the Red Cross classes form voluntary first-aid detachments.

The Crippled Children's Society keeps a register of all crippled children, helps them acquire all possible medical treatment, and undertakes vocational training and home education where these are required. The interests of patients suffering from tuberculosis are protected by the New Zealand Federation of Tuberculosis Associations. As well as assisting the Department of Health with the health education of the public with respect to tuberculosis, it also concerns itself with the after-care and vocational training and guidance of patients.

Provision of care for the aged has involved the joint efforts of the government, hospital boards, municipal bodies and religious and social

[1] *New Zealand Official Yearbook,* Department of Statistics, Wellington: 1963, p. 154.

welfare organizations. A programme for providing meals to old people is in operation. The voluntary organizations which build homes for the accommodation and care of old people receive a building subsidy of 100 per cent of the approved capital cost. These voluntary groups also finance the maintenance and management of the homes and control their operation. Other voluntary organizations manage or support homes for crippled children and for the mentally retarded.[1]

In summary, it can be seen that the introduction of a comprehensive health care programme has not meant the end of voluntary agencies in New Zealand. There remains a very important place and a need for the special services they can offer, both within and to supplement the health care services provided through government.

Israel

Israel has the highest estimated physician-population ratio, 1:400, and a health programme with comprehensive coverage of approximately 80 per cent of the population. Nevertheless it encourages the development of new voluntary health organizations, integrated into the scheme of health and welfare services. They are to support and supplement the medical services beyond the basic care of the educational, recreational, social, camping, and personal needs of patients and families as well as public health education, and the drive for enlightened legislation.[2]

CONCLUSION

The foregoing review of the financial and administrative structure of voluntary health organizations demonstrates a kaleidoscopic variety in origin, objectives, and methods of achieving these objectives. They are distinct in this respect from the more static and well established pattern of government services, but it is the variety and adaptability of voluntary organizations which makes them uniquely suited to seek out unmet needs and to pioneer new methods.

It is obvious from the experience of other countries that the introduction of publicly supported health services programmes in no way diminishes, although it may alter, the role of voluntary effort. In fact, it appears that the voluntary agencies have taken on more important new directions as the

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[1] *Health Services in New Zealand*, New Zealand Embassy, Washington, D.C., 1961.

[2] Paltiel, Freda L., "The Israel Rheumatic Fever Society, a study of a Voluntary Health Organization"; *Public Health*, Vol. 5, No. 4, Israel Ministry of Health, Jerusalem, November 1962, pp. 480-490 (English Translation, Reprint).

government has provided funds to relieve them of established services whose costs restricted their pioneering and expansion into new areas.

Their experience parallels to a degree what happened to hospital auxiliary societies in Canada following the introduction of hospital insurance. Being relieved of the essentially negative role of raising funds for hospital deficits, the auxiliaries have, on an expanding scale, directed their efforts to positive objectives.

There is, in our opinion, an important place for voluntary effort in the comprehensive health care programmes such as we recommend and we have strongly emphasized this point in Volume I.[1] We believe that, as demonstrated in other countries, voluntary organizations, in co-operation with the health professions, universities, and governments, will be able to accomplish even more in the future than they have done in the past. There is more work for both voluntary agencies and governments to accomplish than likely can be accomplished in the foreseeable future.

Yet there are powerful forces at work in society today, particularly specialization and technical change. These are profoundly influencing all organizations in Canadian society and voluntary services are equally affected by these developments. Specialization and the development of new services and methods of providing services will continue as voluntary agencies acquire new responsibilities, but the more this happens, the greater will be the need for co-ordination of these activities.

Changing health problems will require continuous evaluation of the services provided by voluntary organizations. These organizations have increasingly recognized the need for co-ordination of services and we have observed instances where closer co-ordination and even far-reaching financial and administrative integration of several organizations has brought about a more effective approach to their respective objectives. As an integral partner in the health services complex, voluntary organizations also will have to demonstrate their willingness to participate in the wider planning and evaluation of all health services which have become so necessary for the effective functioning of the health services complex.

The organizational structure which we have outlined in Chapters 7 and 8 should facilitate this development. The integration of representatives of voluntary health organizations including those concerned with the prevention of disease or accidents into the institutions responsible for the planning of health services, i.e., the Health Planning Councils, will strengthen their role and lead to their recognition in those areas where the need for their services has been determined. This applies particularly to their relationship with government agencies with whom a true partnership will evolve. Representation on Health Planning Councils will also enable them to observe their activities

[1] *See* Volume I, Chapter 1, p. 12.

within the framework of all community services and to determine unmet needs on the one hand and redundant activities on the other. It will make for the effective pooling of effort among the various voluntary organizations as well as between voluntary and government agencies.

The Commission recommends:

224. That voluntary agencies have an integral place in any comprehensive health care programme and that they participate actively in the work of the various planning councils.

The basic principles of financing voluntary health activities will be altered to the extent that the personal health services they provide will be paid for under the Health Services Programmes. In this respect the financial needs of voluntary organizations will be determined by the services they are required to provide, just as the needs for supplementary services, research and educational activities will become apparent from the operation of the Health Services Programmes, the work of the Health Sciences Research Council, and the review of health needs by the Health Planning Councils. This should go a long way in indicating the extent of financial needs and the required share of the income from united appeals to be allotted for certain activities. The fact that the Health Services Programmes will relieve voluntary organizations of the costs of personal health services will enable them to devote some of their resources to other purposes or to lower their budgetary requirements.

This summarizes our conception of the future of voluntary effort in the field of health services. It would not serve a practical purpose to list specific services which voluntary organizations should or should not provide in the future: the needs change, new types of services develop and old ones become obsolete. Like all other services, those provided by voluntary organizations will change as current needs and current awareness and knowledge of needs change. This is how voluntary services came into being in the past and this is how necessary changes will take place in the future.

One point relating to the present system of financing the activities of voluntary health organizations, however, must be stressed. As more voluntary organizations have been established to meet new needs, the public which is expected to contribute to these various causes has been faced by a bewildering and growing multiplicity of appeals without possessing the information needed to see the seemingly competing demands for support in their proper perspective.[1] There is a danger that this situation will result in apathy towards legitimate appeals unless assurance is given that voluntary work and donations will be used in the most effective fashion. We are con-

[1] Private donations for health research are discussed in Chapter 4, pp. 128-130.

fident that this danger can be overcome by the voluntary organizations adopting a more effective reporting system which is now being used by some national voluntary organizations.

We have already mentioned the annual reports submitted to the Department of National Health and Welfare by voluntary organizations receiving grants.[1] This is a satisfactory way of keeping the public informed and *all* national voluntary organizations should prepare annually such a report on their activities. In this way the public will become aware of the assets and liabilities, incomes and expenditures, as well as the volume and type of services rendered by the various organizations.

The Commission recommends:

225. That all voluntary health organizations submit an Annual Financial Report to the Department of National Health and Welfare, describing their functions as well as showing assets and liabilities, income by source and expenditures under appropriate headings, duly audited in accordance with accepted auditing practices.

226. That the Department of National Revenue take cognizance of the organizations so reporting, when recognizing donations as charitable exemptions under the Income Tax Act.

We are convinced that, as in other countries, voluntary health organizations in Canada will continue to adapt their contributions to the needs of the day and of tomorrow in a constructive and flexible manner so that they can effectively supplement, as fully accepted partners, the private and public endeavours to provide Canadians with the best possible health care that today's knowledge and future scientific progress will be able to provide.

[1] *See* p. 177.

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Organization of Health Services

We have emphasized repeatedly both in the first volume of our Report and throughout this second volume that the principal sources of improved health—other than the responsible behaviour of Canadians—are the number and skills of physicians, dentists, nurses, pharmacists, scientists, technicians and other people who participate in the provision of health services. The quality of health care therefore depends on the education and the training of the large and growing number of those who provide health services. We have also stressed that the quality of health care depends on talents and attitudes not so easily described, on the dedication of health personnel. The relief of pain and suffering, the development of confidence in those in distress, the comforting of the afflicted, the preparation of a person for death, the consolation of those bereaved or who must face the burden of sorrow associated with a severely retarded or crippled child and ultimately, in some cases, the necessity to bear the responsibility for life or death are tasks that must be borne by many in the health professions and the manner in which they are carried out is of major importance for the quality of health care.

Our recommendations relating to the manner in which health services should be organized within the Health Services Programmes recognize the paramount position of the personnel providing health services and will ensure that the quality of health services is maintained and improved. The changes that we envisage are in accord with the Health Charter for they are based on the maintenance of a close relationship between those who provide and those who receive health services including freedom of choice on the part of the patient and of the physician. They also recognize the necessity for the maintenance of free self-governing professions and institutions and the participation of such professions and institutions in the planning and implementation of the future development of the Health Services Programmes. *They do not involve any control over the physician or*

dentist in the practice of his calling.[1] All these hallmarks of high quality care would be maintained and improved in the future just as they have been maintained and improved in the past.

It is necessary, however, to recognize that individual health professionals and health institutions by themselves cannot provide all the conditions needed to ensure that Canadians obtain the best possible health care. In a country with an expanding population, where people are highly mobile and are becoming increasingly urbanized, some form of organization must ensure that the supply of health personnel and health capital expands to meet the needs of the growing population and that personnel and facilities are available in those areas where they are required. Similarly, in an age of rapid scientific and technological change, some organization must ensure that research and technical development is fostered in the field of health and that scientific and technical advances are embodied in better qualified personnel and the most up-to-date equipment. Finally, in view of the need to improve the quality of health care that Canadians receive and to ensure that scarce health resources are used most effectively, some organization must take the responsibility for evaluating the quality of health services and, what is essentially another dimension of quality, the manner in which scarce resources are utilized.

We are aware that many organizations, professional, voluntary and government, have performed valuable work in all these areas. At the same time, through the submissions made to us, through our hearings, and through the work of our research staff, we were made aware of the need for further improvements in the organization of health services and resources if the potentialities of the future are to be realized in the form of good health care. It was these considerations that led us to state in Volume I that an essential element in the provision of the best possible health care for Canadians was the improved organization of health services and to specify the organizational structure that we believed could best meet the needs of all Canadians.

Our purpose here is to examine in more detail the organizational structure that we recommended, to indicate the basis for these recommendations and finally to indicate the improvements that would arise from such changes. We have not recommended changes in organization just for the sake of change. We have recognized that all organizations in the health field, whether private, voluntary, governmental, or some combination of these, are no more than intermediaries, devices for bringing together individuals who need health services with those who can provide them. Nevertheless, if the needs of consumers and providers of health services are to be well

[1] *See* p. 211.

served, organizations must continue to adjust, as they have done in the past, to the dynamic forces that make, and will continue to make for change in this country. Our recommendations in this area do no more than facilitate this process. They are designed to further the co-operation of private practitioners, voluntary organizations and public bodies in making the fruits of the health sciences available to all Canadians without hindrance of any kind and, in so doing, enable them to make the most effective use of all the nation's health resources.

RECENT TRENDS IN BUSINESS AND GOVERNMENT ORGANIZATION

In almost every area of the economy the most striking characteristic of modern organizations, whether they be private or public, is an awareness of the need to change: to adjust to technological development, changes in demand, shifts in population. Moreover, this awareness of the need for change has been accompanied by an increasing concern with planning—with the preparation of projections of demand, with the setting of targets, with the assessment of alternative ways of achieving goals, with the evaluation of past performance for the determination of future actions, with the development of broader views of the consequences of individual decisions for the economy or society as a whole.

To some extent this has been the consequence of the growth in the size of organizations. In many areas of the economy the scarcity of skilled manpower and the productivity gains to be derived from specialization of functions and the consolidation of marketing processes have profoundly influenced organizational structure in the direction of larger scale, reduction in the number of small units and the concentration of production and distribution units in larger centres of population. Such developments are as evident in retail merchandising as they are in automobile manufacturing; in transportation services as they are in food processing. Nor have services produced in the public sector of the economy been immune to such changes. Government agencies and educational systems to name but two have been subject to the same process. The average educational unit for example has grown in size and provided more specialist services for a larger area as the growth of knowledge and the relative scarcity of specialists led to the integration of small local educational units into larger regional units. Units of local government have been expanded as the advantages accruing to larger regions led to amalgamation.

As the size and complexity of private and government institutions have grown there has been an increased awareness of the need to ensure

that the large complex organization actually achieves its goals; that it does meet the needs of the community and uses scarce resources efficiently. The gains associated with large-scale enterprise may be offset by the losses associated with centralization; with a failure to meet the wishes of those who buy the product or with an inability to produce new products, to generate successfully innovation and production. Alternatively scarce resources may be wasted at the periphery through failure to co-ordinate decision-making at the centre. In the case of government, over-centralization may result in a failure to provide adequately and efficiently the services that the public desires.

In a competitive economy, a firm that failed to produce the goods and services that people want, or produced them at a higher cost than a competitor, would ultimately find its profits seriously reduced and perhaps be forced out of business. In these circumstances, the development of high speed data-processing units along with advances in information theory have enabled management of a modern corporation to become increasingly concerned with the assessment of objectives, the means available to reach these objectives and possible conflict of objectives. They have enabled decision-makers to include many more variables in their projection of the future path of the organization thus giving them greater accuracy in fundamental decision-making. They have also permitted more decentralized operations since the activities of such units can be quickly reviewed and changed if necessary. In such circumstances unnecessary fragmentation of responsibility is avoided as well as the wasteful use of scarce talents. The over-all objective of the organization is achieved while effectively decentralizing decision-making to permit the greatest possible freedom for individual activity. In short, interdependence and flexibility are promoted rather than bureaucracy.

Organizations, such as governments, which provide services not subject to the test of the market, are also becoming increasingly aware of the need for a continuous appraisal of their ability to meet the needs of the public and of the means used to achieve their goals. The Report of the Royal Commission on Government Organization has documented the need for these appraisals. Commenting on the problem of duplication and overlapping responsibility in the area of defence, the Commissioners stated that ". . . there is a growing range of activities of common concern to the Services, for which the traditional basis of organization is unsuited. It is increasingly recognized that to maintain three separate organizations for such functions is uneconomic. Moreover, the chronic scarcity of many of the skills involved cannot be ignored".[1] Again the need for decentralized operations within a

[1] The Royal Commission on Government Organization, *Special Areas of Administration*, Vol. 4, Ottawa: Queen's Printer, 1963, p. 68.

framework of centralized policy formation was emphasized by the Commission as follows: "An exaggerated concern with ministerial authority . . . will produce administrative apoplexy at the centre of government and paralysis at the working extremities, and cause frustrating delay and inconvenience to the public".[1] Here, as in the case of business, the use of data-processing equipment and the development of techniques for evaluating the costs and benefits of alternative courses of action, to some extent now make it possible to subject government programmes to rational analysis and the Commission stressed the need for the application of such tools in many areas of government activity.

Along with this emphasis on the evaluation of internal decision-making there has also developed an increased awareness that individual decisions may have unforeseen consequences for the community as a whole. That is, it has become clear that decisions in one area may have, because of a lack of complete information, unforeseen consequences for another area. The concentration of industrial production in metropolitan regions and the economic and social decline of regions where industries have shut down may have consequences for both regions that private decision-makers have not taken into account. We could go on to enumerate these conflicts but the organizational needs are clear. Increasingly it has become accepted that some public or semi-public body must take the responsibility for providing an over-all view, for pointing out where policy and administrative conflicts may lie.

It is from such developments that the current concern with "planning", with the recognition that a broader view of the consequences and the results of decision-making must be taken, has arisen. As a consequence, organizations such as the National Economic Development Council in Britain and the Economic Council of Canada have been developed, containing representatives of groups such as management and labour, and having access to technical staff. These bodies endeavour to establish rates of economic growth, to evaluate alternative paths to achieve growth, and, through the weight of their authority, seek to convince government, business and labour to take a longer term view of economic growth and to adopt policies that do not conflict with but lead to a high rate of achievement. This type of planning has come to be called "indicative planning" since it indicates the path that should be followed but does not give the planning authority the power to take steps to change a situation. As a result of important successes, such planning has become an essential part of the operations of most Western economies.

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[1] *Ibid.*, Vol. 5, p. 76.

RECENT TRENDS IN THE ORGANIZATION OF HEALTH SERVICES

It is evident that the business and government organizations that exist in Canada today are profoundly different from those of a generation ago. They are learning to live in a world of rapid change, where some degree of co-ordination and planning is necessary, where mathematical theories of decision-making and data-processing equipment are used to achieve both the goals of the organization itself as well as those of society as a whole. How far have organizations concerned with health care and health services also adjusted to this dynamic world? How successfully have they mastered the problems of effective organization and planning for the future?

When attempting to answer these questions it is necessary to keep in mind that health services are a relatively unique product in that the ordinary market forces do not operate to the same extent as they do in the production and distribution of most other goods and services. Health services are not generally produced by business corporations raising their own funds in the market, employing health personnel on salaries and wages, carrying on research and in-service training and financing all these activities by selling health services in a competitive market. Rather they are produced by a variety of independent persons and suppliers, some of whom are independent professional men, others government or voluntary organizations. For example, a crucial component in the provision of health care is the hospital in which independent practitioners have access to skilled ancillary personnel and capital at no direct cost to themselves. Hospitals, however, are generally organized on a non-profit basis by voluntary organizations or government bodies, they finance their capital accumulation through philanthropy or government grants and obtain their operating revenue principally through payments made under the Hospital Insurance and Diagnostic Services Act. Again it is not profit-oriented enterprise but governments and voluntary organizations generally that are responsible for the provision of community health services, the operation of home nursing programmes, rehabilitation programmes, the financing of health research and the provision of educational facilities. Such activities are almost entirely financed through taxation or philanthropy.

The special characteristics of health services have led to an institutional structure in which production and the use of resources generally are much less influenced by competition and the search for profits than in the economy generally. It is also the case that the influence of the consumer is much less in this area. Unlike many other goods and services the consumer as a rule is incapable of fully evaluating the health services he receives or even if he needs them. It is true that the decision to acquire health services usually

is made by the individual or family head who decides to go to a physician or dentist. But hospital services, medical services, prescribed drugs and dental services can only be obtained through the decision of a physician or dentist and it is the practitioner generally who determines the amount, type and location of services received. In this area the recipient lacks the competence to judge what is appropriate.

Consumers, of course, are not reliable judges of many of the commodities they buy. Laws have been passed to control the quality of many foods or to provide information to enable them to purchase goods with some degree of competence. Yet health services, along with other professional services such as legal or educational services, are relatively unique in that there seems to be no way to provide the buyer with sufficient information to judge the quality of service he purchases. Moreover, while the consumption of legal or educational services is unlikely to do harm to the individual, this is not the case for many health services. Thus, "unnecessary" surgery, excessive radiological services or too many prescription drugs can have serious consequences for the user. It follows then that for the majority of health services, the amount, the type and the location of health services must be decided by the practitioner on the grounds of medical or health needs. The judgment of the profession determines quality of care; the consumer generally does little more than accept the decision of the practitioner.

But many individuals do not possess the knowledge or are unaware that they are in need of health services at all. Clearly, since many individuals, particularly children, would suffer permanently from failure to obtain health care, it has been necessary to create demand, to make individuals aware of the need to use health services either by advertising, or education, or mass screening programmes (such as those for tuberculosis) carried out by professional, voluntary or government organizations.

Finally, the diversity of services required for the treatment of certain health conditions peculiar to the chronically ill or the disabled whether they are young or old make it difficult for individuals either to identify or to obtain access to the full range of services they need. It is one thing to go to a store to purchase the various ingredients required to produce dinner, it is another to acquire the services of a physician, a public health nurse, a physical therapist, a social worker, a homemaker, a vocational teacher or an ambulance all of which may be necessary for the satisfactory treatment of a disabled or sick person.

Within these special circumstances there can be no doubt that health organizations have shown considerable adaptability in adjusting to a rapidly changing world—this despite the limitations of competition among suppliers of health services. They have taken advantage of the productivity gains associated with the use of specialist personnel and increased amounts

of capital equipment and these have produced significant changes in the location and size of organizational units. For example, the provision of medical services based on the individual practitioner working in the patient's home without benefit of specialist ancillary personnel and equipment has virtually disappeared. Instead, medical services increasingly have been provided in the practitioner's office, or in hospital where a variety of ancillary personnel and equipment are available, payment for which in many cases is obtained through the use of some prepayment mechanism. The average size of the organizational unit in consequence has also tended to grow as physicians work in partnership or group practice and hospital care is concentrated in larger general hospitals. The benefits of these developments in the form of increased efficiency of physicians and dentists and the more effective treatment of illness and disease have been outlined in Volume I.[1]

Of particular importance has been the success of the combined efforts of governments, voluntary organizations and the general public in the provision of hospital accommodation. Despite some acute local shortages, the supply of hospital beds has expanded to meet the demands of the Canadian public. Similarly the co-operative efforts of voluntary agencies, professionals and governments have done much to provide organized services for patients confined to their homes, for the rehabilitation of the chronically ill and disabled, for the education of the Canadian public in the subject of good health, for the financing of health research and the provision of educational facilities and bursaries for the education of health personnel.[2]

Both health professions and health institutions along with governments have recognized that individuals and families generally do not determine the quantity of health services they receive—other than first visits—and that they are unable to evaluate the services they do receive in a significant way. As a consequence, both government and the professions have developed techniques to perform for the individual what he cannot perform himself. By law the practice of medicine, dentistry, nursing, pharmacy and other health occupations is restricted to those who are professionally qualified, hospitals must be approved and in general, Canadian governments acting on behalf of their citizens ensure that institutions and personnel are qualified to perform their duties. Professional bodies require a high standard of achievement before granting a licence to practise a profession or permitting a professionally trained person to classify himself as a specialist in some health field.

The problems involved in the maintenance of a high quality of health care in a world of rapid scientific and technical change have been faced by hospitals and the medical profession through the accreditation

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[1] *See* Volume I, Chapters 7 and 13.
[2] *See* Chapters 6 and 8.

programme of the Canadian Council of Hospital Accreditation.[1] Of special importance are such hospital committees as the Admission and Discharge Committees whereby admissions to hospital and length of stay can be evaluated from the view-point of good medical practice, the Tissue Committees which examine the volume and type of surgery carried out by individual surgeons and the Medical Audit Committee which reviews diagnoses and records and provides a standard method of evaluating the quality of medical care provided by physicians including both the kind and quantity of services.

Physician-sponsored prepayment plans have also begun to develop techniques to evaluate the quality of medical care received by patients. To quote the brief of the Trans-Canada Medical Plans, the " . . . plans, through their subscribers' claim records, through their claims settlement arrangements, through the application of measuring techniques and through the exposure of claims to the medical referee of reference committees, have substantially contributed to the profession's efforts to maintain high quality medical care . . . For unusual claims and those of a problem nature medical reference committees or other similar types of arrangements are available, through the facilities of the provincial medical division, for assistance in adjudication."[2]

Again in the brief submitted to us by the Manitoba Medical Service it is reported that "a statistical profile by physicians' code number is prepared under the guidance of a consultant. This serves to separate those who might at first glance appear to have an unusual pattern of service to subscribers... Interpretation requires that anonymity be withdrawn, when necessary, for the Medical Review Committee analysis of an unusual pattern. The microfilm record of that doctor is then compared with that of his peers in the same field of practice."[3]

The medical profession through refresher courses in medical schools, lectures and classes at meetings of local provincial and national medical societies has also contributed to the improvement of the quality of health services and, in a similar fashion, have the dental, nursing and other health professions. Government agencies too, specifically provincial hospital divisions, are also concerned with maintaining and improving the quality of hospital care.

Yet it is clear from the evidence submitted to us, augmented by our analyses and studies, that the organization of health services still leaves much to be desired. In Chapter 8 we will examine in more detail the short-

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[1] *See* Volume I, Chapter 13, pp. 548-551.

[2] *Trans-Canada Medical Plans (1960)*, brief submitted to the Royal Commission on Health Services, Toronto, May 8, 1962, p. 28. *See also Windsor Medical Services, Inc., ibid.*, p. 13.

[3] *Manitoba Medical Service*, brief submitted to the Royal Commission on Health Services, Winnipeg, January 16, 1962, pp. 14 and 15.

comings that have been evident in the organization of health services at the local level. Despite the contributions of professional personnel, voluntary organizations and government agencies, except in a relatively few instances, organizations have not been developed to provide home care programmes or rehabilitation programmes for the vast body of Canadians. Here, the multiple organization approach, although in some instances it has led to striking new solutions to these problems, has not, in its present form, provided all Canadians with the most effective health services.

In the area of hospital construction, although the need for a planned organization and development of hospital services has been widely recognized as desirable, and although concrete steps have been taken to implement such planning in some instances, there is still much to be done if hospital resources are to be used efficiently while, at the same time, meeting the legitimate needs of patients.

The need for such planning has been aptly stated by the Canadian Hospital Association in its brief submitted to the Commission. "The purpose of a (provincial) master plan is to serve as a blueprint for developing the essential hospital facilities in the proper locations so that there will be available within reasonable distance of all provincial residents adequate hospital services of high quality, without unnecessary duplication or waste of resources."[1] Three basic premises, according to the Association, should underlie the plan:

(1) Since serious illness requiring advanced surgical and medical care occurs in both rural and urban areas, it is desirable to improve the services available outside the main urban centres by providing more adequate facilities for advanced medicine at key hospitals strategically located throughout the province.

(2) Since complex hospital services of high quality, involving expensive equipment and highly skilled personnel, either cannot be provided, or cannot be provided at reasonable cost, in small hospitals and nursing homes, emphasis must be placed on the establishment of larger district hospitals rather than on a large number of small, inadequate and uneconomic units.

(3) To enable medium- and small-sized hospitals to provide more adequate services, it is desirable that larger hospitals should assist the smaller hospitals by providing such services (diagnosis, treatment, teaching and administration) as cannot be provided by them individually.

This movement towards a regional hospital service has been supported by all groups that have examined the problem.

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[1] *Canadian Hospital Association*, brief submitted to the Royal Commission on Health Services, Toronto, May 1962, p. 75.

Regional planning of hospitals was introduced by the Saskatchewan Health Services Planning Commission as early as 1951 and updated in 1961 with the development of a Master Plan calling for the establishment of a reorganized regional hospital system with a smaller number of regions; the establishment of regional hospitals, district hospitals and limited function small community hospitals; and the co-ordination of the general hospital programme with related community health programmes. The Committee for Survey of Hospital Needs in Metropolitan Toronto has recommended the establishment of a Master Plan for the development of hospital facilities in Metropolitan Toronto along similar lines. The Manitoba Hospital Survey Board also has developed a plan relating both to the distribution of hospitals and the adequacy of the supply and distribution of hospital personnel.[1]

Despite these developments, the truly regional planning of hospital-services has still a long way to go before it becomes effective. As we noted in Volume I, the decision to build hospitals has often been affected by considerations other than actual health needs: philanthropy, local pride or even political pressures. Hospitals also have been built because of lack of alternative health facilities or because of the limited nature of coverage under existing health services prepayment plans. The existing organizations concerned with hospitals have not, as yet, succeeded in solving the problem of the wasteful use of hospital resources.

The quality of health care, although in many places as high as any in the world, over the whole range of health services and over the whole country does not, as yet, match the standards which are capable of being reached. Not all hospitals are accredited. Not all hospitals maintain the procedures and the records needed for evaluating the quality of professional work. Many physicians practise in small hospitals where it is difficult to establish a medical staff organization and thus provide adequate professional supervision of quality. In the case of personnel working outside the hospital such evidence as we have suggests that there can be serious deficiencies in the quality of practice.[2]

Finally, in the increasingly important area of planning the future supply of health services, and despite past improvements, the present deficiencies are striking. The inadequacy of present planning is evident from the need to embark on a crash programme to meet the manpower needs of the next decade. Again the inability of the existing organizational structure to provide the specific skills needed in a rapidly changing world is evident from

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[1] A similar approach has been developed in England where the benefits of a regional hospital system, combined with a programme for integrating hospitals more closely with organizations providing care and treatment out of hospital, have led to the development of a regional hospital plan to be implemented fully by 1975.

[2] *See* Volume I, Chapters 2 and 13, pp. 52 and 544-550, for a discussion of these points as they relate to medical practitioners and hospitals.

the shortages of university trained nurses, qualified dental auxiliaries and paramedical personnel. Nor despite the period of time that has elapsed since the introduction of the Hospital Insurance and Diagnostic Services Act, have satisfactory techniques been established relating developments in this area to other areas of health services. The failure to develop the facilities and manpower needed for medical and other health research in Canada is evident from the shortcomings of the present system.[1]

There can be no doubt that the public, the health professions, voluntary health organizations and governments through their individual and co-operative efforts have worked to improve the quality of health services Canadians receive. They have responded to the dynamic forces of change, but there is still room for vast improvement. There are still gaps between what is and what might be. Moreover, the greatest gaps are in the most crucial area—that of formulating long-term objectives at the local, provincial and federal level; the establishment of some systematic method of assessing how far these objectives are achieved; the development of a mechanism for allowing those who use health services and those who provide them to participate fully in the formulation of objectives and the assessment of their achievement. The future organization of health services that we recommend is designed to eliminate these gaps.

FUTURE ORGANIZATION OF HEALTH SERVICES

The organizations that operate in the area of health services in the future will be concerned with far more than establishing objectives and evaluating how satisfactorily these are achieved. Some health organizations will be responsible for paying for health services, others will be responsible for arranging for their provision. Some organizations may carry out all three functions.

In order to examine this complex topic we have thought it desirable to discuss it in two parts. The first part is devoted to an examination of those organizations concerned with arranging for the provision of health services. The second part examines the organizations which will be responsible for paying for health services, establishing objectives and evaluating the success of the various components of the Health Services Programmes.

Provision of Health Services

The organizational structure that we envisage does not involve any essential change in the responsibility for the provision of health services.

[1] *See* Chapter 4.

Individual professional personnel, in the practice of their profession, will continue to exercise their professional functions in a free and independent manner. They will continue to determine the health services that their patients will receive and they remain as "independent contractors" and as members of professional groups with the responsibility for maintaining the quality of health care. *No profession is nationalized; no professional person is turned into a state employee; no practitioner is coerced into working in a specific region or occupation or prevented from practising his profession in accordance with his training, experience, and professional ethics. Indeed what we have recommended in the area of medical care is a continuation and an expansion of the medical care prepayment plans operating on a "service contract" basis that have been developed so successfully by Canadian physicians and those associated with them.*

Voluntary organizations too will continue to perform their role of providing health services or the maintenance of some form of organization that makes available to Canadians the services of professional and ancillary health personnel and equipment. The ownership and operation of public hospitals, which to a substantial extent lie with voluntary groups or religious orders, unless a community wishes to do otherwise, would remain untouched in the programmes we recommend.[1] Nationalization of hospitals in the individual provinces is unnecessary to attain the objectives of high quality and effective hospital care providing steps are taken to develop consultative and planning organizations. Again, as we point out in Chapters 6 and 8, we anticipate that voluntary health organizations will continue to participate in the operation of home care programmes, rehabilitation services, community nursing programmes, the education of health personnel, the health education of the general public and the financing of health research.

Although private practitioners or voluntary organizations will continue to provide the bulk of health services, public authorities will continue to provide most public health services. The scope of government services depends, however, on the historical development within a province with respect to the choice of organization and obviously differs from province to province.

It is evident that Departments of Health will have, as they now have, the responsibility for providing services in the area of environmental sanitation, communicable disease control, the operation of public health laboratories and the provision of transportation in remote or isolated areas. These public health functions are a vital part of health care and cannot, in general, be provided either by private practitioners or voluntary health organizations.

[1] We include here with voluntary hospitals those local community hospitals that are operated by an elected or appointed commission on behalf of local or municipal governments.

On the other hand, some health services can be provided through a government organization, or a voluntary organization or by an individual practitioner. In the case of hospital care, the practice differs according to the province and the type of hospital care. Provincial governments, except in the Province of Quebec, operate most mental hospitals while in half the provinces, provincial governments operate tuberculosis hospitals. Provincial governments in the Atlantic Provinces operate a number of active treatment hospitals, which is rarely done elsewhere in Canada. Laboratory services are another area where the practice differs between provinces as is the provision of immunization, prenatal and post-natal care. We have already referred to the alternative ways of providing home care and rehabilitation services.

Our concern has not been primarily with *who* should provide all the various health services that Canadians need but rather *that they are provided,* and, when provided, are of a high quality. If local communities and provincial governments choose to provide home care, rehabilitation, home nursing and other services through public health departments because they believe this is the best way to maintain a high quality and an effective service there is no inherent reason why they should not do so. Those communities that wish to continue to operate school health services or well-baby clinics can do so. Where provincial or municipal governments operate hospitals we have not recommended that their sponsorship be changed. We do not wish to see governments take over the responsibility for operating voluntary hospitals and in our view there is no reason why they should do so and many reasons why they should not.

The essence of our position is that in the provinces there should be freedom of choice in the type of institution responsible for sponsoring health services. Diversity, with its possibility of experiment, innovation and improvement, is preferable to a completely uniform or centralized programme. Since each province is free to develop its own pattern for providing services there is ample room for experimentation in the search for the best ways of providing those health services that will best meet the needs of the community.

This does not mean that there will be no change in the responsibility of private practitioners, voluntary organizations and governments for providing individual health services. When all Canadians have access to the services of a physician without financial barriers, personal and preventive health services now provided in hospitals or local health institutions in some instances might become the responsibility of private physicians. With the gradual elimination of the large mental hospital, as patients are treated in phychiatric units attached to general hospitals, it may well be that the mental hospitals operated by provincial governments would be replaced by an expansion of the activities of voluntary or municipally operated hospitals. Again, where regional public health services are closely co-ordinated with a regional hos-

pital service, some services now provided in hospitals may be made available in public health clinics while services now provided in public health clinics may be offered by out-patient departments. Some diagnostic and radiological services may shift from the hospital to the group practice clinic while in the case of isolated practitioners the development of the Health Services Programmes could lead to an increased use of provincial government or regional hospital laboratory services as well as the services of visiting specialists.

We also recognize that in the future there may be some redistribution of the responsibility for the provision of community or public health services within provinces. The size of a province and the stage of development of local government both influence the level at which public health services are provided, and accordingly there are variations between one province and the next.[1] In some provinces public health services such as the transportation of the sick, environmental sanitation, communicable disease control, public health laboratories, public health nursing and fluoridation may be the direct responsibility of the provincial department of health, in other provinces responsibility may be allocated to regional divisions, while in still other provinces municipal governments will share in these tasks.

In view of the diversity of arrangements arising out of historical development it is not possible, nor at this time desirable, to recommend a standard form of organization for the provision of public health services. What we are concerned with is that, whatever the distribution of responsibility for providing these services, gaps should not be permitted to exist and public health services be co-ordinated with those provided by voluntary organizations and private practitioners. We have stressed this point strongly in our examination of the provision of services associated with home care and rehabilitation programmes and we wish to emphasize it again here.

In our recommendations designed to improve the health care available to Canadians, in addition to homemaker and public health nursing services associated with the home care programme, we also recommended that organized ambulance services, community mental health clinics and children's dental clinics be established. These services may be provided under the auspices of voluntary hospitals or voluntary health organizations, but if they are not so provided, they must then be provided at either the provincial or local level of government. The extent to which governments will directly be involved in the provision of these services will therefore depend on the alternative forms of organization that provinces and communities wish to develop. If the provision of such services is not undertaken by any other organization, then provincial or local governments must necessarily do so. Canada's health needs must be met no matter who does it.

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[1] *See* Hastings, J. E. F., *Organized Community Health Services*, a study prepared for the Royal Commission on Health Services, Ottawa: Queen's Printer (*in press*).

We do not envisage any increased responsibility of the Federal Government for the direct provision of health services. The responsibility of the Federal Government for health research and statistical organization has been considered in Chapters 4 and 5. Statutory responsibilities involving the provision of personal health services such as Civil Service Health, Civil Aviation Medicine, Quarantine and Leprosy, Immigration Medical Services, will continue. Administration of health services for Indians and Eskimos in the provinces, as recommended by us in Volume I to ensure that all residents of a province will receive equal treatment, would change federal activities in these areas.[1] Similarly, the Department of National Health and Welfare would continue to provide environmental sanitation services for the Federal Government and to provide consultative services to the provinces in various areas, as well as carry out its statutory responsibilities in the area of food and drug control.[2]

Our proposals are not intended to affect the provision of health services to specific groups. Thus, health services to members of the Armed Services and to veterans, and the planning by Emergency Measures Organization for catastrophic events will continue to be under the direction of the existing agencies. It will be noted in this connection that the proposed organization of health services for the civilian population will enhance the effectiveness of these services in the case of an emergency.

It is not possible to produce an all-inclusive blueprint for the future provision of health services that would meet all contingencies. We cannot and do not wish to specify who should provide each and every health service. What we foresee is not a vast centralized bureaucratic organization solely responsible for the provision of all services with little opportunity for individual initiative and responsibility. Even though efficiency and responsibility are characteristics of large private and public corporations as well as government departments, the special nature of health services in Canada has led us to support a decentralized system in the provision of health services which is in keeping with the federal nature of this country and the historical development of this area of service.

Administration and Planning of Health Services

Since the provision of health services will continue to be the responsibility of a variety of health personnel and organizations it is vitally necessary that the administrative arrangements that are developed will facilitate the co-ordination, improvement and planning of health services as well as the participation of representatives of consumers and producers in the decision-making process.

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[1] *See* Volume I, Chapter 2, Recommendation 1(11), p. 21.
[2] *See* Volume I, Chapter 8.

In Volume I, when discussing the manner in which services would be made available under the Health Services Programmes we stated that all improvements in organization also should take place within the spirit of the Health Charter. We repeat here the relevant statements.

All administrative organizations and procedures must be directed to maintaining and enhancing free, independent and self-governing professions.[1]

Administration at the provincial level should be by a Commission representative of the public, the health professions, and government, reporting to the Legislature through the Minister of Health. It should also assume administration of the hospital insurance plan in the province. The provincial government should be represented on the Commission by the Deputy Ministers of Health and Welfare. There must be committees representative of the various professions to advise on professional matters and the members of these committees as well as the professional members of the Commission should be appointed only after consultation with the respective professions.

Provision must be made at local, regional, provincial and federal levels for representative Health Planning Councils to ensure democratic participation in the setting of goals and objectives and the formulation of proposals for meeting human needs.

The Federal Government should share in the administrative costs of the Health Services Programmes to a maximum not to exceed 5 per cent of its total contribution.

The finances for the Programmes must be sufficient to provide a high level of remuneration to health personnel, for the health profession must attract and retain a larger proportion of young people in the future than they have in the past.

The purpose of these recommendations is to ensure that the best possible health care for Canadians becomes an objective of policy implemented in accordance with Canada's evolving constitutional arrangements. Within the organizational framework that exists to facilitate the achievement of this goal the health professions, academic institutions, and hospitals must retain their right to self-government. In establishing the methods and the means whereby this goal is achieved there must be full participation, co-operation and consultation involving the health professions, voluntary organizations, hospital organizations, municipal, provincial and federal governments and representatives of the general public.

With the achievement of the best possible health care for Canadians as an objective of national policy it is essential that the administration, planning, and improvement of health services must be the responsibility of organizations that are primarily concerned with health and health needs.

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[1] *See* Volume I, Chapter 2, Recommendation 1, pp. 19-21.

The establishment of a comprehensive universal health services programme financed through prepayment arrangements removes the provision of health services from that area which has been loosely called welfare. In such a programme access to the health services needed to maintain and improve the health of Canadians will no longer depend on income, age or condition but on the needs of individuals as defined by professional practitioners. In view of the benefits, both human and economic, that ultimately will ensue from such a development, the abandonment of the welfare approach to the provision of health care must be recognized as a forward step. However, health organizations must also be aware of developments in other areas or of the impact of their own activities elsewhere. Government bodies, both provincial and federal, will have to weigh the demands of the health services sector against all other demands on the resources of the Canadian economy. Clearly, housing facilities, educational facilities, recreation facilities, along with counselling services provided by social agencies all influence health and their activities must form part of the body of information needed for decision-making by health organizations. Decisions made by health organizations in the area of hospitalization, home care and rehabilitation all have consequences for other organizations that must be recognized. Health organizations cannot be oblivious of the impact of their activities on the over-all development of the economy.[1]

But such activities are not part of the primary responsibility of health organizations. These must concern themselves with ensuring that the conditions needed for the improvement of health services are established and maintained. The administration, planning and improvement of health services should be their paramount concern. All else is secondary.

PROVINCIAL ADMINISTRATION

Because they have essentially different functions we recommend that the administration of health services at the provincial level be carried out by two organizations: provincial (and regional or local) Departments of Health and Health Services Commissions. Departments of Health would bear the responsibility for public health services; provincial Health Services

[1] It is, of course, evident that the demands of the Health Services Programmes and the educational programmes and capital facilities associated with them cannot be treated in isolation from the total resources available to the Canadian economy and from other demands made on these resources. In Volume I, we have suggested that in view of the growth of real per capita Canadian income over the foreseeable future, the allocation to the health services sector of the economy of the resources required to operate the programme is unlikely to have a deleterious effect on the economy. On the other hand, the timing of the introduction of new programmes, the rate at which new construction is undertaken—once the crash programme is completed—must depend on the state of the economy at any particular moment of time. It is beyond our Terms of Reference to examine the methods whereby expenditures on health services are reconciled with total expenditures and the various alternative ways of using all the resources available to a nation. That all governments will carry out such evaluations when introducing Health Programmes is certain. One of the roles of Health Planning Councils must be to make governments and taxpayers generally aware of what resources are required for high quality health services programmes and the benefits that accrue to Canadians from such programmes.

Commissions the responsibility for personal health services provided under provincial Health Services Programmes. We recognize the need for co-ordination in these two areas at the provincial government level and have recommended that the provincial Deputy Minister of Health be a member of the Commission *ex officio*. We also comment on the relationship between the Commission and regional and local Departments of Health in Chapter 8.

A Health Services Commission, free from the responsibility for directly providing personal health services, representative of the professional groups concerned, as well as of the provincial government and the general public, and with access to the knowledge and requirements of the health professions, the voluntary organizations, local governments and the public, through its membership and through planning councils, will be able to develop the personal health services that the people of a province require. Similarly, Departments of Health will be able to concentrate on the development and improvement of those public health services that a modern community increasingly needs. It has been suggested however, that, with one provincial administrative body charged with the organization of all personal health services within the Programme, this may have as its consequence the diversion of funds from one category of health services to another resulting in a reduction of the quality of care in the first area. With one organization responsible for administering all the funds, the budget for any one fund could prove to be inadequate.

A number of points must be considered in these circumstances. The first, and of overwhelming importance, is that Canadians in accepting the principle of prepayment of health services through federal-provincial programmes must provide sufficient revenue to retain and attract the health personnel needed to operate all programmes. If the growing population of Canada is to receive adequate health services of improving quality, the supply of qualified personnel must continue to increase and at a more rapid rate. This can only come about if the health professions become more attractive. In Volume I of our Report we referred to the expressed willingness of Canadians to pay for the benefits of a comprehensive health care programme and the necessity of Canadians to be made aware of the relation between the taxes and premiums that they would pay and the health services they would receive.[1] In view of these recommendations, the over-all funds available to finance the programmes should be adequate.

In addition, in the financing of a comprehensive universal health services programme, we concluded that the best method of implementing such a programme was through the establishment of health insurance "funds" along lines similar to the Hospital Insurance Programmes. Thus each health service would be financed from its own Fund to which the federal and

[1] *See* Volume I, Chapter 21, pp. 878 and 879.

provincial governments would contribute and to which other ear-marked revenues would be allocated. There would be, therefore, a separate federal health grant for each of the recommended services, for example, a separate Medical Services Fund, a Dental Services Fund, etc.

Such an approach would alleviate the fears of those who believe one programme would be sacrificed to develop another.

Despite the provision for separate insurance funds this does not mean that the development and planning of individual health services can take place in isolation. The provision of hospital, medical, prescribed drug, prosthetic and home care services are so intimately bound up one with the other that they cannot be administered separately. The establishment of the best possible health care for Canadians requires that Canadians obtain high quality health services and also that health resources are used in an economical way. It is evident that these objectives are closely related. What is not always realized is that they can be related in two ways. It is true that if the health services sector is starved for resources then the quality of health care must deteriorate. It is also true that the indiscriminate allocation of resources to a particular health service without a thorough examination of the consequences of this act may result in a lower quality of health care in aggregate as resources are diverted from other areas that could conceivably yield a higher return in health improvement.

To a substantial extent the provision of hospital services illustrates these points. If insufficient hospital beds are built, then the quality of health care suffers. Alternately the use of scarce resources to expand active treatment hospital beds may lead to a failure to provide chronic hospitals, or hospital-based home care programmes and out-patient departments. Patients may then be treated in inappropriate conditions while physicians, nursing, and other health services may not be used to the best advantage. Both the economic use of scarce resources and the quality of health care would be affected by this decision.

This possibility illustrates the desirability of regional planning to take into account more than just hospital beds. It must take into account the needs of local communities and the consequences of the plan for the distribution of physicians' services, nursing services, dental services, prescription drug outlets, paramedical and other personnel, since all these would be affected and in turn affect the distribution of hospital services. The over-all needs of the community must be reconciled with the needs of individuals whether these are consumers or suppliers of health services. We examine this problem in somewhat more detail in Chapter 8 but it is evident that its satisfactory solution can only take place within an administrative organization which is responsive to the needs of all groups and is responsible for the administration of all aspects of health services.

The problem has been stated appropriately by the Advisory Committee on Hospital Insurance and Diagnostic Services in connection with the present and future costs of hospital services in Canada.[1] The Committee pointed out that hospital services formed an important part of total health services and that factors in other areas contributed to pressures which, in many circumstances, added to the cost of hospital services. These factors would need to be considered in their relationship to hospital services. The Committee believed that principles should be developed which could serve as guides to the various provinces in the development of hospital services which would best meet their individual needs. Such an appraisal should be on a continuing basis since hospital services are part of a dynamic process which must reflect changing patterns of health care. The primary purpose of this appraisal would be to establish principles which could be incorporated into the planned development of essential health services with cost being kept constantly in mind and balanced against the value of the arrangements in terms of high quality health care for the Canadian people.

Our recommendation that the provincial Health Services Commissions should assume responsibility for the administration of the provincial hospital insurance plans will ensure that within each province the development of all personal health services will take place within an administrative organization that minimizes duplication of services, that permits the development of integrated services, and that is responsive to those who use and those who provide health services.

An important function of Health Services Commissions will be the evaluation of the Health Services Programmes. The formulation of standards of quality health care and particularly the evaluation of high quality professional practice is not an easy task. Yet the task already begun by professional and hospital organizations along with various government agencies must be carried further and a Commission, through its own personnel, its staff and its advisory committees, must participate in this development.

With the representation of health professions on the Commissions, and the establishment of professional committees advising the Commissions on professional matters, we can be confident that the Commissions will be equal to this important task.

To meet their various responsibilities Health Services Commissions must, if the size of the province or regional diversity warrants it, create regional Health Services Co-ordinators whose responsibility would be to maintain close contact with regional or municipal health organizations, planning councils, other organizations, and individuals providing health services within the region. Such a co-ordinator would be aware of local

[1] Submission of The Advisory Committee on Hospital Insurance and Diagnostic Services to the Government of Canada, Ottawa, January 31, 1964.

problems, he would be a source of information for members of the health professions, public officials, Health Planning Councils, as well as the Commission. The role that such a person could play and the qualifications needed for these tasks are discussed in some detail in Chapter 8.

The responsibilities of the Health Services Commissions are great and the manner in which they are carried out will largely determine the success or failure of the Health Services Programmes. With independence and qualified staff there is no reason why they should not succeed. The semi-autonomous nature of these bodies should attract competent staff and provide them with the opportunity to seek out new solutions to health problems. They will be bolstered in their endeavours by close association with Health Planning Councils and with those providing services.

FEDERAL ADMINISTRATION

The Department of National Health and Welfare will continue to be the body responsible for the administration of all health grants provided by the Federal Government except for research in the health sciences which would be transferred to the Health Sciences Research Council. It would be responsible therefore for the administration of all Health Services Grants, the Public Health Grant, Professional Training Grants[1] and grants made from the Health Facilities Development Fund. It would also continue to provide consultation and information services in these areas.

Because of the significant role of the Department in this area it is of crucial importance that it co-operate closely with all other organizations involved in the administration and planning of health services, especially those at the federal level.

Our concern for democratic participation in the setting of methods and objectives, and our knowledge that the achievement of objectives requires the co-operation of all groups affected, led us to recommend that a Health Planning Council of Canada be established at the federal level, such a Council to be responsible for the planning of health services and to report to Parliament annually through the Minister of Health. Again, because of our awareness of the need for an independent body to undertake research into the evaluation of Health Services Programmes—research that is difficult to carry out by those responsible for the actual administration of the Programmes— we have recommended that the Health Sciences Research Council undertakes these tasks as a part of its broad responsibilities in the area of health research.

[1] Although any line of demarcation in this area must necessarily be an arbitrary one, we envisage the Health Sciences Research Council bearing the responsibility of administering grants for the training of professional research workers where training involves the conduct of research and the Department bearing the responsibility for the administration of other professional training grants.

This does not mean that the Department will not have to be concerned with the improvement of the Health Services Programmes and Public Health Programmes, or with the development of the facilities and manpower needed to operate these Programmes. Clearly the administration of the grants associated with these Programmes implies an awareness of the methods and objectives of the Programmes. On the other hand, if the Health Planning Council of Canada and the Health Sciences Research Council are to perform their broader functions, this can be done only in the closest co-operation with the Department. With the Health Planning Council reporting to Parliament through the Minister of Health and the Health Sciences Research Council to the Committee of the Privy Council on Scientific and Industrial Research such co-operation should be readily achieved. The evaluation and planning of future health services require that the shortcomings that have existed in the past be eliminated. It will be the joint responsibility of the Department, the Planning Council of Canada and the Health Sciences Research Council to see that it is done.

Over the last century, the Canadian Government has administered its health functions in various forms ranging from a separate Department of Health to branches of a department considered to be performing related functions. From Confederation until 1872 federal health activities were under the control of the Department of Agriculture. The various health programmes were later divided among the departments of Marine and Fisheries (marine hospital service), Inland Revenue (proprietary and patent medicines), Immigration and Colonization (immigrants' medical services), and Trade and Commerce (food and drug laboratory). There also existed, operating under the Conservation Commission, a National Council of Health which dealt with matters relating to public health. A new emphasis on health led the Canadian Medical Association and voluntary health organizations to petition the Federal Government for the establishment of a health department which came into existence in 1919 as the Department of Health.[1] Its merger, in 1929, with the Department of Soldiers' Civil Re-Establishment, whose responsibilities were then declining, led to the creation of the Department of Pensions and National Health.[2]

The Second World War greatly increased activities related to veterans of both World Wars and led to the transfer of the Pension Branch to the new Department of Veterans Affairs. At the same time, welfare matters such as old age pensions and family allowances had become a major and recognized concern of the Federal Government and these, related in some degree

[1] *Statutes of Canada*, 1919, 9-10 George V, Chapter 24, an Act respecting the Department of Health.

[2] *Statutes of Canada*, 1928, 18-19 George V, Chapter 39, an Act respecting the Department of Pensions and National Health.

to health problems, in 1944 were combined with health functions to form the new Department of National Health and Welfare.[1] Since then many functions have been added to both the Health and the Welfare Branches of the Department. In the health field we refer particularly to the National Health Grants Programme and the administration of the Hospital Insurance and Diagnostic Services Act.

As the responsibilities of the Health Branch of the Department will increase in the future, arising from our recommendations generally and particularly those relating to the Health Services Programmes, health manpower and facilities, and the Food and Drug Directorate, a review of the administrative structure of the Department is imperative. We are convinced that a separation of the two branches of the Department has become necessary and would benefit both health and welfare services. Such a move would be in keeping with our recognition that health expenditures are primarily an investment in human capital and not welfare expenditures.

Most provinces at one period combined provincial health and welfare services in one department. Ultimately, these have again been separated, especially since the inauguration of the Hospital Insurance Programme. The last province to separate health and public welfare functions and to establish separate departments was the Province of Manitoba which did this in 1961.[2]

The Commission recommends:

227. That, in view of the growing responsibilities of the Department of National Health and Welfare in both the health and the welfare fields, and particularly in view of the increased responsibilities that would be placed on the Department with the implementation of the Health Services Programmes, and taking account of the advisability of administering health services separately from welfare services, the Health Branch be restored to the status of a separate Department of Health.

Health Planning Councils

In its recommendations relating to the establishment of Health Planning Councils the Commission had two objectives: first, to ensure that in any attempt to eliminate divergences between private and social interests all parties affected are consulted and participate in the recommendations

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[1] *Statutes of Canada*, 1944-45, 8 George VI, Chapter 22, an Act to establish the Department of National Health and Welfare.

[2] Based on Special Committee on Social Security, *Health Insurance*, Report of the Advisory Committee on Health Insurance, Ottawa, 1943; and *The Federal and Provincial Health Services in Canada*, Second Edition, Canadian Public Health Association, Toronto, 1962.

made, and second, to ensure that the future needs of Canadians be met in an effective and timely manner.

We have emphasized that in an area of human activity, as large and as complex as health services and characterized by rapid and scientific change, the need for careful and far-sighted planning cannot be avoided. Nor can such planning proceed in one province or region without an immediate concern for what is happening elsewhere.

In view of the public responsibility for the provision of health personnel and facilities it is therefore necessary for some public or semi-public body to accept the responsibility for establishing the future needs of the community, the region, the province or the nation. Such functions must, of course, be part of the general activities of all organizations concerned with the provision of health services or the education of health personnel. Professional associations, departments of health, departments of education, departments of labour, and voluntary organizations all must assess future needs as part of their general activities. Health Services Commissions too cannot carry out their responsibilities without a continuing reappraisal of the present and future needs of the provinces. The Federal Department of Health, assuming a separation of its welfare and health functions, as part of its administrative responsibilities also must be concerned with the future needs of the nation, particularly those that fall within the responsibility of the Federal Government.

But the desirability of bringing to bear all the knowledge available, and the need to provide some means for ensuring the co-operation of all those affected by change, have led us to recommend that representative local, regional, provincial and federal Health Planning Councils be established and charged with the responsibility of establishing future health needs and the resources and programmes required to meet them.

Health Planing Councils must create the climate of opinion in which the co-ordination and effective organization of health services and facilities can take place. Where change and adjustments must be made they will only occur if the necessary consensus is developed by the planning councils—if those affected by change see and approve the reasons for them.

Since some changes will take place in the area of hospital services, medical services, dental services, home care services, rehabilitation services, and public health services, there must be strong representation from medical societies, dental societies, nursing associations, voluntary health organizations, and local government on regional and local councils. Quarterly meetings of regional health councils do not seem too many if they are to become a unified group and to have the necessary influence.

Provincial, regional and local Health Planning Councils also must take the responsibility for indicating, in the light of prevailing conditions,

how preventive, treatment and rehabilitation services are to be co-ordinated at the local level, how personal and public health services are to be integrated, how the isolation of the public health officer from the mainstream of medicine is to be remedied. There may be a good case for ensuring that the administrative areas for hospital services and community health services be coterminous. Such development would certainly permit the most efficient use of the Regional Health Services Co-ordinator.

Just as a provincial health plan or policy cannot be determined by government fiat but must flow from the needs of the community, so must a federal health policy flow from the expressed needs of all Canadians. Policy must evolve through the co-operative exploration of health problems, of existing arrangements and alternative solutions.

The implementation of the Commission's recommendations and the revision of plans and policies that will take place in the future require that at the federal level a Health Planning Council of Canada take the responsibility for ensuring that the health needs and problems of all Canadians are considered as a whole. With representatives of major organizations in the field of health, with representatives of business, labour, and agriculture, with representatives of those who both use and provide health services, this Council can interpret the wishes of Canadians to Parliament and provide a powerful source of information for the Federal Government as well as for provincial Planning Councils, Health Commissions and federal-provincial co-ordinating bodies.

The value of Health Planning Councils will depend on the quality of their recommendations. If Councils are to contribute to the development of high quality health services, if they are to provide the fundamental objectives and plans on which action will be taken, they must have available competent staff. Too often is it the case that a planning council is established without responsibility, without staff and in a short time falls into disuse. Councils must have available to them the administrative staff they need to carry out their responsibilities in an effective manner.

Although Health Planning Councils must possess a small executive staff to formulate recommendations about the future developments of health services, their success will depend on the availability of information. Because of the composition of Health Planning Councils, and because they are not involved in the administration of the Health Services Programmes, it would be quite difficult for Councils themselves to collect all the information, particularly the statistical information, they would need for their decisions. We recognize that this is so and we envisage that much of this information will be provided through the establishment of technical committees or by those organizations directly engaged in either statistical collection or programme administration.

Where provincial Health Planning Councils or the Health Planning Council of Canada are concerned with general health problems, they would have access to the advice of professional and technical committees drawn from the relevant disciplines. For example, the Health Planning Council of Canada when examining the problems of mental health would obtain a report from an Advisory Committee on mental health, representative of those with special knowledge in this area.

We believe that at the provincial level, the Health Services Commission should be charged with the responsibility for carrying out projections of provincial (and regional) needs for personnel, facilities and research and that it should submit an annual report to the provincial Health Planning Council and prepare any special studies requested. Similarly, the Health Sciences Research Council should make projections of Canada's need for personnel, facilities and research on behalf of the Health Planning Council of Canada and submit annual reports to this Council. It should also carry out any special studies that the Council may request.

The planning of health services, and with it the supply of health personnel and capital, cannot be avoided. In such planning, projection of future requirements is inevitable. The question is not will projections be made but how they are made. An ordered investigation of what is going on is a necessary condition for initiating policy. Planning tools such as standard bed ratios, population-personnel ratios or measures of occupancy rates that are now available, must be supplemented by more reliable and detailed guides. The objective should be the establishment of "moving plans" whereby the assumptions upon which the recommendations of the planning councils are based, as well as the implementation of the recommendations, are checked annually and revisions made and incorporated. If the quality of decision-making is to improve, it must be possible to recognize quickly divergences from a plan and to minimize errors. Planning Councils and all other health organizations must co-operate to see that this is done.

With access to data from other organizations and with the body of knowledge available to its members, Health Planning Councils should be able to provide a continuing assessment of Canada's future health needs which would be both realistic and forward looking: realistic in the sense that it is based on the best statistical information available and the intimate knowledge of those who represent local areas, regions and provinces; forward looking in that it would seek not merely to maintain the existing level of achievement but strive to attain the best possible health care obtainable in terms of the findings of health research and of the resources available.

We cannot emphasize too strongly that if Health Planning Councils are to succeed they must feel that the tasks they perform are important and that their recommendations are a fundamental part of the knowledge used

to establish and to adapt health programmes. If these conditions exist, Canadians from all walks of life, but particularly from the health professions, will be willing to serve on planning bodies. Men of intelligence and energy will be willing to undertake the arduous tasks that voluntary participation in such bodies requires.

Through the co-operative planning carried out by Health Planning Councils, the health needs of the country can be established and the positive interests of professional groups, voluntary organizations, local government boards and indeed all concerned with the maintenance of flexibility at the local level, and decentralization of administration, can be fulfilled. In establishing patterns of co-ordination and standards of quality, decisions would not be made by some bureaucratic body and handed down without discussion or consultation. Rather recommendations will spring from those who are closely affected by policies and by programmes. They will be produced by those who know what are the health needs of the community.

Federal-Provincial Co-operation

One of the areas where consultation and co-operation are essential is in the relationship of the provincial and federal governments with respect to both policy and the administration of the Health Services Programmes. Here we propose two organizations, the first a Federal-Provincial Health Ministers Conference, and the second a Federal-Provincial Health Services Co-ordinating Committee.

The need to discuss issues of health services policy has led to the holding of periodic meetings between the Minister of Health of the Federal Government and the Ministers of Health of the provinces. We see such meetings being continued annually, with special meetings where necessary, to discuss issues of health services policy that may arise in the future.

The Federal-Provincial Health Ministers Conference would have available to it the recommendations from provincial Health Planning Commissions, the Health Planning Council of Canada and the Federal-Provincial Health Services Co-ordinating Committee, along with information developed by Departments of Health, Health Services Commissions and the Health Sciences Research Council.

The Federal-Provincial Health Services Co-ordinating Committee should consist of the chief executive officer of provincial health departments and health services commissions in the provinces and territories as well as the Deputy Ministers of the Federal Departments of Health and Welfare. The Deputy Minister of Health should act as chairman of the Committee. This Committee would act as the co-ordinating body for all administrative matters involving interprovincial and federal-provincial relations in the area of health services and resources.

The organization presently carrying out these functions is the Dominion Council of Health, consisting of the Federal Deputy Minister of Health who is chairman, the chief executive officer of the provincial Departments of Health and other persons, not to exceed five in number, appointed by the Governor in Council for a period of three years.[1] The duties and powers of the Council include:

(1) The consideration of matters relating to the promotion or preservation of the health of the people of Canada and the initiation of recommendations and proposals to the Minister of National Health and Welfare and other appropriate authorities in regard thereto;

(2) The furnishing of advice to the Minister of National Health and Welfare in respect to the matters provided in section 5 of the Department of National Health and Welfare Act, relating to the promotion or preservation of the health of the people of Canada, over which the Parliament of Canada has jurisdiction.

In the performance of its duties the Council establishes advisory committees and sub-committees on both general and technical health problems. In establishing advisory committees the Council can consult with such persons as it feels necessary, and has done so.

In the organizational structure recommended by the Commission, the responsibility for the development of recommendations relating to the promotion or preservation of the health of the people of Canada lies with the Health Planning Council of Canada. In these areas, the Health Planning Council of Canada, like the Dominion Council of Health would have access to the services of technical and other committees. The Federal-Provincial Health Services Co-ordinating Committee would have access to their recommendations.

On the other hand, many of the problems discussed and resolved by the Dominion Council of Health are public health problems of a more specific or technical nature. For example, the Council has sponsored advisory committees and received reports on immunization, epidemiology, hepatitis, the medical aspects of motor vehicle accidents, the disposal of radio-active wastes, the problems relating to the sale of meat, etc. The Federal-Provincial Health Services Co-ordinating Committee, like the Dominion Council of Health, clearly must continue to be concerned with these issues. What has to be decided is the source of technical and other advice.

Here the Health Sciences Research Council and the Federal Department of Health can play an important role. In areas of more fundamental research, the Health Sciences Research Council would have access to the skills and talents needed to prepare reports for the Co-ordinating Committee. In

[1] *Statutes of Canada, op. cit.*, s. 7(1).

more technical areas, the Committee could draw on the resources of the Federal Department of Health or on advisory committees established on its behalf by the chairman of the Committee, the Federal Deputy Minister of Health.

The Deputy Minister of Health, as chairman of the Committee, since he administers both public and personal health services grants, will be able to co-ordinate much of the information that the Committee will require. He will have access to the reports of the Health Planning Council of Canada and the Health Sciences Research Council, the other major sources of information and advice.

This federal-provincial organization should provide an important clearing-house for clarification of mutual problems and for the co-ordination of programmes and policies in all areas of health.

A SUMMARY DESCRIPTION OF HEALTH ADMINISTRATIVE ORGANIZATIONS[1]

In summary, we foresee the various administrative bodies that we have recommended as taking, in general, the following forms and having, in general, the following functions.

Provincial Health Services Commissions

To ensure that the provincial Health Services Commissions would be representative bodies we have recommended that they should consist of a chief executive officer or chairman and representatives of the public, the health professions and government. The government representatives would consist of the Deputy Minister of Health and Deputy Minister of Welfare who would be *ex-officio* members of the Commission. The representatives of the health professions and the public would be appointed from panels nominated by professional bodies and lay organizations. In this situation the professional members of the Commission would be appointed only after consultation with the respective professions. A Commission would be responsible to the provincial legislature and report through the Minister of Health.

The principal responsibilities of a Health Services Commission would be five. First, to be responsible for the administration of the various Health

[1] This summary is limited to the administrative aspects of health care, where organizations are engaged in the provision of public or personal health service such activities have been described elsewhere.

Services Funds[1] and the Health Facilities Development Fund. Second, to provide advisory and consultant services to those individuals and organizations providing health services. Third, to carry out medium- and long-term projections of the provincial needs for personnel, facilities, health research and organization on behalf of the provincial Health Planning Council and submit an annual report to the Council. Fourth, to receive the recommendations of the provincial Health Planning Council in the areas of programme development, personnel, facilities, research and organization. Fifth, in the light of these recommendations to ensure that the development of the Health Services Programmes takes place in an orderly fashion and that in this process close liaison is maintained with all those providing health services.

Under the Health Facilities Development Fund, a Commission would be responsible for the administration of Hospital Construction Grants (which would become a part of such a fund) and for grants to assist in the provision of medical, dental, public health, nursing and other health profession educational facilities, including medical schools, dental schools, schools of public health, schools of nursing, basic science buildings and equipment. Under the Dental Construction and Equipment Grant a Commission would be responsible for the provision of facilities associated with the Children's Dental Health Programme.[2] Although the provincial Departments of Health would continue to be responsible for grants made under the Professional Training Grants, a Commission would co-operate with the Departments of Health and Education and with provincial universities in the development of this area. Finally, as part of its responsibility for administering Health Services Funds, a Commission would be responsible for paying for services rendered within any of the Programmes by the professions, hospitals (both voluntary and government operated), voluntary health organizations and departments of health.

A Commission would also be charged with the responsibility for negotiating fee schedules, or rates of payment for services rendered, with the appropriate professional bodies or health organizations. In this area we

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[1] In our Recommendation 120, in Volume I, we stated that regulations made under the Hospital Insurance and Diagnostic Services Act be interpreted to cover the cost of patient care provided by hospital-based home care programmes. Recommendation 121 stated that the regulations made under the Hospital Insurance and Diagnostic Services Act be interpreted to include as a shareable cost, payments made to community-based home care programmes for care provided to hospital patients returned to their homes but retained on the hospital register. Recommendation 122 stated that the Public Health Grant be used to assist in financing community-based home care programmes. Since the Hospital Insurance and Diagnostic Services Grant would be administered by the provincial Health Services Commission and the Public Health Grant by the Department of Health it is suggested that the funds made available under the Public Health Grant for home care programmes be transferred to the Health Services Commission for administrative purposes.

[2] Financing group practice clinics would be carried out through loans made available under the National Housing Act.

have recommended that where there is inability to agree there would be provision for an appeals procedure within the province.

In its administration of the various health funds a Commission would be charged with the responsibility for evaluating the success of the programmes including the conduct of statistical research in this analysis. Such evaluations would be carried out only by appropriate professional personnel in co-operation with professional advisory committees appointed after consultation with the respective professions or hospital associations. In this manner the quality of health services will be determined by those with professional responsibility for improving the quality of health services.

A Commission would also be charged with the responsibility for initiating the organization of new services recommended by the provincial Health Planning Council. Among the first tasks would be to ensure that where home care and rehabilitation programmes were not in operation, steps be taken to develop them either through voluntary organizations or departments of health; that the recommendations relating to the mentally ill and retarded and crippled children are implemented; that immediate efforts be made to develop the children's dental and optical services programmes.

Provincial Health Planning Councils

To ensure democratic participation in the setting of goals and objectives of the Health Services Programmes a provincial Health Planning Council should be appointed by the provincial government from panels nominated by professional bodies, voluntary organizations, university, municipal, farm, business, labour and other representative associations. A Council should engage a chief executive officer and staff to be responsible for the Council's activities; it should be financed through funds provided from the administrative funds of the provincial Health Services Commission. It should report annually to the provincial legislature through the Minister of Health.

The principal responsibilities of the Council would be five. First, to make recommendations relating to programme development and the improvement of health services within the province. Second, on the basis of projections developed by the provincial Health Services Commission and the Health Sciences Research Council to make recommendations relating to the provinces' medium- and long-term needs for personnel and facilities. Third, to make recommendations relating to proposals for new voluntary and government activities in the field of health services. Fourth, to make recommendations relating to the co-ordination of the activities of professional personnel, voluntary organizations and governments in the area of health services. Fifth, through a sub-committee on health personnel, to

make recommendations relating to the recruitment and education of health personnel. Such a sub-committee would be advised by, among others, a Nursing Education Planning Committee, a Dental Auxiliary Education Committee and a Committee on Paramedical Personnel, and should work in close co-operation with the provincial Departments of Education and Labour.

Provincial Health Planning Councils must maintain close contact with the Health Planning Council of Canada, the Health Sciences Research Council, the provincial Departments of Health and other institutions responsible for aspects of health care.

Regional and Local Health Planning Councils

Where the size or diversity of a province warrants it, regional and local or municipal Health Planning Councils should be established by provincial governments in the same manner as the provincial Health Planning Council. They should be provided with an executive secretary to work with the Regional Health Services Co-ordinator[1] and with the health officers of regional and local health departments, and they should report regularly to the provincial Health Planning Council. Funds for the operations of these regional and local councils should be made available by the provincial Health Services Commission.

The responsibilities of regional and local Health Planning Councils would be to make recommendations to the provincial Health Planning Council relating to programme development and the improvement of health services in their area, the needs of the region for personnel and facilities, voluntary and government action in the area of health services, and to make the provincial Health Services Commission aware of the impact of health policies on the region or municipality itself.

Provincial Departments of Health

Although the administration of the Health Services Programmes would be the responsibility of the provincial Health Services Commission of which the Deputy Minister of Health is a member, the provincial Department of Health would continue to be responsible for the administration of the Public Health Grant and, in co-operation with the universities and the provincial Health Services Commission, Professional Training Grants. It would also continue to be responsible for the essential and traditional public health functions.

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[1] In some instances it may appear desirable for the Health Services Co-ordinator to serve as Secretary to the Council.

Federal Department of Health

The Department of Health, following the allocation of the welfare functions to a separate Department of Welfare would have expanded responsibilities as recommended in Volumes I and II of this Report. It would be responsible at the federal level for the administration of health grants, including:

(1) Public Health Grants

(2) Health Services Grants
  (a) Hospital Services
  (b) Medical Services
  (c) Dental Services for children, expectant mothers and public assistance recipients
  (d) Prescription Drug Services
  (e) Optical Services for children and public assistance recipients
  (f) Prosthetic Services
  (g) Home Care Services

(3) Professional Training Grants

(4) Health Facilities Development Grants

In the administration of these grants it would, as it now does, provide advisory and consultant services in connection with specific grants and also carry out programme research.

In the special area of prescription drugs, the Department would be responsible for enlarging its Drug Advisory Committee and the development and publication of a National Drug Formulary and a Drug Information Service.[1]

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[1] *See* Volume I, Chapter 2, Recommendations 61 and 62, pp. 41 and 42.

"61. That the functions of the Drug Advisory Committee which is responsible for advising the Department of National Health and Welfare be expanded, and its membership enlarged to include representatives of the Canadian Medical Association, l'Association des médecins de langue française du Canada, the Canadian Pharmaceutical Association, the Canadian Hospital Association, the provincial Schools of Pharmacy, the provincial Colleges of Pharmacists, and the provincial Departments of Health.

"62. That the Food and Drug Directorate, with the assistance of the Advisory Committee, prepare and issue a National Drug Formulary which would be maintained on a current basis. This Formulary would include only those drugs which meet the specifications of the Directorate, and would be identified as such, and therefore eligible for inclusion in the Prescription Drug Benefit, one of the objects being to minimize the cost of prescribed drugs. There should be established an appeals procedure for dealing with rejected applications, and an Information Service which would issue periodic bulletins providing the latest information on drugs and drug therapy to physicians, pharmacists, and hospitals."

In Volume II, Chapter 10, addenda to Recommendations 61 and 62, p. 297, we have suggested that representatives of the dental profession be added to the expanded Drug Advisory Committee and that members of the profession receive the bulletins issued periodically by the Drug Information Service.

Health Planning Council of Canada

The Health Planning Council of Canada would be concerned with matters relating to the promotion or preservation of the health of the people of Canada.

It should be appointed by the Federal Government from panels recommended by professional bodies, voluntary agencies, business, labour, farm and other associations. It would be financed by the Federal Government and would possess its own chief executive officer and planning staff. It would report annually to Parliament through the Minister of Health and make special reports when requested.

The principal responsibilities of the Health Planning Council of Canada would be first, to study the health needs of Canadians and to make recommendations relating to programme development and improvement of health services; second, on the basis of data supplied by the Health Sciences Research Council and other statistical collection agencies, to study and to make recommendations relating to the medium- and long-term needs for personnel, facilities and health research; third, to study and to make recommendations relating to the co-ordination of the activities of professional, voluntary organizations and governments in the area of health services; and fourth, to seek full and regular co-operation with provincial Health Planning Councils, provincial Health Services Commissions and provincial Health Departments. The recommendations of the Council would be available to the Federal-Provincial Health Services Co-ordinating Committee and to the Federal-Provincial Health Ministers Conference for their consideration.

Health Sciences Research Council

The Health Sciences Research Council should be the principal advisor to the Government of Canada in the planning and support of health research and the allocation of research funds. As such, it would be responsible for the assessment of Canada's research needs and would have power to appoint the medical, dental and other professional staff and to establish the technical advisory committees required to fulfil these functions. The organization, financing and responsibilities of the Council have been described in Chapters 4 and 5.

The Council would be responsible for the administration of Health Sciences Research Grants; for participation in the development and maintenance of a continuing system of health statistics and of studies related to the assessment of current health problems and their trends; for the development of medium-term and long-term projections of Canada's needs for health personnel, facilities and research on behalf of the Health Planning Council

of Canada; for the evaluation of intramural research conducted by departments of the Government of Canada in the area of medical, dental and related scientific research; for the evaluation of the effectiveness of the various elements of the Health Services Programmes as a way to improve the quality of health care Canadians receive.

Federal-Provincial Health Services Co-ordinating Committee

This body should consist of the chief executive officers of provincial Health Departments and Health Services Commissions in the provinces and territories and the Deputy Ministers of the federal Departments of Health and Welfare. The Deputy Minister of Health should act as chairman of the Committee. It would be financed by the federal and provincial governments and its members would report to their respective organizations.

This body would act as the co-ordinating body for all administrative matters involving interprovincial and federal-provincial relationships in the area of health services and resources. It would have access to technical and other advice from the various Health Departments, Health Planning Councils and the Health Sciences Research Council.[1]

Federal-Provincial Health Ministers Conference

This body consisting of the Federal Minister of Health and the provincial Ministers of Health would have annual meetings, and special meetings when necessary, to discuss issues of health services policy. It would have access to information and proposals from all other organizations. It would ensure periodic meetings at regular intervals to discuss common health problems.

CONCLUSION

The Commission has recognized that diversity and decentralization are essential to encourage and permit experiment and improvement. If individual initiative is stifled or regimented then any organization becomes ineffective. The recommended health programmes for Canadians leave individual professional practitioners free to continue their practice as "independent contractors" as is the case for other health organizations. Moreover, with ten provinces each developing its own institutional structure, within that structure is room for diversity, for different solutions to the problems of organizing regional hospital systems, of providing medical services, and all the other programmes and services. The comparative success of each of

[1] This Co-ordinating Committee would absorb the functions of the Dominion Health Council and carry out the broader responsibilities outlined above.

these different approaches will be evident to all Canadians who can then choose or modify—on the basis of merit.

Having set out what we believe is involved in the comprehensive health care programmes which we have recommended, we want to make clear what is *not* involved in the implementation of these programmes. The pattern of organization will not represent a single, unified, monolithic government-controlled system.

It is not a single system because we visualize ten provincial programmes and separate programmes for the Yukon and the Northwest Territories.

It is not a unified programme in that it permits diversity among different provinces and the Territories, as long as such programmes meet the basic health needs of the nation including universal coverage regardless of age, or condition, or ability to pay.

It is not a monolithic system because it consists of diverse administrative and advisory bodies at all levels of government, federal, provincial and local, that include in their membership representatives of the health professions, the public and voluntary associations, that will be required by law to report to the respective legislatures and to Parliament.

It is not government controlled because of the emphasis on the *co-operative* aspect of planning, implementing and organizing health care programmes in Canada in which all sectors of society and government participate on a continuing basis and also because it leaves the practice of medicine and of dentistry wholly in the hands of physicians and dentists on whose integrity and competence will depend a high standard of professional performance based on free professions in a free society.

But in this complex society we cannot run the risk of having no co-ordination or plan for consistent and adequate growth. All social institutions and professions, all business and government organizations are in the process of adapting to the changes generated by population movement and growth, specialization and the rapid accumulation of knowledge. Universities and their staffs are seeking to adjust to their growth in size, the new tasks required of them, and their integration into business and community life. Even nation states have had to seek for new organizational forms to meet the challenges of an increasingly complex society. The European Economic Community is but one attempt to achieve the co-operation and constructive planning that modern technical and economic change requires.

The provision of health services also must be co-ordinated and planned. What we recommend here is not regimented co-operation and planning enforced by some all-powerful central body but a programme for achieving co-operation and agreement about the objectives we want and the means to achieve them. No matter what attitude to administration or

planning one adopts it is not possible to administer or plan for hospital, medical, dental, optical or drug services separately. The development of a hospital services programme or a drug services programme requires that a medical services programme be considered at the same time. What is crucial is that all affected by indicative planning and by the co-ordination of health facilities have a voice in such developments. We have shown how this can be done by the participation of the public, government and the professions in decision-making and the establishment of policies and targets at the provincial and federal levels and by consultation with interested parties at the regional and local levels.

We recognize that since the funds for the operation of the Health Services Programmes come primarily from the federal and provincial governments there must be some public control over the development of these Programmes. Providing the terms of the Health Charter are observed this control should not be subversive of the ends that all Canadians seek. On the other hand, we believe that the establishment of provincial Health Services Commissions, along with representative Health Planning Councils at all levels, will provide the independence that is needed if these organizations are to attract the talented, responsible and dedicated people necessary to close the gap between the actual and potential level of quality health care. We also believe that the organizational arrangement we have recommended will provide a structure founded upon democratic ideals and practices and in harmony with the evolving federal-provincial pattern of co-operative programmes.

The use of public funds in any form, whether it be to subsidize private insurance funds or voluntary prepayment plans must necessarily involve public responsibility for the expenditure of such funds. As we have demonstrated, the availability and the provision of health services are of public concern whether a universal comprehensive prepayment programme is available or not. But when such a programme is introduced, the public interest is enhanced. Fortunately, the public interest is essentially the same as the interest of those who provide health services—to see that the Canadian public gets the best possible health care.

The organization of any health services must be considered in relation to all other health services. The need of the patient for continuous high quality care and the interest of the community in the use of scarce resources in an effective manner reinforce each other. Effective organization and individual responsibility are not mutually exclusive. Co-operation and consultation can go far to see that Canadians get the best possible health care at a cost that is not beyond the community's capacity to pay and that leaves the professions with the rights and responsibilities that free professions must have if they are to remain independent and creative.

8

Co-ordination of Health Services at the Community Level

INTRODUCTION

At the local level, personal health services are provided by physicians, dentists, nurses, and other health practitioners, acting independently or through hospitals, voluntary organizations, and government agencies. The recommended Health Services Programmes will not alter this existing pattern. Nevertheless, at the local level the problem of the co-ordination of health services must be solved if the Health Services Programmes are to be effective in providing care of high quality in a way which embodies the principles stated in the Health Charter for Canadians.[1]

In Chapter 7 we discussed the recommended future organization of health services at the provincial and federal levels. This chapter deals with the organization of health services at the local or community level. The need for co-ordination at this level was constantly urged upon the Commission by spokesmen for a variety of organizations.

PRESENT PROVISION OF LOCAL HEALTH SERVICES

We have described the multiplicity of agencies and services which now serve the health needs of our communities. For the patient there are a number of choices. He will most likely turn to a general practitioner, either the one

[1] It must be clearly understood that we interpret the mention of the *best* possible health care in our Terms of Reference to mean care of the highest possible quality and not necessarily the *most* possible health care. It also means the best possible health care under the prevailing circumstances or conditions. Though every effort must be made to maintain certain minimum standards in all parts of the country, it will be impossible to overcome all differences, and allowances will have to be made for services in certain regions such as sparsely settled areas, particularly in the North.

whom he considers his family physician or one chosen on the advice of friends or neighbours. Similarly, he will seek the services of a dentist. If he attempts self-diagnosis, he may decide to consult a specialist. If it is his eyesight that troubles him, he will choose between ophthalmologist and optometrist. There are osteopaths, podiatrists, chiropractors, and other practitioners he may decide to consult.

In order to provide his patient with high quality care, the physician will want to use all the available services. These may include X-ray examinations, laboratory tests, a course of treatment by a therapist, specialist service and/or admission to one of the several types of hospitals. The great merit of the modern hospital is that it incorporates a wide range of services, including nursing, and a physician can readily treat a number of his patients on his daily hospital round. But there are, in addition, an increasing number of community-based services available to patients, often equally adequate as the services in hospitals and less expensive.

One of the major problems in urban centres where these agency services are numerous is that of communication. As we pointed out in Volume I,[1] the physician needs some kind of assistance in mobilizing such of these services as he requires outside the hospital as well and as readily as he is served inside the hospital.

In point of fact, hospital developments themselves strengthen the case for co-ordination of all services on a broad community basis. The growing complexity, costliness and specialization of the hospital has had far-reaching effects not only on the individual institution but also on the structure of what is emerging as a hospital system.

The modern hospital transcends the financial capacity of many municipalities, and much of the costly modern equipment cannot be used efficiently if it serves only small populations. This necessitates the regional planning of hospitals and in the larger centres a division of labour among local hospitals as far as certain types of expensive equipment and specialized services are concerned. Regionalization would not be possible, however, if modern transportation and communication had not at the same time facilitated travel so that many patients can safely be brought to a strategically located hospital outside their own community. This means a trend towards a degree of centralization of hospital services, particularly in the acute-treatment general hospital and in some of the highly specialized rehabilitation services.

We find, then, that as in many other activities such as trade, industry and education, we have come to think of the community as having a much larger geographic and population base than the traditional self-contained municipality. Modern transportation, communication and the accelerated technical revolution have necessitated planning on a much broader basis

[1] *See* Volume I, Chapters 2 and 15, pp. 61 and 624.

than in the past. Regional rather than local planning resulting from these circumstances means the acceptance of objectives determined on a broad regional rather than a limited local basis, leading to a pooling of interest which—though somewhat reducing local autonomy—brings to the less populated areas regular access to the more highly specialized services which can be maintained efficiently only for larger population groups.

Apart from this arrangement of hospitals in terms of their size, location, equipment and hence the services they provide, there has been a shift in establishing certain types of hospitals. The increasing load of chronic illness and the high cost of acute-treatment hospitals have contributed to the separation of the chronically ill in special institutions or wings for the chronically ill and convalescent. On the other hand, with modern treatment methods, effective care can be given to mentally ill and tuberculosis patients in general hospitals. The special facilities required for rehabilitation services have led to the addition of wings to general hospitals as well as to a new type of institution: the rehabilitation centre.

As attempts have been made to co-ordinate hospital services, hospitals have sought to adjust their services to the changing needs of the same patient during his stay in the institution. This idea has received formal recognition by the introduction of the principle of progressive patient care whereby the patient in the same hospital moves from intensive treatment to the self-care stage.

The position of the voluntary community agencies is beset with numerous uncertainties. An agency providing, for instance, physiotherapy services to children or adults must plan its operation with perhaps little or no guidance as to the extent of the problem, or knowledge of similar or related services available. It may also have to make arrangements with service clubs or other community agencies for such services as appliances, equipment, or the transportation of patients. The planning of new services and the adjustment of existing ones is often left to the initiative and ingenuity of individuals or agencies without the benefit of an adequate appraisal of needs and resources. Public health departments more often than not lead an existence of their own, separate from the main stream of personal health services.

These local developments in health services have resulted in:

(1) a multiplicity of services,

(2) a multiplicity of auspices, and

(3) a multiplicity of administrative arrangements.

This multiplicity however, is the natural result of progress made in the health field within the existing framework of Canada's social, economic, and political institutions. Roemer has described similar developments in the United States:

> "There can be no doubt that the overall effect of all these social processes is to make American health service more and more socially

> organized. Yet the organization occurs in segments. Particular needs are met with particular programs. Actions are taken by government at all levels and by hundreds of voluntary agencies. Special efforts are applied to a certain population group, a certain disease, or for the provision of a certain type of technical service. The focus may be preventive or therapeutic or it may be both. The organization may involve direct provision of some health service by a structural social entity, or it may involve the imposition of certain formal standards and economic arrangements over the provision of services by individual medical practitioners. Social organization may also apply to the world of medical research or professional education."[1]

Clearly, under these circumstances we cannot expect (a) these community services to develop fully, (b) effective use to be made of them, (c) the services to be well planned without gaps on the one hand or overlapping on the other, (d) assurance of a high quality of service, (e) patients and physicians to be aware of and accept these services, unless we plan.

EMERGING PATTERNS OF LOCAL HEALTH SERVICES

There can be no doubt that with continuing scientific and technological progress, with expanding urban centres and in the absence of planning and co-ordination, such fragmentation of our health services will continue. If we are to reap the full benefits of existing and future scientific advances and provide adequately for the growing load of chronic illness and disability, we must arrange for the co-ordination of the many parts of the health services. This is not a new or revolutionary proposal. Attempts at co-ordination have been going on for many years, rehabilitation services being a notable example.

While the shortcomings of this lack of co-ordination at the community level in the face of an ever-increasing fragmentation and multiplicity of services have become apparent, there have been a number of developments which may mitigate this situation. Among the most clearly discernible new forms of organization are developments in general practice, medical group practice, organized home care, and the co-ordination of a wide range of rehabilitation services.

General Practitioner

Due to a number of developments, the role of the general practitioner in the health services complex is undergoing a re-appraisal. The longer lifespan has resulted in an increased number of older people requiring treatment, largely for chronic conditions. A continuing high birth rate has meant that

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[1] Roemer, M. I., "Changing Patterns of Health Service: Their Dependence on a Changing World", *The Annals*, March 1963, pp. 54 and 55.

the general practitioner sees more maternity cases. The increased awareness of psychiatric symptoms by the physician and the public has stimulated attempts to integrate psychiatric services into the main stream of health services with the general practitioner playing a vital role in the early diagnosis and treatment of these disorders. The increasing emphasis on the social as well as the medical rehabilitation of the patient has reinforced the need for the general practitioner with his knowledge of the patient's social environment. The growing knowledge of the importance of social factors in health and illness has served to highlight the continuing care of the whole patient with the general practitioner as the key figure in this arrangement.

Thus, we find in Canada, as in other countries, particularly the United States, two different trends in the pattern of practising medicine. On the one hand, as medical science has advanced rapidly, there has been a strong tendency towards increasing specialization which promises the best possible health care by encouraging research and advanced work in combating specific health problems, both of the body and the mind.[1] On the other hand, there has been increased emphasis on the "wholistic" approach in medical care, with the emphasis on the whole patient, as a man, rather than merely as a disease entity.

Although important medical progress has resulted from increasing specialization in the health field, it has created new problems that may be summed up under the term "medical fragmentation". The situation in the United States has been described as follows:

> "... there is no doubt that the fragmentation of medical practice has resulted in the fragmentation of the patient. The situation could easily develop to the point of 57 varieties of specialists but no doctor to treat the individual. The task of putting the patient together again—of reconstructing the 'whole man'—is an essential next step in the progress of medical practice."[2]

This fragmentation of health services has also occurred in Canada, but an opposing trend is evident in the growing recognition of the importance of the general practitioner or "family doctor" in the provision of medical services. The present and future role of the general practitioner has caused uncertainty and dissatisfaction among some practitioners about their function in a profession that has become increasingly specialized; but the new trend stems from basic changes in the pattern of medical treatment and the growing recognition of the patient rather than the illness as the focus of health care.

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[1] For further discussion of the role of the specialists in medical practice, *see* Volume I, Chapter 7, pp. 248 and 249; Judek, S., *Medical Manpower in Canada*, a study prepared for the Royal Commission on Health Services, Chapter 4, Ottawa: Queen's Printer (*in press*); and MacFarlane, J. A., *et al., Medical Education in Canada*, a study prepared for the Royal Commission on Health Services, Chapter 9, Ottawa: Queen's Printer (*in press*).

[2] Somers, H. M., and Somers, Anne R., *Doctors, Patients and Health Insurance*, The Brookings Institution, Washington, D.C., 1961, p. 33.

With the advancement of scientific knowledge, specialization in medicine will continue to grow, but it will not replace the general practitioner, nor would such a development be desirable, especially in Canada's social and geographic setting. Only in the larger urban centres will all the existing specialties be represented. It is true, on the other hand, that modern means of transportation and communication make specialists' services accessible even to patients at a considerable distance, which means that there is less need for the general practitioner to engage in areas of medicine for which he has not been specially trained.

Although some hospitals, particularly the larger institutions and teaching hospitals, often restrict staff privileges of the general practitioner in favour of the specialist, the former normally treats his patients in a community hospital. His hospital appointment allows him to carry out those procedures in which he is fully qualified. These hospital privileges also enable the general practitioner to consult with the specialist and thereby add to his knowledge of medicine. The continuous association with specialists is probably one of the most effective means at the disposal of the general practitioner for maintaining and improving the quality of the care he provides.[1]

The specialist has assumed some of the functions of the general practitioner: the obstetrician, normal deliveries; the paediatrician, care of children; the internist, uncomplicated medical cases, and so on. In part, this has been brought about by public demand. Notwithstanding this trend there continues to be a need for the general practitioner to retain his role as the family physician. Only he seems to be in a position to treat the whole patient. While he may refer an increasing number of cases to a specialist, referral and consultation may well develop into a two-way flow as patients after acute stages of severe illness are returned to the general practitioner for continued care, the supervision of home care services or rehabilitation procedures. General practice also plays an important and growing role in such fields as health maintenance and mental illness and has a place in the context of group practice.

Thus the future role of the general practitioner is of increasing significance. He will provide both preventive and curative medical services to those under his care on a continuing basis. When complex conditions arise, he will seek advice from his specialist colleagues: "You might call this man a patient-oriented community-based physician".[2]

These developments and the resulting intensive re-appraisal of the role of the general practitioner have implications for medical education. Is it to be based on the present pattern of the basic medical education or on a new

[1] Suggestions regarding the qualifications and training of the general practitioner of the future are contained in MacFarlane, J. A., *et al., op. cit.*

[2] Johnston, W. V., *The College of General Practice in Canada—Its Tremendous Trifles*, Presentation to the Australian College of General Practitioners, Sydney, Australia, October 24, 1963, p. 11.

body of knowledge that warrants separate departmental organization in the medical school and teaching hospitals with teachers having qualifications in this area?

What can be done to equip the general practitioner adequately for the more complex tasks that he is expected to perform in the ever changing pattern of medical practice? The U.S. study, referred to earlier, mentioned a four-pronged approach put forward by various sections of the medical profession:

> "1) upgrading the GP; 2) replacing the GP by a better trained type of family or personal physician—the internist and pediatrician are most frequently mentioned; 3) training all doctors in the philosophy and techniques of 'comprehensive care'; and 4) promoting an institutional environment which will facilitate a coordinated approach. These four methods are by no means mutually exclusive although some of their proponents appear to think so. All are worthwhile objectives in themselves. It is to be hoped that experimentation along all four lines will continue. It appears, however, that certain of the approaches are more practical than others and that the fourth, in particular, is the *sine qua non* for effective reconstitution of the 'whole patient'."[1]

In Canada, this question of the future training and role of the general practitioner has been under discussion and review for some time. The establishment of the College of General Practice of Canada was a result of the new attention focused on general practice in an era of specialization. The College was established by the Canadian Medical Association in 1954, after a study had concluded:

(1) That many physicians of the highest calibre were drawn and should continue to be drawn to the field of general medicine.
(2) That, in fact, medicine had become so complicated and specialized that the general physician has become even more necessary than before as the patient's medical adviser, as well as personal doctor.
(3) That the highest standards of health care did not depend upon ever narrowing specialization, but rather that general physicians should be encouraged to and be free to achieve their own standards of practice, comparable to those of the specialists.[2]

For his changing function the general practitioner has to be prepared by emphasis in his education on these new aspects of his practice, aspects which are not now being covered adequately in the specialty-oriented training of the large teaching hospital. Some Canadian medical schools have already begun to add experienced general practitioners to their teaching staff. Medical students in some medical schools can see patients cared for in general practice outside the hospital in physicians' offices, in out-patient clinics, in patients' homes, and in the context of such community services as public health clinics

[1] Somers, H. M., and Somers, A. R., *op. cit.*, pp. 33 and 34.

[2] *College of General Practice of Canada*, brief submitted to the Royal Commission on Health Services, Toronto, May 1962, pp. 5 and 6.

or home care plans. In 1960, the College of Medicine of the University of Saskatchewan stated that during the six previous years from 18 to 22 general practitioners at a time have been acting as clinical teachers, comprising as a group the Department of General Practice of the University Hospital.[1] The report comments very favourably on the contribution rendered by these teachers, particularly in the psychiatric field.[2] Moreover, like all physicians in the face of rapidly growing scientific knowledge and changing medical techniques, the general practitioner needs the continuing education on which great emphasis is being placed by the College of General Practice. "The core of the College's active membership regulations is the unique mandatory requirement of one hundred (100) hours of organized and approved post-graduate study in each two-year period."[3] This the Commission recognizes as a major contribution to the quality of health care, and so necessary has continuing education become that the profession should do all in its power to see that *all* general practitioners meet *at least* these minimum standards.[4]

While the need for the teaching in these new aspects of general practice has been established, the exact role of general practice within the medical school and its curriculum is still under discussion. Is general practice to continue to be part of the physician's basic training? Is it developing into another specialty? Or is it the function of general practice to bring about the synthesis of the various specialties? There are departments of general practice in hospitals. Should there be, correspondingly, departments of general practice in the medical schools?

These questions were studied at a conference called by the College of General Practice in 1962. One of its findings regarding undergraduate medical education was that "a programme must be developed which will give the student a more realistic view of family practice in the community", i.e., more realistic than that which can be derived from the rather selected group of patients who use the out-patient facilities of hospitals. Family physician "preceptors" for students are part of this future programme which the Conference recommended.[5] The Second Conference on Education for General Practice[6] further studied the status of education in general practice within the medical school. At this Conference the problem was clearly identified. The answer must be found to the question of "when does a subject attain departmental status in the university and what are the criteria for the

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[1] The College of Medicine, University of Saskatchewan, *Brief to the Advisory Planning Committee on Medical Care of the Province of Saskatchewan*, Saskatoon, 1960, pp. 55 and 56.

[2] *Ibid.*, pp. 56 and 57.

[3] College of General Practice of Canada, *op. cit.*, p. 7.

[4] *See* Volume I, Chapter 2, Recommendation 150, p. 72.

[5] College of General Practice of Canada, Conference on "Training for General Practice", November 28 and 29, 1962, Preliminary Report, p. 2. *See* Report on Second Conference on Education of General Practice.

[6] Sponsored jointly by the Association of Canadian Medical Colleges and The College of General Practice of Canada, Toronto, November 27-29, 1963.

appointment of a professor in this field".[1] The Conference came to the conclusion that, at the time, the setting up of chairs in general practice would be premature, pending the answers to the foregoing questions, but "that the College of General Practice of Canada bears the major responsibility in defining Canadian General Practice and in establishing the body of scientific research necessary to implement education for general practice".[2]

The College of General Practice has already outlined a programme of research.[3] The content of general practice will have to be redefined in view of its yielding certain areas to the specialties while the responsibility of the general practitioner may be extended in others, such as in the care of the whole patient in his family and community, and in psychiatric care, home care and rehabilitation. The developments in these areas of medical care have been rapid in recent years and the recommendations made by this Commission will add momentum to this trend.

It is, therefore, both important and urgent that the general practitioner of the future be fitted for his newly emerging role. We endorse the conclusion that "the continued flow of practitioners into the General Practice field must be assured and will depend on the example of their teachers".[4]

The supply of teachers, on the other hand, depends on suitable conditions for their teaching.[5] The field of general practice includes large elements of preventive, social, and community medicine, but these are probably not the only elements. There is, no doubt, room for improvement in the training of the general practitioner even in relation to his traditional duties.[6] The new concept of general practice, however, has created a pressing need for a re-appraisal of his education and of the demands on the qualifications of his teachers. In order to achieve a high level of general practice, we must ensure the excellence of the teachers themselves by providing them with opportunities for advanced study and research commensurate with those available to their specialist colleagues. Our recommendations are, therefore, for comparable financial support once the criteria for their training have been established by the competent agencies of the profession and the medical schools.

The Commission recommends:

228. That the Association of Canadian Medical Colleges, in consultation with the College of General Practice of Canada and others concerned

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[1] *Ibid.*, p. 227.
[2] *Ibid.*, p. 234.
[3] College of General Practice, *op. cit.*, pp. 20 and 22.
[4] The College of Medicine, University of Saskatchewan, *op. cit.*, statement by Dr. S. A. Orchard, Appendix J, p. ii.
[5] *Ibid.*
[6] Clute, Kenneth F., *The General Practitioner*, Toronto: University of Toronto Press, 1963.

give immediate attention to the question of setting up administrative Departments of General Practice in the teaching hospitals and subsequently, Chairs of General Practice in the Faculties of Medicine.

229. That, as part of a seven-year crash programme, special Professional Training Grants of $5,000 per year be allocated to medical graduates undertaking post-graduate study to qualify for the teaching of general practice in the Faculties of Medicine.

Group Practice

The medical group or clinic combining under one roof general practitioners and a spectrum of specialists, paramedical personnel, and laboratory and X-ray facilities, is a further development with a number of advantages to the physician and the patient.[1] These groups may be considered as a much needed move towards a synthesis of the medical specialties. There are many forms of partnerships and groups, all of which involve in some degree a change from independent solo practice to an organizational arrangement offering certain other advantages.

One result of these new patterns of practice is a closer association of the physician with his colleagues. This may extend to either his professional activity or the economics of his practice, or both. Closer professional association means the benefit of shared knowledge, but it also results in the acceptance of various forms and degrees of professional collaboration. This, as well as the enhanced authority of the provincial Colleges of Physicians and Surgeons[2] is an important step towards maintaining a high quality of physicians' services.

Home Care

Having described organized home care in Volume I of this Report[3] as a health service that should be made available within the framework of the recommended Health Services Programmes, we wish to examine here briefly its role as an emerging pattern of health services.

Home care plans so far have not been the outcome of national, provincial, or regional planning,[4] but have originated locally for a variety of reasons in a number of different circumstances. Whatever their origin, however, home care plans—like medical group practice—result in the co-ordination of hitherto separate and independent services. In most cases, home care

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[1] For more detailed discussion *see* Volume I, Chapters 7 and 13.

[2] *See* Volume I, Chapter 2, Recommendation 38, p. 34.

[3] *See* Volume I, Chapter 15.

[4] With the exception of the home care services provided by the public health nurse in British Columbia.

plans are established as alternatives to in-patient hospital care. It follows that if care outside the hospital is to be substituted, a range of services, similar to those needed by the patient if he were in the institution, must be provided. These services may well exist in the community, or could be made available, but it has been found that their mere existence has not automatically resulted in their effective use. To achieve this end, it has been necessary to establish a co-ordinating agency in the form of the organized home care plan. Once such a plan is in existence, the physician can refer patients to it very much as he refers them for admission to the hospital, indicating the services required, but without the need on his part to deal with each of the various service agencies separately.

This we regard as an important attribute of organized home care, and one which merits far greater attention than it has hitherto received. Where there is close contact between the hospital and a home care programme, we have, in fact, a model for co-ordinated health services in the community. The shortcoming of most existing plans is their limited extent. Even in cities where they exist, they are available only to a very small part of the population.

What is the impact of increased home care on the physician's time and pattern of service? We have mentioned that the physician can see a greater number of his bedridden patients more quickly and easily in the hospital than if he has to visit them at their homes. Early transfer of a patient from the hospital to home care results in a saving in terms of hospital days and costs. It usually comes at a stage in the patient's illness when he does not need daily visits from a physician but may require periodic visits by the nurse and other health workers.

In the foregoing discussion of the changing patterns of the physician's services we have referred to the changing role of the general practitioner in a world of growing specialization. The services under a home care plan require supervision by a general practitioner even though a specialist may be called in from time to time. Further study is needed to determine if an extension of the scope of home care programmes will affect the respective functions of the general practitioner or the specialist. The same applies to the greater attention given to the co-ordination of rehabilitation services reaching beyond the hospital stage and also requiring medical supervision or follow-up. These may develop new aspects of general practice which, in order to be handled effectively, must also be reflected in the education, training and role of the general practitioner.

In any community organization of health services, we assign great importance to the integration of preventive health services and such health maintenance projects as may be effectively developed. Encouragement must also be given to the various means of promoting physical and mental fitness.

Preventive Services

Preventive measures have been most specific and most spectacular in their success in the control of communicable diseases. We have emphasized the need for maintaining our guard in these areas and for bringing them to bear on newly emerging or newly recognized health hazards.[1] The effect of immunization can be seen immediately and clearly in the decline of such diseases as smallpox, diphtheria, or poliomyelitis. But there have been other means of prevention at work contributing to the general decline in mortality and the increasing life expectancy of Canadians. Among them are the environmental health measures: better sanitation, safe water supplies, gradual control of air pollution and food and drug control. Improved standards of living generally are contributing to better health even though they may give rise to certain "health hazards of plenty", such as obesity and diabetes. Not all of these measures are health services but they must not be lost sight of in the future organization of the community health services. To the extent that they are part of the functions of health agencies, they must be integrated into the proposed organization. We have discussed the risk of adverse effects from diagnostic X-rays,[2] but this is only one aspect of the danger from radiation which will require intensified study and control measures. The same applies to a variety of carcinogenic substances, known and still unknown, in our environment. The health of animals, for example, both wild and domestic, is a recognized environmental factor in the health of man.

Environmental health measures in the places of work contribute to physical and mental health. All this has opened a wide new field added to the traditional functions of the public health agencies. Public health facilities must be geared to their new tasks and public health positions must offer conditions comparable to other health fields if they are to attract well qualified personnel.

It should also be reiterated in this context what we have said of the individual's responsibility "to observe good health practices and to use available health services prudently".[3] But here again he needs the help of health agencies to determine scientifically what good health practices are. It is the task of health education—another function of the health agencies—to interpret to him these findings in a manner which he can understand and is likely to accept. Among the good health practices are personal habits, healthful recreation, maintenance of physical and mental fitness, and healthful nutrition. The activities of the Welfare Branch of the Department of National Health and Welfare under the Fitness and Amateur Sport Act[4]

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[1] *See* Volume I, Chapter 5, pp. 166 and 167.
[2] *See* Chapter 3, pp. 82-84.
[3] *See* Volume I, Chapter 1, p. 12.
[4] C-131, Fourth Session, Twenty-Fourth Parliament, 9-10, Elizabeth II, 1960-61.

are intended to provide Canadians with the knowledge and opportunity of activities to promote fitness.

Nutrition is another area of the individual's responsibility for his and his family's health where the responsibility can be exercised only on the basis of authoritative information provided by the health agencies responsible for scientific research in this area. Together with sanitation and adequate housing, improved nutrition has no doubt played a major part in achieving the high standard of health Canadians enjoy today. Still problems continue to persist. One is overweight and its adverse consequences on the health of many Canadians. The other relates to the substandard diets on which many people in Canada still live. Hence, the role of nutrition in the framework of the future health services can hardly be overemphasized.[1] Yet little is known on a consistent and continuing basis of the nutritional status of Canadians. Proper nutrition, however, is not merely a matter of quantity but also of the right kind of food consumed.[2] Together with fitness programmes, nutrition services may play an important part in the prevention or alleviation of chronic diseases.

While the prevention of some diseases has to await a breakthrough in medical research, we have now the knowledge necessary to prevent most accidents. We have discussed in Chapter 6 the role of voluntary agencies in this field, stressing particularly the need for the reduction of traffic accidents, but accidents in the home and in industry, on the farm, and in recreation also remain major health problems. Prevention is partly a matter of publicly provided or enforced safety devices, but very largely it remains a matter of personal responsibility. Full awareness and exercise of this responsibility, supported by knowledge through education, can greatly reduce the toll in life and health.

Knowledge about these matters will reach families and individuals through the many channels of health education. The general practitioner in his new role will have a major part to play in this, whether in the context of his private practice or in some form of health maintenance clinics.[3] The periodic examinations we have recommended[4] are intended to provide physicians, dentists and patients with an opportunity for preventive measures

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[1] Stare, F. J., "Why the Science of Nutrition?", *Nutrition Review*, Volume 8, No. 1, January 1950, p. 4. ". . . Where we have such wonder drugs as penicillin and aureomycin to combat the ordinary infectious diseases such as pneumonia, nutrition stands as the single most important factor affecting our personal well-being. . ."

[2] Subcommittee on Control of Nutritional Diseases, *Control of Malnutrition in Man*, American Public Health Association, New York, 1960, p. 1. "Lack of dietary information, misinformation, fads, and food taboos can and do produce malnutrition in the midst of wealth and plenty."

[3] Roth, F. B., *Statement on Health Education*, prepared for the Institute on Community Education for Health, Saskatoon-Regina, 1961. "Those who accept responsibility for providing health care must provide the necessary leadership to develop the widest possible understanding of the complex nature of the health needs and services."

[4] *See* Volume I, Chapter 2, Recommendation 30(*h*)(ii), p. 32.

of the kind we have discussed, and the immunizations recommended as part of the Medical Services Benefit[1] will ensure that this form of protection against communicable diseases is maintained.

Rehabilitation

In Volume I of our Report we have dealt with rehabilitation largely as a health service, i.e., rehabilitation in the sense of medical restoration. We have referred there to personnel and facilities required and also to the strong rehabilitation component in home care programmes.

In this chapter we are chiefly concerned with the manner in which a rehabilitation service stimulates the co-ordination of the whole range of services required to restore the once disabled to their fullest possible role in the family and the community. This goes beyond the scope of health services proper and, depending on the case, may involve also the services of education, welfare, training, job placement, and other community services directed towards the social and economic as well as the medical aspects of the patient's illness. During the stage of medical restoration the new emphasis on the rehabilitation of the patient means new patterns of service. We see rehabilitation or physical medicine wings being established in general hospitals; an increasing number of therapists employed in general, mental, and tuberculosis hospitals; the emergence of the rehabilitation centre with its in- and out-patient facilities; and the development of rehabilitation and follow-up facilities and services in the community outside the hospital. In many communities facilities for the rehabilitation of the physically disabled have developed over the recent years. More recent is the development of corresponding services for the psychiatric disorders in an attempt to remove as many cases as possible from the traditional large mental hospital and also to reduce the necessity of hospitalization of the mentally ill in the psychiatric wards of the general hospitals.

These local services and home care plans for the mentally ill, like all mental health services, are still largely subject to the traditional separation from general health services, a separation extending also to some home care plans. The acceptance of our Recommendations regarding the integration of mental and tuberculosis services with the general health services[2] will remove this anomaly but the emphasis on community care for the mentally ill and the retarded, including their fullest possible rehabilitation, will considerably add to the demand for services outside the hospital, a demand which needs quantitative evaluation if we are to have a sufficient supply of personnel and facilities. One major obstacle in the path of such an assessment is our lack

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[1] *See* Volume I, Chapter 2, Recommendation 30(*h*)(i), p. 32.
[2] *See* Volume I, Chapter 2, Recommendations 29 and 108, pp. 31 and 56.

of knowledge regarding the reservoir of patients needing rehabilitation services, physical as well as mental, which is one of the most important tasks for the health statistical agencies.

Rehabilitation, however, does not stop once medical science has done all it can for the patient. Nor must we lose sight of the fact that where prosthetic devices and aids are needed medical science is greatly supported by the latest achievements in the physical sciences and that modern engineering contributes greatly to the design and effectiveness of such devices; examples of this are the extraneous power-operated prostheses which have been developed, particularly for children with congenital abnormalities.

The intricacy and complexity of modern prosthetic aids make increasing demands on the personnel and facilities providing these services. To ensure, therefore, a high quality of service, it will be of the utmost importance to maintain appropriate standards in the training of prosthetists and orthotists, as well as in the equipment used and the facilities for its manufacture and fittings.[1]

Medical rehabilitation services at all levels must be geared to meet the demands of intensified rehabilitation services and they must have the resources to meet these demands and, in particular, to ensure the necessary liaison and co-ordination with all agencies involved in this complex service.

Health services are becoming increasingly interrelated with and often dependent on other community services. One of the basic components of home care plans, for instance, is a homemaker service. Other social services such as the provision of meals may be required. In this case health and social services work hand in hand. The chain of rehabilitation services, on the other hand, often means a gradual fading out of the health services proper to give way to welfare services (e.g., sheltered employment), education and training services, placement services, and various forms of follow-up services with or without medical supervision. Many of these services offer excellent opportunities for voluntary action by groups organized to provide certain types of services.[2]

This concept of a spectrum of services indicates the need for the effective co-ordination of all services bearing on rehabilitation, introducing a new dimension into our discussion of the co-ordination of services. Modern principles of rehabilitation require the closely co-ordinated interaction of a variety of health services, usually under different auspices. This may include

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[1] *See* Volume I, Chapter 2, Recommendation 115, p. 60. In view of the contributions by modern engineering techniques to the design of prosthetic aids, we have in Volume I recommended "That funds be made available through the Health Sciences Research Council for research and experimentation into the creation and distribution of prosthetic devices, the development of effective techniques; and by Professional Training Grants for the training of the necessary technical personnel".

[2] *See* Chapter 6.

institutions of different types and services outside institutions which, as already pointed out, require close co-ordination with organized home care programmes.

Many of these principles are recognized in the Vocational Rehabilitation and Disabled Persons Act of 1961. The Act provides for federal contributions to the provinces amounting to half the cost of comprehensive programmes for the vocational rehabilitation of disabled persons. Under the Act, federal activities are co-ordinated and, correspondingly, co-ordinators of rehabilitation services in the provinces have been appointed. The department responsible for carrying out the provisions of the Act at the federal level is the Department of Labour.

It is indeed to the credit of all agencies concerned with the implementation of the Act that in the short time since its passage, an effective and impressive organization has been built up. The Act has, however, one serious shortcoming namely the restriction of its provision to *vocational* rehabilitation aimed primarily at the potentially gainfully employed.

This restriction excludes the large number of disabled persons who, because of age or the degree of their disability, cannot hope "to become capable of pursuing regularly a substantially gainful occupation" but who may nevertheless profit from rehabilitation services to the extent of greater independence from the help of others. They may be able to live in the community instead of in an institution or they may be able to dispense with somebody looking after them. This means returns in happiness and satisfaction as well as economic benefits. Until all those who can profit from rehabilitation services are covered by one co-ordinated system, the co-ordination is not complete thus seriously reducing the effectiveness of the programme. Difficulties exist not only for cases obviously excluded from the provisions of the Act but also for the numerous borderline cases where much time and effort is wasted in determining under which department's jurisdiction the case may come.

We are aware that the Act is broadly interpreted and that homemaking, for instance, is specifically accepted in the agreements with the provinces as a "substantially gainful occupation", but the Act remains restricted to a concept of gainful employment. This restriction may have had some justification originally. The interest in rehabilitation shifted after World War II from the Armed Services to those employed in industry,[1] but it has now broadened into a concern for the disabled regardless of their vocational status.

We note that the National Advisory Council on the Rehabilitation of Disabled Persons at its third meeting in May 1964 unanimously passed a motion requesting the Department of Labour to re-interpret the term "disability" with a view to including all those socially handicapped where a

[1] *See* the activities of the Workmen's Compensation Boards.

reasonable expectation of vocational rehabilitation exists.[1] In our view the provisions of the Act should apply to all disabled persons who may profit from any of the services provided under the Act, regardless of their vocational potentialities. It should be noted that the agreements with the provinces under the Act specify the services provided under the Act which go beyond vocational rehabilitation proper.[2]

The Report of The Royal Commission on Government Organization (Glassco Report) recommended in regard to the medical aspects of rehabilitation that these be co-ordinated by the Department of National Health and Welfare.[3] In its final volume, the Glassco Commission recommended that the Civilian Rehabilitation Branch of the Department of Labour be moved to the Welfare Branch of the Department of National Health and Welfare.[4]

Having recommended the separation of the administration of health and welfare into two departments at the federal level, we face the question of what should become of the Civilian Rehabilitation Branch. By recommending the broadening of the Act, we make it clear that we would like to see all rehabilitation resulting from health defects co-ordinated by one agency without limiting it to certain population groups (such as the employable) or to certain types of health defects (such as either physical or psychiatric). We are equally anxious to ensure that the administering agency cover all services —health, welfare, education, employment—which can possibly aid the impaired. This is basically a matter of legislation as well as of the spirit, knowledge and intentions of those called upon to administer it, no matter what department of government they are administratively associated with.

As long as the aforementioned requirements are met, it matters less which department is responsible for co-ordinating rehabilitation services, but in view of existing problems we conclude that the most satisfactory solution would be an independent agency[5] on which the various departmental interests are represented, under a chairman to be appointed because of his personal qualifications rather than his affiliation with a particular department.

Whatever the structure of this agency, it should be responsible for rehabilitation services of all kinds for all types of health problems, including

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[1] Minutes of the Third Meeting of the National Advisory Council on the Rehabilitation of Disabled Persons, Department of Labour, Ottawa, 1964, p. 13.

[2] Section 4 . . . "(*b*) services and processes of restoration, training and employment placement designed to enable a disabled person to dispense with the necessity for institutional care or the necessity for the regular home service of an attendant;

"(*c*) providing for utilizing the services of voluntary organizations that are carrying on activities in the Province in the field of vocational rehabilitation of disabled persons."

[3] The Royal Commission on Government Organization, *Services for the Public*, Vol. 3, Ottawa: Queen's Printer, 1962, p. 212.

[4] *Ibid., The Organization of the Government of Canada*, Vol. 5, Ottawa: Queen's Printer, 1963, pp. 89-90.

[5] Established similarly to the Canadian Pension Commission or other Commissions or Boards of the Federal Government.

psychiatric disorders and mental retardation. The corresponding organization at the provincial and local level may follow similar patterns, integrated with the organization of health services outlined in this and the previous chapter.

The Commission recommends:

230. That the Vocational Rehabilitation of Disabled Persons Act, 1961, be amended by removal of its restriction to *vocational* rehabilitation and that the terms "disabled person" and "vocational rehabilitation" be revised and redefined accordingly.

231. That a new rehabilitation agency of the Federal Government be established, with representation from the Federal Department of Health, the Department of Welfare, the Department of Labour, the Department of Veterans Affairs, and the Unemployment Insurance Commission reporting to Parliament through the Minister of Labour.

232. That the National Advisory Council on the Rehabilitation of Disabled Persons, with representation from the federal departments concerned, provincial governments, voluntary agencies, medical professions, universities, and employer and employee organizations, act in advisory capacity to the new rehabilitation agency.

CO-ORDINATION AND HEALTH SERVICES ADMINISTRATION

We support the pattern of a multiplicity of health services found in many of our communities today but we recognize that a deliberate effort at co-ordination is needed in order to make such services as effective as possible.

The appointment of this Royal Commission provided for the first time an opportunity for a review by one agency of all aspects of all health services in Canada. In our Report we make it quite clear that we cannot offer solutions to all problems nor will all the solutions which we recommend be applicable indefinitely. On many occasions we emphasize that we can only establish benchmarks which, because of the many dynamic factors in the health field, will need continuing study to bring our observations up to date and to adjust them in the light of changing trends. We have, however, come to the conclusion that in order to make the best possible health services available to all Canadians we must abandon the haphazard and piecemeal approach of the past.

The recommended provincial Health Services Programmes, once fully implemented, are each an indivisible entity. This is reflected in the recommendations for the integrated planning and direction of all health services.

As we have indicated, at the local level the auspices under which the many health services operate are shared among free self-governing professions, voluntary private and semi-public agencies, and local governments.

What we wish to present is a broad outline of possible forms that co-ordination can take but which can be adapted with due allowances made for regional variations and established institutional and professional working relationships.

To set as an objective the co-operation of a variety of agencies is difficult but by no means unrealistic. Voluntary health organizations have been co-ordinating their efforts to an increasing extent. If, so far, these have been sporadic efforts, they illustrate the need as well as the readiness of the agencies concerned for greater co-ordination and co-operation. There is no reason to assume that co-ordination would not be effective on the larger scale which has become necessary. It must work if we are to retain the present basic structure and yet have effective health services.

Although it is vital for good health care that services be co-ordinated in view of the varied conditions and patterns for providing health services in the provinces, it is not possible or desirable to specify in detail how such co-ordination should be carried out. What the patient and the physician need are the ancillary services that make medical care outside the hospital setting effective. What is vital is that such ancillary services are made available and that the information as to how they can be obtained is made known to physicians and others who require them. This type of development already exists in a number of home care and rehabilitation programmes although these are limited to a relatively few areas.[1] What is required is that it be extended to all areas of Canada and that physicians, hospitals, public health authorities and voluntary agencies everywhere participate in the development of co-ordinated programmes. The physician benefits in that he would have ready access to a wider variety of ancillary services for out-of-hospital patients than he otherwise could obtain. The patient benefits from access to services that enable him to regain health. The community benefits from the more effective use of scarce resources, both physical and human.

While we have neither specified who should be responsible for organizing out-of-hospital programmes nor stated who should be responsible for the provision of information about the services available to patients and physicians, we envisage two organizations as sharing the responsibility for seeing that the job is done; these are the provincial Health Services Commissions and Health Planning Councils.

The Regional Health Services Co-ordinator, acting on behalf of the provincial Health Services Commission, is crucially placed to ascertain the gaps in the needs of the community and where co-ordination is required.

[1] *See* Volume I, Chapter 2, Recommendations 116 to 123, pp. 61 and 62.

The regional or local Health Planning Council similarly will be aware of the needs and wishes of health professionals, local governments and voluntary agencies and will be in a position to formulate plans and make recommendations relating to the manner in which co-ordination should be achieved. Together, they may recommend that the co-ordination be the responsibility of the regional or local public health authorities, a particular voluntary agency, a major hospital, or another organization, but they must ensure that the task is done.[1] The leadership and the planning, however, would come from the community through the participation of all interested parties in the making of decisions.[2] The physician, and through the physician the patient, would have access to those services without which good health care out of hospital cannot be achieved.

This means the emergence of a new type of health personnel, namely the health services administrator. The qualifications required for this role will depend largely on the scope of the task the individual is expected to perform. In many of the existing home care programmes the co-ordinator or administrator comes from the visiting nursing service because of familiarity with other community services, with general conditions in the community, and with the particular problems of home care patients. This has worked out very satisfactorily. For administering the more complex systems for large populations, however, formal training in the administration of health services will be required. While small communities may be well served by a person who has been working in the field and gained experience, the knowledge and ability necessary in more complex situations can be better acquired by the formal training—undergraduate and post-graduate—increasingly made available at universities.

The Commission recommends:

233. That the Health Professions University Grant be available for the establishment of undergraduate and post-graduate courses in health services administration at selected Canadian universities.

234. That, as part of a seven-year crash programme, special Professional Training Grants of $3,500 per year be made available to graduate students proceeding to a higher degree in such courses.

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[1] The Health Services Regional Co-ordinator might well be the secretary of the regional or municipal Health Planning Council.

[2] In planning health services for the aged the Canadian Medical Association suggests that "The leadership and responsibility for planning programs for the aged should emanate from the community through meetings of all interested agencies including the medical profession. A central committee representing various interested groups is possibly the best method of establishing community programs. The Provincial Government should be represented on these committees as it is in a position to stimulate action for the development of facilities and to provide financial assistance where necessary." Canadian Medical Association, *Health and Institutional Care Aspects of Aging*, a submission to the Senate Committee on Aging, Ottawa, November 5, 1964.

Regional or Municipal Organization

Two points emerge from the foregoing discussion: (1) the proposed co-ordinating organization should evolve from already existing or emerging patterns through the systematic application of tried and accepted forms of organization rather than the imposition of a new administrative machinery; and (2) the basic model should be adapted to local conditions and requirements taking into account the existing basic administrative organizations. Flexibility will be the watchword.

It follows that the area to be considered as a community or region for the purposes of the health services organization cannot be uniformly defined and delineated. It may consist of an existing metropolitan area, health unit or region, a region identified as such for purposes of hospital planning, groups of municipalities or counties, or an area whose boundaries have been determined by a study of utilization patterns.

The implementation of the programme will result in two agencies at the regional or municipal level: (1) the regional and/or municipal Department of Health, and (2) the regional and/or municipal Health Planning Council.

The regional and/or municipal Department of Health will provide the organizational basis for home care and rehabilitation programmes if these are not provided elsewhere. It will maintain liaison with the provincial Department of Health, the provincial Health Planning Council and with other organizations concerned with the provision and organization of services associated with rehabilitation and home care. It will co-operate with the Health Services Regional Co-ordinator and the regional and/or municipal Health Planning Councils in the planning for health services for the benefit of the physician and the patient.

The regional and/or municipal Health Planning Council will make recommendations to the provincial Health Planning Council for programme development and the improvement of health services in the local or regional area. It will also make recommendations regarding the regional needs for personnel, facilities and organization, and the activities of voluntary and government health organizations. It will appoint an executive secretary to work with the health officers of regional and local health departments and the Health Services Regional Co-ordinator in the establishment of regional or local health plans.

It is inherent in the principles laid down in the Health Charter for Canadians, and in our concept of the proposed organizations and councils that the fact of their establishment alone will not alter the existing distribution of functions and responsibilities between the professions, voluntary organizations, and governments. Nor should they necessarily serve to maintain the *status quo*. As in the past, any changes in the present role of the

respective agencies will come about as the result of the continuing evolution in our health services and social institutions. The only difference will be that the haphazard, sometimes inadequate and sometimes wasteful development of the past will be replaced by a careful assessment of current and future needs, followed by appropriately planned expansion of the services required.

CONCLUSION

Volume I of our Report dealt with the basic concept of the recommended Health Services Programmes, their financial structure, and questions concerning the resources necessary for the orderly development of their component parts. In the previous chapter, we discussed the administrative implications at the federal and provincial levels, which would ensure that the various programmes develop into the comprehensive system that alone can bring to all Canadians the best possible health care. In the subsequent chapter, we will discuss the special problems of health services in the sparsely settled areas of our country, particularly the northland. In this chapter, we have dealt with the problem of how to co-ordinate into an effective whole the multiple services now existing in many of our communities and how to develop the best possible services under varying circumstances applicable to different areas and localities.

Where there is a multiplicity of services and agencies, there is a need for co-ordination. Tracing the development of Canada's health services, it becomes clear that the present situation is the result of the growing fragmentation of the vast body of scientific knowledge as well as of the social and political patterns. These factors together with changing health problems brought about new services, new disciplines and a transformation in such basic components of the health services as medical practice and hospital services. In this situation, the need for some form of synthesis of the proliferated component parts has been felt for some time by those who have to work with them. As a result new patterns have developed here and there, such as medical group practice, organized home care services, and co-ordinated rehabilitation services, all of which carry some of the seeds of co-ordination. The basic features of co-ordinated community services are there and all that is needed is their systematic application and encouragement instead of letting each community grope for a solution of its own problems without the benefit of the experience already available elsewhere.

Together with an appreciation of the need for co-ordination, there has developed a growing awareness of the necessity for broader planning beyond the scope and needs of an individual institution or even community. Regional hospital planning, as we have pointed out, has become accepted

as the only logical way by which to provide hospital services of high quality, and provide them efficiently.

Though the pattern of medical practice has been undergoing great changes, the physician nevertheless remains the pivotal point of the various types of health services now available. In a world of specialists, it has become imperative to review and redefine the role of the general practitioner. The details of such a re-assessment of the respective functions of medical practitioners, as well as of the education preparing them for their role, must be left to the proper academic and professional agencies, but there is, no doubt, an urgent need for action in this field.

In recommending health planning councils and outlining the roles of the health services regional co-ordinators and health services agencies, we have developed models which we consider to be workable and effective in typical situations. Their exact composition and scope, jurisdictional and geographical, however, must be flexible and will vary with local needs and resources. There are bound to be differences between the outports of Newfoundland and the outlying communities of the Prairie Provinces, or between the large metropolitan centres and the vast empty spaces of the North.

A multiplicity of agencies and auspices in local health services is part of Canada's social and constitutional fabric. Variety, in a country as vast and heterogeneous as ours, is not only necessary but also beneficial because of the varied experiences to be gained, and the assessment of the best results achieved with given resources and individual and community initiative. But it can be advantageous to Canadians only to the extent that it results from carefully examined needs and thorough planning in all its ramifications and implications. This is what the proposed organization is intended to accomplish for the benefit of all Canadians in every part of this country.

9

Health Services in the North

THE MEANING OF THE NORTH

> "Returning to the thin southern strip of Canada where most of us live, we are sadly aware of the fact that our country cannot achieve its full destiny as long as its unique but distant parts remain unknown and undeveloped."

These are the words of a traveller to the North on his return. The distinguished traveller was Canada's Governor General, General Georges Vanier.[1] His predecessor, Vincent Massey, the first Governor General ever to visit the North and also a great Canadian, came back from that historic visit with this observation:

> "Like every other part of this great country, at first sight mysterious and even forbidding, it is now revealing itself as a land where it needs only energy, determination and ingenuity to build large and thriving communities."[2]

It is perhaps because few Canadians have shared the experience of travelling in those remote parts, that they have only reluctantly, patronizingly and in a very detached fashion accepted the North as part of their country and the native people as their fellow citizens.

Canadians must accept the North: it is part of their country, for better or for worse, but all the evidence is that it will be for the better. Should Canadians accept it grudgingly as a liability, or does the northland hold some promise that, besides just being there, it will some day return the investment and contribute to Canada's progress and wealth?

A Prime Minister has answered that question with a challenging and emphatic yes:

> "Canada's northland is a vast safety deposit box of minerals that represent the title-deeds to freedom's survival. The great northland is no

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[1] Vanier, The Right Honourable Georges, in Foreword to *The Unbelievable Land*, ed. Smith, I. N., Ottawa: Queen's Printer, 1964, p. vii.

[2] Massey, The Right Honourable Vincent, *Speaking of Canada*, Toronto: The Macmillan Company of Canada Ltd., 1959, p. 14.

> longer a forbidding waste . . . As the world enters an age in which science will dwarf the achievements of the past, the northern storehouse of Canada must be rendered accessible and available."[1]

In many ways, the North has already contributed. It has provided a vast proving ground for scientists; it contains strategic defence positions; it has enriched the arts by the work of the artists living there as well as by inspiring those coming from the South to seek its mysteries. Apart from these abstract though no less real values, the North, step by step, has been yielding returns to the far-sighted businessman and those who have studied and know the northland are far from seeing it as a sterile appendage only to the productive southern part of the country. It has been stated in fact:

> "There are, it is true, some millions of acres of arable land in the Yukon and the Mackenzie Valley and, while it may come as a surprise to many, on much of that land crops of grain and vegetables can and undoubtedly will be successfully grown. There are also extensive areas of commercially valuable forest far, far north of any regions that we have thought about in the past as being important sources of timber and timber products. These are even now beginning to be used, and most of them will probably one day have value. There are also commercial fisheries, some in existence, others that can be developed, which will be worth several millions of dollars each year. However, when all these surface resources have been developed to their fullest degree—as developed they almost certainly will be—they will still be far over-shadowed by the growth that will be based on the resources that lie below the surface. The main economic possibilities of the Yukon and of the Northwest Territories lie in the domain of minerals".[2]

Exploration of these resources has been greatly facilitated by the airplane which provided the chief means of opening up the North. Telecommunication is following and gains are consolidated cautiously on the ground here and there by roads and railways pushing farther north.

Canada officially assumed the title and ownership of all British possessions to the north of what was then Canada by Imperial Order in Council of 1880. For such title and possession to be recognized internationally, however, neither discovery, nor propinquity, nor any unilateral proclamation suffice. "To receive international recognition possession demands the acceptance of two responsibilities, continuing interest in the territory, and a concern for the welfare of its inhabitants."[3] There should be no doubt that both conditions are met in regard to Canada's North.

But the area discussed in this chapter is by no means clearly defined nor is it homogenous. Because health services are part of the administrative organization, the line is conveniently drawn between the provinces generally

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[1] Diefenbaker, The Right Honourable John G., address delivered before the Toronto Board of Trade, February 4, 1957.

[2] Jenness, D., *Eskimo Administration: II, Canada,* The Arctic Institute of North America, Technical Paper No. 14, 1964, p. 17.

[3] Robertson, R. G., "The Long Gaze" in *The Unbelievable Land,* ed. Smith, I. N., Ottawa: Queen's Printer, 1964, p. 133.

to the South, and the Yukon and the Northwest Territories to the North. Geographic factors, however, do not exactly coincide with administrative and jurisdictional boundaries. If this chapter is devoted to the sparsely populated areas of the North, it must be understood that some of our remarks will be applicable also to certain northern areas in the provinces.

Nor are the Territories themselves homogenous in regard to their health needs and resources: the Yukon, for instance, is approaching more closely provincial patterns and, as railroads and roads open up new areas in the Northwest Territories, some communities there have begun to develop similarly to their southerly counterparts. The Mackenzie District is being settled and becoming accessible faster than the remaining part of the Northwest Territories, while elsewhere in the Territories we still encounter small nomadic population groups as well as permanent settlements. Some of these have a sound economic basis, others have come about just by people gathering from surrounding areas, still waiting to bridge the gap between the traditional life and the new. Because of this variety of conditions and circumstances, our observations are bound to contain generalizations which may not, or not to the same degree, be applicable to all parts of the North.

The main problems, however, are common, though in varying degrees, to the entire area. They are: small populations widely scattered over a large territory, harsh climate, lack of communications and transportation, lagging social and community services, all closely related to problems of economic development in this area.

To grasp fully the problems and the challenge of the North, one has to wing over hundreds and hundreds of miles looking down on nothing but barren tundra with no sign whatever of human habitation and no trace of human activity. Statistics alone cannot quite convey this impression but the figures of population density serve as a good illustration. In 1964,[1] the population density was as follows:

Yukon	0.08	people per square mile[2]
Northwest Territories	0.02	" " " "
Rest of Canada	8.3	" " " "

Thus, the population density in the Yukon is about one-hundredth, that in the Northwest Territories about one-four-hundredth, of that in the area covered by the provinces. Looking at it the other way, there are over 50 square miles of area per person in the Northwest Territories, about 13 in the Yukon, and only about one-tenth (0.12) of a square mile per person in the rest of Canada, and even this is only thinly populated in comparison with other parts of the world.

[1] Based on population estimates as of October 1, 1964.

[2] Including land and fresh water area because the latter also has a bearing on distances and communications.

While cities like Toronto or Vancouver are usually frost-free from early in April or May until October or early November,[1] some parts of the Arctic have no appreciable period free from frost and others have only a brief period of six or eight weeks.[2]

These circumstances, together with the absence of the means of ground transportation on roads and rails, which are familiar in the South, clearly indicate that the planning of any community services in the North must be based on considerations essentially different from those that apply in the rest of Canada. It is for this reason that we review the health services in the North separately from those with which we have dealt in most of the preceding parts of our Report.

The North presents a particular problem and the necessary action must be geared to this particular need. In the settled areas of Canada our concern has mainly been with ensuring that all have access to services which already exist and which are to be developed in accordance with our recommendations: but, basically, the services are there and the need is for their development, organization, and financing. The problem of the North, however, is the bringing into existence a viable system of health services.

The programmes we have discussed and the recommendations we have made in the preceding parts of our Report deal with the health services in the provinces, an area containing 99.8 per cent of Canada's population. But there remains an area comprising four-tenths of the total area of Canada, about 1½ million square miles, lying outside the provinces. There are about 40,000 people in this area—about one-fifth of one per cent of Canada's population. This numerically small group, the population of the Northwest Territories and the Yukon, is characterized, however, by circumstances vastly different from those encountered in the provinces.

Health services for those people and the area they inhabit must become part and parcel of Canada's future health services. Our task is completed only when we have recommended such measures as we believe will ensure that the best possible health care is available to *all* Canadians. Accordingly, the Health Charter for Canadians[3] provides for a universal programme, which means that "adequate health services shall be available to all Canadians wherever they reside and whatever their financial resources may be."

We had to accept the fact that in a country as wide and varied as Canada, the nature of services provided will have to vary between regions and that the meanings of what constitutes "the best possible health care"

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[1] Victoria from the end of February until early December.
[2] Dominion Bureau of Statistics, *op. cit.*, pp. 53-55.
[3] *See* Volume I, Chapter 1, p. 11.

will have to be interpreted in the light of prevailing conditions. We have, therefore, recognized that geographic factors will impose certain limitations.[1]

We recognize that such limitations exist even within the provinces and also that general living conditions vary. We have, therefore, emphasized the need for flexibility in the proposed organization of health services and its adaptation to regional and local needs. We are also aware that poverty and slowness of community development are not limited to the North. It is in the Territories, however, that these phenomena, compounded by the harsh climate, largely determine the general needs of wide areas, thus demanding a special approach on a large scale rather than remedial action in certain limited local areas.

HEALTH PROBLEMS

In discussing in Volume I the particular health problems of the North, we have referred to the inhuman living conditions we found in some settlements.[2] Those conditions are not common to all parts of the Territories but they are sufficiently widespread to cause alarm and demand quick and determined action. The contrast between the primitive conditions of those vegetating in tents and snowhouses with those of officials living in houses providing most of the comforts we know in the South, only serves to accentuate the plight of the former group. We must assume that Canadians have been only dimly aware of these circumstances, which would not be tolerated anywhere else. Even in the more bearable climate of the South, no one would be allowed to even spend one night, let alone a whole winter, or a lifetime under such degrading conditions.

That these conditions are still fairly general and not isolated instances, can be deduced from the health indicators which reflect the social rather than the medical problems. We have demonstrated this[3] by presenting certain vital statistics, and particularly referring to the distressingly high rate of infant mortality, that is, of children in their first year.[4] The danger does not end when the children reach their first birthday; on the contrary, while infant mortality in the Northwest Territories is about four times as high as in Canada as a whole, mortality among children aged 1 to 4 is about eight times as high.[5]

These are health problems created by the conditions under which a substantial part of the population live. It should be noted that the figures

[1] *Ibid.*
[2] *Ibid.*, Chapter 5, p. 224.
[3] *Ibid.*, p. 223.
[4] *Ibid.*, p. 154.
[5] The rate for the Northwest Territories in 1963 was 8.2 compared with the Canadian rate of 1.1 (data supplied by the Dominion Bureau of Statistics).

quoted are already the result of some improvement during recent years. Both the age-adjusted death rate and the infant mortality rate have been declining as shown for the Northwest Territories:[1]

	1959	1960	1961	1962	1963
Age-adjusted death rate	14.8	14.9	14.6	13.2	11.9
Infant mortality rate	129.3	144.4	111.0	119.9	104.2

However, the wide spread still existing between the rates in the Territories and the Canadian rates indicates that these health problems cannot be resolved without a substantial amelioration of general living conditions.

But the health problems created by poor living standards are not the only ones peculiar to the North. There are, in addition, the problems arising out of the need for adjustment to new conditions. Those native to the North have to change traditional ways to adjust to new patterns, while those coming from the South have to adapt to the climatic and social environment of the North.

Common to both groups, and to all residents of the North, whether they be there permanently or only for a short duration, is the problem of obtaining adequate service in emergencies. Such emergencies may affect an entire community, in the case of an epidemic for instance, or the individual and his family as in the case of sudden illness or serious accident. The possibility of something like that happening may, in fact, deter people from accepting assignments in the North. One needs to think only of being there with a persistent toothache without ready access to a dentist.

These exigencies, of course, will not be eliminated for some time to come even with the most adequate services, and they will continue to be a case of the limitations imposed by geographic factors referred to earlier. But these risks can be substantially reduced by the implementation of our recommendations.

HEALTH SERVICES NEEDED

To meet the health needs of the North, it is necessary first to secure the required personnel, equipment and facilities; and second, to make these resources physically available when and where they are needed.

Visiting the health installations in the North one cannot help being impressed by the high calibre of the personnel and their inspiring sense of

[1] Dominion Bureau of Statistics, Annual Reports of Vital Statistics, Ottawa: Queen's Printer.

service. The problem is that there are not enough and that those who are there do not get enough inducement to stay for a reasonable length of time.

Even from the very brief and sketchy picture we have given here, it will be obvious that certainly for many years to come we cannot expect patterns of professional practice as they prevail in the South of Canada to be established in the North. Private professional practice, for instance, will remain the exception rather than the rule, limited to a few larger and economically well established settlements.

The type, size and distribution of institutional facilities will have to be based on criteria peculiar to the needs of the region. While in the well organized parts of the country the hospitals, health centres, and other facilities can be built without much difficulty, wherever indicated by planning in terms of the population served, the North imposes considerations of logistics concerning both the erection and operation of these facilities. The regional planning we have recommended for the Health Services Programmes in the provinces, assumes a different dimension the farther north one moves from the few-hundred miles wide belt where most of Canada's population is concentrated. The location of the bases for health services must be selected from only a very limited number of suitable sites, whereby one always has to reckon with the possibility that the suitability of a certain centre may change at short notice with changing population patterns. The greater dependency of northern health services on the means of transportation and communication also will make them more subject to obsolescence due to technical advances in these fields. Obsolescence, however, is not confined to health facilities: our society has accepted paying a high price for it; when a faster airplane appears on the market, a whole fleet of old but serviceable ones may be discarded. While only one or two decades ago Canadians pointed with pride to the many small communities that could boast their own small hospital, and while these hospitals served a real need at the time, many are no longer necessary nor desirable today. In planning for the North, we must accept the risk of perhaps faster obsolescence of some of the equipment and facilities. This stresses the need not only for careful planning but for speedy implementation of plans so that the most effective use can be made of health resources.

Although the principles and objectives we have formulated for the recommended Health Services Programmes should also be made the ultimate aim in the North and the programmes should be extended into areas where the general community development warrants it, for a vast area the northern health services must have regard to:

(a) the problems of distance, climate, small and scattered populations and the difficulties of transportation and communication;

(b) the difficulty in attracting and retaining in the service qualified personnel willing to serve in the North.

With the exception of the few areas in the Yukon and the western part of the Northwest Territories where urban centres have developed, conditions of the North generally have the following results: they preclude the methods of private professional practice; they require different standards of design and bed-population ratios for hospitals; different criteria for an adequate establishment of personnel; and also different types of personnel such as the midwife and the lay dispenser.

To overcome these problems constitutes a formidable task. They must be faced, however, because the situation in the North cries out for a solution. The problems have been studied for many years by eminent experts in the numerous fields of anthropology, sociology, medicine, engineering, economics, education and many others. Solutions are being attempted here and there, and possibly could succeed some day on a broad scale—if we are content to wait until new generations of the people achieve higher standards of education, until sound economic development covers the arctic regions, and until gradually, step by step, community services are established. But can and should we wait that long? Our answer is: We must plan now and act as soon as possible.

We have described the basic problem as one of supplying the necessary resources and then of bringing them within the reach of those who need them.

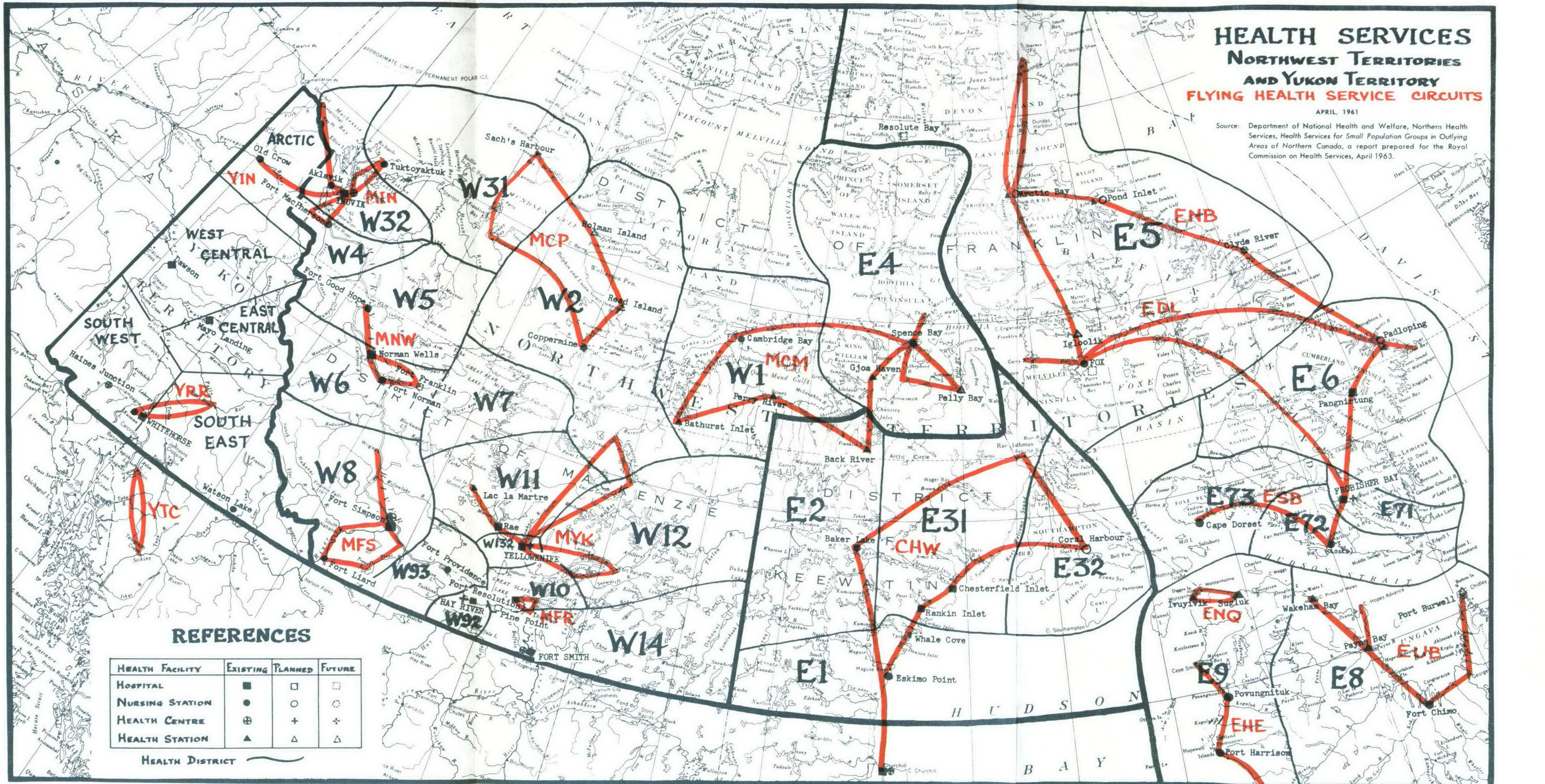
The Northern Health Service of the Department of National Health and Welfare is the agency responsible for the health services in the Territories, comparable in some respects—but not all—to a provincial health department. The Northern Health Service has prepared five-year plans for the development of health services in the Yukon and the Northwest Territories respectively, for the period 1962 to 1967.[1] These plans are being implemented and they should receive all necessary support. The Service must also be given the resources necessary for the continued planning, periodic review and adaptation of existing plans to new situations, and the implementation of these plans. The principles of regional planning for the strategic location of more elaborate installations such as hospitals will have to be observed whereby the criteria such as bed-population ratios will have to be adjusted to the needs of sparsely populated areas covering great distances.

Organized Flying Health Service Circuits

In a document[2] prepared at the request of this Commission, the Northern Health Service outlined an imaginative plan for organized flying health service circuits. It would bring regular visits several times a year, by health personnel to the scattered communities of the Yukon and the Northwest Territories. The following map shows these circuits:

[1] *See* Volume I, Chapter 8, footnote 7, p. 337.

[2] Northern Health Service, *Health Services for Small Population Groups in Outlying Areas of Northern Canada*, mimeographed, Ottawa, 1963.


HEALTH SERVICES
NORTHWEST TERRITORIES
AND YUKON TERRITORY
FLYING HEALTH SERVICE CIRCUITS
APRIL, 1961
Source: Department of National Health and Welfare, Northern Health Services, Health Services for Small Population Groups in Outlying Areas of Northern Canada, a report prepared for the Royal Commission on Health Services, April 1963.
REFERENCES
HEALTH FACILITY | EXISTING | PLANNED | FUTURE
HOSPITAL
NURSING STATION
HEALTH CENTRE
HEALTH STATION
HEALTH DISTRICT
YIN
MIN
MCP
MNW
YRR
YTC
MFS
MYK
MFR
MCM
CHW
ENB
EDL
ESB
ENQ
EUB
EHE
ARCTIC
WEST CENTRAL
EAST CENTRAL
SOUTH WEST
SOUTH EAST
W1
W2
W4
W5
W6
W7
W8
W10
W11
W12
W14
W31
W32
W92
W93
W132
E1
E2
E4
E5
E6
E8
E9
E31
E32
E71
E72
E73
Old Crow
Aklavik
Fort MacPherson
Inuvik
Tuktoyaktuk
Dawson
Mayo Landing
Haines Junction
Whitehorse
Watson Lake
Fort Good Hope
Norman Wells
Fort Franklin
Fort Norman
Fort Simpson
Fort Liard
Fort Providence
Fort Resolution
Hay River
Pine Point
Fort Smith
Lac la Martre
Rae
Yellowknife
Sach's Harbour
Holman Island
Coppermine
Read Island
Cambridge Bay
Bathurst Inlet
Perry River
Gjoa Haven
Spence Bay
Pelly Bay
Back River
Resolute Bay
Arctic Bay
Pond Inlet
Clyde River
Igloolik
Fox
Padloping
Pangnirtung
Frobisher Bay
Cape Dorset
Lake Harbour
Coral Harbour
Baker Lake
Chesterfield Inlet
Rankin Inlet
Whale Cove
Eskimo Point
Churchill
Ivuyivik
Sugluk
Wakeham Bay
Payne Bay
Port Burwell
Fort Chimo
Povungnituk
Port Harrison
HUDSON BAY
HUDSON STRAIT
DAVIS STRAIT
YUKON TERRITORY
DISTRICT OF MACKENZIE
DISTRICT OF KEEWATIN
DISTRICT OF FRANKLIN
NORTHWEST TERRITORIES
APPROXIMATE LIMIT OF PERMANENT POLAR ICE

We recommend the implementation by 1967 of this plan which would ensure the greatest possible effectiveness of health personnel, and which would greatly strengthen the preventive services by regular health supervision and early detection of problems before they are allowed to develop into serious and costly emergencies. Aircraft and personnel at suitable base points for each circuit should be subsidized by the Northern Health Service so that they would be available on a stand-by basis while also serving other agencies. To ensure year-round service, landing strips should be prepared at all locations to be served by the circuits, and where feasible the use of helicopters or other aircraft requiring short landing strips should be considered.

Other Services

Among the health services provided in the eastern Arctic are the regular annual visits by health teams on the C.C.G.S. *C.D. Howe* of the Department of Transport.

There is a great need for the sake of the resident population as well as for the health personnel stationed in the North to have regular periodic visits by a specialist[1] both for consultation in specific cases and for more general seminar sessions for groups of personnel brought together for this purpose from the area.

Regular visits by a dentist and dental auxiliary personnel must also be ensured.

Both resident personnel and the transportation by the flying health service circuits can be fully effective only with the aid of an adequate system of telecommunications. Telephone and radio communications have been expanded in recent years but not sufficiently to provide all nursing stations and lay dispensers with a round-the-clock communication with a centre having a resident physician where they could obtain advice or summon help. Such 24-hour service should be provided to all personnel who may have to contact an outside centre at any hour of the day or night.[2]

It will be essential for the means of transportation and communication to be planned and provided in such a way that they can be used not only by the health services but also by other agencies. This is one important area where the co-ordination we recommend generally is absolutely necessary if all services are to be planned and operated efficiently.

Of great importance in the smaller settlements is the lay dispenser and the depots of medical supplies suitably stocked.[3] Lay dispensers have provided invaluable services in localities where professional personnel could not be maintained. We have emphasized the need for and the benefits of continued education for health personnel and this applies particularly to the

[1] Particularly in orthopaedics, ophthalmology, psychiatry, paediatrics, internal medicine.
[2] *See* Volume I, Chapter 2, Recommendation 36, p. 34.
[3] *Ibid.*

lay dispenser. Annual refresher courses and the manual designed and to be distributed by the Northern Health Service will greatly enhance the dispenser's effectiveness.

For the still more isolated individuals and small groups the Service has developed the "Eskimo Family Medical Pack", whose wide distribution to all in need of it we recommend.

A matter of particular concern in the North is the transportation of patients to and from a centre where necessary diagnostic or treatment procedures can be applied. We recommend that ambulance services, and in isolated areas, air ambulance services be provided as under the Health Services Programmes.[1] It may, however, be necessary for patients to travel to a distant centre although there is no need for an emergency ambulance service. To equalize in such cases the situation of the northern residents with those in the South, we recommend that transportation costs to the nearest centre in the South be considered part of the Medical Services Benefit.[2]

Conditions of the North create medical and service problems peculiar to this area and different from the problems in the South. We recommend, therefore, that the Health Sciences Research Council appropriate funds for applied research in the North, including studies of the effect on health of habits (such as nutrition) and living conditions.

Supply of Personnel

As an objective and part of general policy we believe that education and training in the health professions and occupations should be given to the permanent residents of the North.[3] Promising beginnings have been made with the training of local residents as sanitation workers and nursing assistants. This should become an essential part of personnel policy in the North and be extended so as to offer residents education and training in all health fields either in regional centres in the North or in established schools in the South. There should be no compulsion for these trainees to practise in the North but these people are better suited and in general probably more

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[1] *Ibid.*, Recommendation 30(n), p. 33, and Recommendation 36, p. 34.

[2] *Ibid.*, Recommendation 30, p. 32.

[3] What D. Jenness proposes in regard to navigation, applies to a large extent also to other services in the North: "Denmark has trained some of its 30,000 Greenlanders, first cousins of our Eskimos, to handle all the traffic along the coasts of their large island. Would it not pay us to follow the same policy in the Northwest Territories—to train our Eskimos, who are familiar from childhood with the arctic environment, to man and navigate not only the coastal motor-schooners that a few of them already operate, but the large ice-breaking ships and cargo vessels that now ply our northern waters? The leaders of our Eskimos half a century ago left no successors. They raised up no Winston Churchill to take up a microphone and call to Canadians from coast to coast: 'Give us the education and the training, give us the opportunity to work, and we, in partnership with you, will build up a new Arctic.' " Jenness, D., *Eskimo Administration: II, Canada,* Arctic Institute of North America, Technical Papers No. 14, 1964, p. 178.

inclined to such a career in the North than are the more transient personnel from the South.

For the latter, conditions should be such as to retain them for at least three to five years; longer if possible. To achieve this, great care must be taken in the selection of personnel in regard to their personal suitability. In order to be able to select, however, one must attract a sufficient number of applicants. This can be done only by a realistic personnel policy, taking into account the disadvantages apparent to the candidate and his personal aspirations. These are matters of unaccustomed climate and living conditions, but also certain hardships created by the separation from relatives and education facilities. Children attending schools or universities also must receive consideration. All these matters resemble very largely the problems faced by international civil servants and we suggest that United Nations personnel policies be taken as a model in evolving policies regarding pay, allowances, leave, and travel provisions, and other exigencies peculiar to this type of employment.

This may in some cases have to include benefits in kind such as housing which, even in the South, are used to attract medical personnel into outlying areas. On the other hand, some people will prefer to build and arrange houses to their own taste and need. Housing allowances could compensate for the cost differential.

In the recruitment of personnel one should also appeal to the enthusiasm and idealism of those, particularly among the students and young graduates, who wish to apply their knowledge and skill in places where it is most needed.

We have suggested in Volume I of our Report[1] that a study be made by the Health Sciences Research Council of the feasibility of organizing a medical school, probably at Memorial University in St. John's, Newfoundland, to graduate physicians specially trained in the exigencies of frontier medicine. We have made particular reference to the role of such a school in the training of professional personnel from emerging nations and we have likened its function to that of St. Francis Xavier University at Antigonish, Nova Scotia, in regard to the co-operative movement. As in the latter field, there are frontiers in the fields of health and other community services in Canada. The sparsely settled areas of the provinces and the Territories are areas where we have yet to pioneer with better services, and personnel educated and trained at a school such as we envisage for Memorial University will be needed there. The facilities of this medical school could be extended to serve also in the training of other personnel, for instance public health nurses for service in the North, and it could also provide short courses or refresher

[1] *See* Volume I, Chapter 2, p. 70.

courses for lay dispensers and certain categories of auxiliary personnel who may be called upon to render health services in isolated areas.

The northland, furthermore, provides good opportunities for the field work in connection with the school for those who want to practise frontier medicine either in Canada or elsewhere. To use it in this way would have the added advantage of familiarizing medical or nursing students with the challenge and the problems of the North thus enticing some to practise there and perhaps make others realize that they could not stand up to it though they might have planned to start their career in the North.

When such field work is undertaken in the course of the curriculum, the transportation costs to and from the station in the North should be paid from the Professional Training Grant.

INTEGRATION OF PLANNING AND SERVICES

We have stated that the outstanding health problems of the North are those closely related to the social environment. While better health services and perhaps certain social developments have resulted in some improvements, there is no hope that health services alone can drastically reduce the mortality among infants and children, the morbidity from respiratory ailments and tuberculosis, and bring to the people of the North a longer, healthier, and happier life. This can only be achieved by a simultaneous attack on all fronts against disease, poverty, and the problems in the wake of uprooted traditions and adjustments to new social patterns.

The eventual solution must result in employment opportunities for the people of the North if the region is to become more than merely a base for weather stations, scientific outposts, or defence installations manned by personnel on a temporary basis. The prospects for economic development appear to be good; certainly hopeful beginnings have been made. But this offers no immediate or short-term solutions. It may be ten or twenty years, or a generation or two before substantial inroads will be made into the economic dependency of the Territories, and this only if the development is thoroughly planned and if it includes the education and training of the local labour force.

But what until then? Are we going to allow babies and children to die at an appalling rate, and their parents to live out their lives and die in the misery they are in now? Will those we saw in tents and snowhouses still be there next winter and the winter after? Are we going to continue to bring out the tuberculous, arrest their disease, and send them back again into the environment where they first contracted the disease? Will we continue bringing children to excellent schools for a few years to learn the

ways of the South, only to send them back into filth and poverty? Are we going to continue experimenting with educating people to a wage and money economy, only to send them back to their old ways a few years later?

There, more than in any other part of Canada, is the indivisibility of health and social well-being demonstrated. Having discussed the health problems and having made recommendations for the health services in fulfilment of our Terms of Reference, we must add that these measures to be successful have to be accompanied by measures securing proper housing, sanitation, and water supply as well as adequate livelihood. The latter should result from a productive activity. Where this cannot be provided now, it must be aimed at and prepared for while other measures are used to tide these people over their present in-between stage. Housing is cited time and again in the reports of the Northern Health Service as the main obstacle to better health. We are convinced that Canada can afford to provide its few thousand citizens in the North who are without proper housing, with accommodation that measures up to decent health standards. It cannot afford to leave these several thousands of its citizens in conditions which it rightly condemns and helps to ameliorate anywhere else in the world.

This is one aspect of needed integration of planning and services in the various areas of community development.

We have already referred to another dimension of a close interrelationship of health and other services, namely in the area of transportation and communication. The envisaged system of air circuits and the 24-hour telecommunication service will likely not be fully used for health service purposes but be available on a stand-by basis. This equipment can, therefore, be available to the other services with appropriate arrangements for emergencies. We look upon these not specifically as health services but as services for the general administration for the area with due allowance to be made for the needs of the health service.

This, however, must not be permitted to delay the implementation of any of the health services which are planned, nor must the supply of houses and other community facilities be delayed. We do not hesitate to look upon the situation in many parts of the North as an emergency which has been permitted to continue for too long.

We believe that there are no insurmountable technical difficulties and that the necessary material can be in readiness for the opening of the next shipping season. We shall deal below with the financial problems.

What is needed, though, is closer integration of the various administrations involved so that the planning, the actual operation, and the financing can be undertaken most effectively.[1]

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[1] *See* The Royal Commission on Government Organization, Ottawa: Queen's Printer, 1963, Vol. 4, pp. 173-180, on the "Co-ordination of Federal Activities in the North".

COSTS

Most of the recommendations presented at the end of this chapter deal with the improvement of certain practices: they concern largely the implementation of already existing plans which will be absorbed within the departmental budget. It is important, however, that the Northern Health Service be enabled to implement the measures budgeted for within the framework of the northern administration without the risk of having its budget reduced in the course of adjustments within the Department of National Health and Welfare, the future Federal Department of Health according to our recommendation.

A new service, however, would result from our recommendations for the flying health services circuit.[1] Looking at it strictly and solely as a health service, we consider its cost small in relation to the benefits, including economic ones, to be derived from it. The annual cost of operating the plan is estimated at $230,000.[2] The cost of treatment services for Eskimos alone in the fiscal year 1961-62 was approximately $3.2 million.[3] The cost of the flying services would be about the same as that of treating 35 cases of active tuberculosis.[4] And it may be noted here that in an outbreak of tuberculosis, one small village produced within six months 80 cases of active tuberculosis,[5] leading the investigator to comment: "Needless to say I can think of better ways for us to spend the half million dollars in public money that this epidemic will cost us—ways that would have benefited these children a good deal more".[6] It must be noted that the services provided by the Northern Health Service combine both the traditional public health functions of prevention and education, and those of treatment. The same would apply to the planned flying circuits of health personnel which would have the great advantage not only of preventing certain health problems altogether but also of detecting and combating others before they grow to more serious proportions.

We also refer to Recommendation 36[7] providing for air ambulance, two-way radio communication, additional nursing stations and medicine depots in isolated northern and other regions. Furthermore, transportation and communication services would serve other community and departmental needs as well as those of the health service.

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[1] As described on pp. 268 and 269.

[2] Composed of $130,000 travel costs and $100,000 as the cost of extra personnel required and their logistic support.

[3] Accordingly this does not include the expenditures for health services to Northern Indians and persons of "white status", the latter being borne by the Territorial Governments (Northern Health Service, *op. cit.*, pp. 6 and 7).

[4] Northern Health Service, *op. cit.*, p. 7.

[5] Moore, P. E., *An Epidemic of Tuberculosis at Eskimo Point, Northwest Territories*, Ottawa: Queen's Printer, 1963, p. 1.

[6] *Ibid.*, p. 16.

[7] *See* Volume I, Chapter 2, p. 34.

So much for the financing of the health services proper. Where we do expect substantial additional costs, is in the area of other community services which bear a direct relationship to health but which are outside the scope of our recommendations. Here again the departments concerned have budgeted for improvements and if we could be satisfied with the gradual development we have described, the financial aspect would be taken care of within the regular departmental budgets.

We have pointed out, however, the extreme seriousness and urgency of the situation which demands immediate action rather than a long-term development. It may perhaps mean providing now, say, 2,000 houses for northern residents which otherwise would be provided over a number of years.

This would mean paying off to these people a long overdue moral debt, something which may not be possible to accommodate in a departmental budget. Canada has now reached a stage in its history, approaching its centennial celebration, where stock is being taken of many things that we have left undone in the work-a-day rush to build the country and to put it on a sound economic foundation. We are pausing now and plan to catch up with some of the things we missed. They are the better things in life, and we are making plans now to build the art centres, museums, monuments which we did not stop to think about until now but which we feel we should have for the 100th anniversary. Now among the things we forgot, overlooked, or just did not get around to look after adequately, is the North and its people. To provide these people with proper houses would be at least as fitting a memorial to them as are the art centres to those of us in the South. Both the nature of the undertaking and the amount involved would, we feel, make this a worthy centennial project. It would, at once, enable the departments concerned to carry out the urgently needed massive action and to provide within their regular budgets for intensified measures in other community developments to go hand in hand with the improved housing and health services.

THE NORTH IN CANADA AND ELSEWHERE

Canada's North presents a picture of daring adventure; of great personal devotion and sacrifice; of some successful economic developments; and, despite some mistakes and failures, of good government planning and many improvements in recent years. But only in recent years and, as we have pointed out, regular annual budgets are hardly suited to implement a programme of rapid development in the face of a huge backlog. Thus the North has largely remained neglected and underdeveloped; what is being done, is done half-heartedly, not being sure whether we should or should not

do more about it. Church and secular missions have been established in the North for many years; they have done some heroic things as witnessed by the massive hospitals and hostels they have erected beside their churches. Those early missionaries who went up there and others who went to ease the burden of the people, have our admiration. But there the matter has rested. Can we—economically—afford to develop the North or can we—morally—afford not to develop it?

Canada is not alone with its problems in the North and, as in so many other cases, we can ask ourselves what the others are doing and how much they can afford to do. To draw comparisons between different countries is never easy because of the many variables involved. The North, for instance, is difficult to define. We think of it as implying barren land and a cold climate, the kind we would find in Canada north of, say, the 60th parallel. In Scandinavia, however, we have to go much farther north to find similar conditions. Oslo and Stockholm, for instance, are farther north than Churchill, Manitoba. These cities, as well as Juneau and Anchorage in Alaska, and Leningrad in Russia, all lie close to the 60th parallel. Trevor Lloyd, who has travelled widely in the North has come to the conclusion that *"we have been* slow in developing the North—we were even negligent in the 1920's and the 1930's, when some other countries were very active". He adds, however: "But we have special difficulties that do not apply quite so much to the other northern lands."[1]

Despite these differences, for which we have to make allowance in our conclusions, the basic problems are common to all the northern region: the harsh climate, barren and inaccessible land inhabited by an originally primitive people. We have seen what Canada has done with it. How about the other countries?

In our analysis of health conditions in general, we have repeatedly followed the practice of looking at the infant mortality rate as being broadly indicative of the general health status. Following are some comparative figures for the Northwest Territories, Alaska, and Greenland, showing roughly the differences in the rates between the respective ethnic groups:

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[1] "North Norway, for example, is not arctic; it is at the most subarctic. You can buy a steamship ticket to travel around the North Cape of Norway on any day in the year, and that is in 70° north latitude—which is about the same latitude as the northernmost point in Alaska—which you certainly can't get around in a steamship, except in the summertime and not always then. West Greenland, where the Danes have brought about such remarkable educational, economic and social development, is also specially favoured. In the southwest, it also is an area open to navigation throughout the year and it has a relatively mild climate even in the North. Even our friends across the North Pole in the Soviet Union, although they have a well deserved reputation for being experts in the Arctic, don't have as difficult an Arctic as we do. They don't have the maze of Arctic islands that we have between the open sea and the mainland, which make sea transportation so very difficult. And the mighty northward flowing rivers of Siberia provide excellent transportation routes from the southern cities to the Arctic coast." Lloyd, T., "The Land and the People", in *The Unbelievable Land,* ed. Smith, I. N., Ottawa: Queen's Printer, 1964, p. 3.

	Infant Mortality Rate (per 1,000 live births)		
	Indians	*Eskimos*	*White Status*
Northwest Territories (1961)*	81	185	21
	Non-White	*White*	
Alaska (1959)†	72.9	26.9	
	Children of Women Born in Greenland		
Greenland (1961)‡	65.9		

* *Report on Health Conditions in the Northwest Territories 1963,* Northern Health Service, Ottawa, 1964 (mimeographed), Table 5.

† *Statistical Abstract of the United States, 1962,* U.S. Department of Commerce, Washington, U.S. Government Printing Office, 1962, p. 68.

‡ *Sundhedstilstanden i Grønland, Landslaegens Arsberetning 1961,* Beretninger vedrørende Grønland, Sydgrønlands Bodtrykkeri, 1963, p. 19.

The difference in the conditions revealed by the infant mortality rate of the Canadian Eskimo and his counterpart in Greenland (allowing for the somewhat different definition) is further illustrated by the difference in their housing conditions.[1] A booklet describing the Canadian Eskimo, published in 1957, shows an Eskimo tent with the caption that "during the northern summer, canvas tents provide *sufficient* [our italics] shelter for Eskimo families".[2]

In Greenland, however, tents and igloos were practically non-existent by 1957, having been replaced by solid houses. In 1958, six years ago, a Canadian traveller to Greenland made the following observation regarding housing on his visit to one locality:

> "We saw two or three stone and sod houses, one of which we went into, much to the dismay of the Danish officials who obviously hadn't planned this! It seemed warm and had a coal-stove burning Greenland coal but had little else besides a bed platform, of which I took a photograph. These houses are to be demolished next year and in all fairness I must say we saw very few poor houses throughout our trip."[3]

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[1] *See also* Volume I, Chapter 5, p. 224.

[2] *Peoples of the Northwest Territories,* Department of Northern Affairs and National Resources, Ottawa: Queen's Printer, 1957, p. 24.

[3] *Indian and Northern Health Services Report on a Visit to Greenland (August-September, 1958),* Department of National Health and Welfare, Ottawa, (mimeographed), p. 11.

A description of Greenland, the third edition of which was published in 1961,[1] states:

> "Everywhere, whether in large or small settlements, the Greenlander has his own house and feels at home there . . .The old turf houses may still be seen at a few small settlements, but they are lined with wood and fitted with proper windows. In general, the Greenlanders now live in large or small wooden houses, their size and appearance governed by the man's resources and his wife's skill in housekeeping."

While primitive one-room houses still exist, "as a general rule, the houses are big enough to hold a kitchen and living-room below and one or two bedrooms above".[2] This is part of the general development.

Regarding the housing situation in Alaska, it is estimated "that about one-half of the Alaska natives live in modest frame buildings constructed of commercial lumber or of driftwood, packing crates, and other miscellaneous pieces of wood. Of the remainder, two-thirds live in crude log houses, one-third (or fewer) in sod igloos excavated underground for purposes of warmth".[3]

We have no comparable statistics available for the Soviet Union but the general impression is one of rapid and spectacular development of the Russian Arctic. Thanks to specially designed ships and large icebreakers, navigation in the Arctic is ensured for five to six months. "Igarka, one of the Soviet biggest ports lying north of the Arctic Circle on the same latitude with the Canadian towns of Bathurst-Inlet and Aklavik, is now open for navigation not for a week or a week and a half, as it was a few years ago, but for four to five months a year. Owing to icebreakers the navigation period increased twice at still higher latitudes of the Arctic region."[4] Apart from the cities and industrial centres in Northern Siberia, life in the small and remote settlements has also changed. We have before us the description of life in the villages of the Chukotka Peninsula, the piece of land on the Arctic Circle jutting out from the Asian Continent towards the Bering Strait: "In the old days when people spoke of Chukotka, they always associated it with hunting and reindeer-breeding. Today, among the indigenous population, there are workers of different trades, doctors, engineers, teachers, writers, sea captains and livestock experts."[5] These latter are needed to tend to all sorts of livestock acclimatized to the area including cattle,

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[1] *Greenland,* The Royal Danish Ministry for Foreign Affairs, Denmark; Perfecta-1961, pp. 50 and 51.

[2] *Ibid.,* p. 52.

[3] *Eskimos, Indians, and Aleuts of Alaska—A Digest,* U.S. Department of Health, Education, and Welfare, Washington, 1963, p. 5.

[4] Fedorovich, V., "Crushing Icefields of Baltic, in *Soviet Union Today,* June, 1964, p. 30.

[5] "The Rebirth of Chukotka", editorial in *Soviet Union Today,* March, 1964, p. 18.

poultry, and farm animals.[1] In the Soviet Union alone about a million people live in the high Arctic. More than five million people inhabit the northern forest areas connected with the northern sea route.[2]

We have at the outset of these international comparisons emphasized the differences and disadvantages of the Canadian North as compared to that of our neighbours. We should add a reference to the far greater resources of the United States and the Soviet Union which also render comparisons somewhat invidious. But what about Denmark's accomplishments in Greenland? The population of Greenland (33,000 in 1961) is only slightly smaller than that of the Yukon and the Northwest Territories (39,000). The Danes have a considerably lower per capita income than Canadians, and their Gross National Product is less than one-fifth of Canada's.[3] Denmark has to ship building materials, medical supplies, some foodstuffs and most other products across some 2,000 miles of the North Atlantic.

But here too there is a difference, apart from certain climatic factors. The Danes had a head start in developing Greenland. They can boast that "the work of educating the Greenlanders began over two hundred years ago and illiteracy was abolished more than a hundred years ago".[4] A hundred years ago, Canadians were still busy consolidating the southern parts of their country, but since then have overtaken or caught up with many other countries in their economic, social, and political development and the time has surely come when the North must be included in this development. In the words of a former Deputy Minister of the Department of Northern Affairs and National Resources and Commissioner of the Northwest Territories, "The North will not then be run by us outsiders, with the real owners looking on. It will be run by the people who live there. It can be done. Greenland has gone a long way toward that goal and I am convinced that we can do it too".[5]

The government departments and private agencies concerned with and interested in this area and its people have accomplished much to be proud of. They and their officers have the know-how, the ability, and the will to go ahead. There is a need now for integrated planning of their efforts, but the foremost need is for an end to the public apathy and indifference and the massive financial and moral support for those who can do the job.

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[1] *Ibid.*

[2] Shumsky, P., "Arctic Problems and Warm Meetings", in *Soviet Union Today*, February, 1964, p. 3.

[3] United Nations, *Year Book of National Accounts Statistics 1962*, New York, 1963.

[4] Brun, E., "Greenland Today", mimeographed pamphlet, pp. 4 and 5.

[5] Robertson, R. G., *op. cit.*, p. 137.

RECOMMENDATIONS

What then are the steps necessary to remedy the grave situation we have described? We have no illusions that it is going to be an easy task but we are convinced that Canada can do it, can afford it and, in fact, must do it now to make up for the time lost and opportunities missed. We cannot overemphasize the need for development on a broad scale of social and economic action of which health services are only a part but the part this Commission is most immediately concerned with.

The inescapable conclusion in regard to health services is that there must be a comprehensive master plan for the speedy implementation of organized services capable not only of dealing with emergencies such as epidemic outbreaks, but providing a permanent and continuing surveillance and treatment service.

We have recommended[1] that the Federal Government enter into similar arrangements with the territorial administrations as those envisaged for the provinces, for the introduction and operation of comprehensive and universal programmes of personal health services, including:

Medical services,[2]
Dental services for children, expectant mothers, and public assistance recipients,[3]
Prescription drug services,[4]
Optical services, for children and public assistance recipients,[5]
Prosthetic services,[6]
Home care services.[7]

In addition, the hospital insurance programme is to continue with the recommended changes.[8]

We refer particularly to Recommendation 36,[9] providing for special services in northern regions, including air ambulance, two-way radio communication, nursing stations and medicine depots.

Under the circumstances prevailing in the northern region, we recommend as an addendum to Recommendation 59[10] that the contributory payment

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[1] *See* Volume I, Chapter 2, Recommendation 1, p. 19.
[2] *Ibid.*, Recommendations 29 to 38, pp. 31-34.
[3] *Ibid.*, Recommendations 39 to 57, pp. 36-39.
[4] *Ibid.*, Recommendations 58 and 60, p. 41.
[5] *Ibid.*, Recommendations 83 to 94, pp. 49 and 50.
[6] *Ibid.*, Recommendations 113 to 115, p. 60.
[7] *Ibid.*, Recommendations 116 to 123, p. 62. In regard to organized home care services in northern communities, we refer to the experience gained by an existing home care plan under frontier conditions in Grande Prairie, Alta.
[8] *Ibid.*, Recommendations 95 to 112, pp. 53-58.
[9] *See* Volume I, Chapter 2, p. 34.
[10] *Ibid.*, p. 41.

of $1.00 per prescription should not apply under the Health Services Programme of the Territories.

In order, however, to bring these services to the wide areas of the Territories which cannot develop the type of community services we have described in the foregoing chapters of our Report, additional measures are necessary. Bearing in mind the great and compelling need for a comprehensive, imaginative and far-reaching approach to meeting the health and related requirements of the people in Canada's northland, we make the following recommendations to suitably supplement those concerning the Health Services Programmes. We also stress that in view of the great urgency for improved conditions in these areas, these recommendations be given the same high priority as we have assigned to the programmes for a Children's Dental Programme and for the services to retarded children and crippled children.[1]

The Commission recommends:

Northern Health Service Plan

235. That every possible support be given to the Northern Health Service of the Department of National Health and Welfare to speed the implementation of the five-year plans to provide adequate health services for the Yukon and the Northwest Territories, and that the implementation be telescoped into a shorter period of time as resources become available.

236. That the Northern Health Service implement by 1967 its proposed comprehensive flying health service system linking the various communities with their health service base.[2]

237. That, as far as possible, such transportation services be integrated with the needs of other agencies; and that at each of the communities covered, suitable landing strips and other facilities be prepared and maintained to serve aircraft and, where feasible, helicopters in all seasons.

238. That an integrated telecommunication system be established to provide a 24-hour service for voice communication and that a visual system be implemented when this becomes practical; such communication systems for the purposes of the health services to be integrated with the needs of other agencies in a community.

239. That provisions be made for regular periodic visits to northern stations by medical specialists for consultation and seminars.

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[1] *Ibid.*, p. 92.
[2] *See* pp. 268 and 269.

240. That provisions be made for regular periodic visits to northern stations by dentists and dental auxiliary personnel.

241. That training, refresher courses, manuals and the necessary equipment be provided to maintain a high degree of effectiveness among lay dispensers.

242. That the provision of "family medical packs" to isolated families and small groups be speeded up and that the necessary instruction manuals be made available.

Northern Health Service

243. That, while the present five-year plans for the improvement of health services in the Yukon and the Northwest Territories are implemented, more far-reaching plans for a further five-year period be formulated in order to ensure the future development and improvement of health services in the Territories.

244. That the budgetary requirements of the Northern Health Service of the Department of National Health and Welfare be considered within the framework of the territorial budgets rather than as part of the departmental budget.

Personnel: Recruitment, Education, and Employment Conditions

245. That every effort be made towards the training of indigenous residents of the Territories by intensifying the ongoing training of nursing assistants and progressively for more advanced education and training of professional and technical health personnel.

246. That, as part of a seven-year crash programme, grants be made available from the Professional Training Grant, to cover the cost of such education or training.

247. That, on the coming into operation of a medical school at Memorial University at St. John's, Newfoundland,[1] part of the curriculum and training be directed towards the needs of health services in Canada's North and other sparsely settled areas.

248. That Memorial University at St. John's, Newfoundland, establish in connection with its future medical school, specialized courses for the training of other health personnel in the specific knowledge and skills required for the practice in the North and other sparsely settled areas.

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[1] *See* Volume I, Chapter 2, pp. 70 and 71.

249. That financial assistance be made available from the Professional Training Grant to enable personnel in training for health service in the North to do their field work in the Yukon or the Northwest Territories.

250. That conditions of employment for health personnel be such as to attract and maintain for periods of at least three to five years well qualified personnel. This relates to remuneration as well as other benefits designed to equalize working conditions as far as possible with those in the South. Among such provisions should be:

(a) competitive and attractive salaries and allowances to compensate for cost differentials,

(b) upgrading of positions,

(c) leave of absence provisions to provide for

(i) regular periodic vacations with transportation for the personnel and their family paid to and from a predetermined home base;

(ii) compassionate leave for the personnel in cases of serious illness in the family, and transportation paid to and from the nearest centre in the South for personnel and/or their family in the case of serious illness or death among their nearest relatives in the South;

(iii) educational leave to facilitate continuing education and self-improvement;[1]

(d) financial aid towards the education and maintenance of children where service in the North entails separation from their parents,

(e) suitable housing accommodation.

251. That the selection of health personnel for service in the North be exercised with great care with regard to professional qualification as well as personal suitability and aptitude required under the circumstances.

Transportation as a Medical Care Benefit

252. That all residents of the Territories requiring medical attention not available in their home areas be flown out for such attention and returned on discharge as part of the Medical Services Benefit.

Research

253. That the Health Sciences Research Council provide funds for the conduct of applied research into specific health and health service problems in the North.

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[1] For example, physicians may be granted one year's study leave in the middle of a 5-year term of office.

Co-ordination of Northern Government Activities

254. That the existing agencies for the co-ordination of the activities in the Territories of federal government departments be strengthened, with adequate representation for the health services, both at departmental headquarters and at the regional and local levels.

General Community Development

255. That intensive efforts be made for general community services to be developed simultaneously with the health services.

256. That the Centennial Commission as a centennial project survey the possibility of adopting the implementation of a demonstration project, in two far northern locations, of community development including adequate housing, proper sanitation services and essential education, health and other facilities.

CONCLUSION

We expect that our programme for the health services of the North will be met by some with comments similar to those regarding the proposed Health Services Programmes generally: they may be well intentioned but Canadians cannot afford to pay for them. We have, in Volume I, demonstrated that the Health Services Programmes are well within the reach of Canada's present and future economy. The cost of improved health services will, to a large extent, be matched by a reduction in welfare expenditures, especially if health services are accompanied by the general development of the area. Investment in this general development will yield economic returns even more immediately than health services alone, but we have no illusion that at least in the immediate future better services will mean higher costs and we have to answer the questions: first, can Canada afford it; second, if so, are Canadians willing to pay the cost.

Regarding the ability to pay, there can be no doubt in the light of our cost analysis in Volume I, and in the light of the degree of northern development, achieved not only by the United States and the Soviet Union, but also by the smaller Scandinavian countries and especially by Denmark in Greenland. Surely, Canada can match this.

There remains the question of whether Canadians are willing to shoulder the extra cost of health and other developments in the North. The answer to this must be found in the answer to the question whether we want the North as an integral part of Canada, or whether we write it off as a liability and withdraw our national boundaries to the 60th parallel, leaving

the Territories to be independent and fend for themselves, or more likely, to be absorbed sooner or later by their neighbours to the west, east, or north. This latter alternative, if ever taken seriously, has been discarded by all responsible politicians and scientists. But if, and as long as, we want the North to be part of Canada, we must treat it as such and we must extend to Canadians in these parts the same services, "within the limitations imposed by geographic factors",[1] as are provided for Canadians elsewhere.

We have emphasized that in order to become fully effective, health services must be accompanied by the vigorous and well-planned development of other aspects of life in the North. Not only some ill-conceived but also many splendid but isolated projects undertaken in the past have wasted precious time and money, and often turned enthusiasm into despair and frustration or resigned apathy, because they were limited in scope and not followed through as part of a general plan.

We have shown that health services by themselves cannot eliminate health problems such as tuberculosis or a high infant mortality which are largely the result of poor environment. The provision of jobs depends on education and training, and unless accompanied by improved health will not, in the long run, improve the economic situation. Better housing and other environmental conditions will yield results only if accompanied by health services, education, and economic measures. Education, with the best of schools, will fail to achieve its ends unless it leads to the logical conclusion of employment and decent community life.

There is a good example, in Canada, of what a concerted development of health services together with general social and economic improvements can accomplish. We compare below the average annual infant mortality rates in the Northwest Territories and Newfoundland for the periods 1931-1935 and 1959-1963, respectively:[2]

	Northwest Territories	Newfoundland
1931-1935	110	116
1959-1963	122	38

It may be that the increase in the Northwest Territories is more apparent than real due to more complete registration and perhaps random fluctuations.

[1] *See* Volume I, Chapter 1, p. 11.

[2] Based on Dominion Bureau of Statistics, *Vital Statistics, 1962*, Ottawa: Queen's Printer, 1964, p. 191; and *Vital Statistics, 1963, Preliminary Annual Report*, Ottawa: Queen's Printer, 1964, p. 4.

But the spectacular decline in Newfoundland demonstrates the combined effect of better health services and improved living standards generally.

In drawing this comparison, we are aware of important differences between Newfoundland and the Northwest Territories, geographically as well as economically. But the fact remains that the health of the people in Newfoundland has improved whereas it has not—certainly not nearly to the same extent—in the Northwest Territories despite the expansion of health services. Hence our contention that simultaneous development of health and other community services is necessary if worthwhile progress is to be foreseen in any particular field.

Whether or not the extension of these services in the North will "pay" in the economic sense, is of secondary importance. We have expounded our view that "the achievement of the highest possible health standards for *all* our people must become a primary objective of national policy and a cohesive factor contributing to national unity".[1] This includes Canadians in the North as well as in the South. Even if provided with the best services possible under the circumstances, Canadians in the North will be facing hardships and problems not encountered by their fellow citizens in the South.

We do not subscribe to the view that improving community services in the North serve only to maintain artificial and useless communities.[2] Even if there were no indigenous people in the North and no prospects for economic development, Canadians would go there to establish and maintain stations to aid transportation, communications, weather forecasting and other scientific exploration, as well as some military installations. To develop community services in Greenland is not an economic proposition for Denmark, yet Denmark has raised the living standards of Greenlanders considerably though this has to be done across 2,000 miles of ocean.

It has been said "that the North, with its vast stores of hidden wealth, is ready to come into its own. The wonder and challenge of the North must become a vital part of our national consciousness. All that is needed is an imaginative policy which will open its doors to Canadian initiative and enterprise".[3]

Such a policy, to be truly effective, requires a national effort on the part of all governments. This point was emphasized by another Prime Minister: "I think all the Provincial Governments and the Federal Government appreciate the importance of development in the North. Progress is being made and I sympathize with any Canadian's view that this progress

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[1] *See* Volume I, Chapter 1, p. 11.

[2] We have heard the statement that what is happening in the North is only "helping the Eskimos to look after the white people who are there to help the Eskimos".

[3] Diefenbaker, The Right Honourable J. G., speech delivered at Quebec City, April 27, 1957.

should be speeded up and developed and that greater recognition should be shown in action of the essential importance of the North Country".[1]

One of the problems in maintaining adequate services in the North has been the failure to attract and retain qualified personnel. In this regard, lessons can be learned from the international civil service where it is also largely a question of attracting people to places remote from their usual residence.

We strongly urge that the imaginative policy we propose be undertaken, and implemented as a massive crash programme. The funds? Much of the cost is already provided for in departmental budgets which will profit from greater and more effective interdepartmental co-ordination. To facilitate a massive start to cope with the backlog in programmes such as housing, it may be timely and appropriate to make available centennial funds and to identify certain projects as centennial contributions by Canada to the people of the Territories.

We also think that partnership with private enterprise should be strengthened for the benefit of both partners.

We wish to see our plan understood as something far greater than a welfare programme for those people in the North who are not as yet sharing fully in Canada's progress. It should mean that the North and its people be accepted in fact as part of Canada. This country is now approaching its centennial celebrations. Many worthy memorials are planned on this occasion in all the provinces. The Canadians in the Territories too should have occasion to share in this jubilee. At some time in the future they too will demand monuments and art centres. At this time, however, what greater memorial could we erect in these parts than healthy communities?

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[1] Pearson, The Right Honourable L. B., at a Press Conference in Vancouver, September 17, 1964.

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Recommendations

The Commission presented in Volume I, Chapter 2, its main recommendations Nos. 1 to 200 for a Health Services Programme for Canada. We present in Volume II a number of additional recommendations in areas that round out the comprehensive Health Services Programme submitted in Volume I. These supplementary recommendations have been included in Chapters 2 to 9 and the evidence and the reasoning leading to their formulation have been presented in the text. We reproduce these Recommendations here, Nos. 201 to 256, under the following headings, with a reference to the appropriate chapters shown in brackets.

1. Pharmacists (Nos. 201-203, Chapter 2)
2. Paramedical Personnel (Nos. 204-210, Chapter 3)
3. Opticians (Nos. 211-212, Chapter 3)
4. Professional Titles (No. 213, Chapter 3)
5. Radiography (Nos. 214-217, Chapter 3)
6. Ambulance Services (Nos. 218-219, Chapter 3)
7. Health Research (Nos. 220-222, Chapter 4)
8. Voluntary Organizations (Nos. 223-226, Chapter 6)
9. Federal Department of Health (No. 227, Chapter 7)
10. General Practitioners (Nos. 228-229, Chapter 8)
11. Rehabilitation (Nos. 230-232, Chapter 8)
12. Health Services Administrators (Nos. 233-234, Chapter 8)
13. Northern Health Service Plan (Nos. 235-256, Chapter 9).

Certain of the recommendations in Volume I have been modified to clarify the full intent of the Commission and these are shown in the form of addenda at the end of the chapter, covering Recommendations Nos. 59, 61, 62, 80, 109 and 195.

Recommendations Nos. 1 to 200 in Volume I and 201 to 256 in Volume II represent the sum total of all the recommendations made by this Commission.

1. Pharmacists

201. That small hospitals, particularly in communities which find it difficult to employ a full-time pharmacist, employ a part-time pharmacist to serve selected neighbouring hospitals jointly or to combine retail pharmacy with hospital employment.

202. That, in view of the shortage of qualified pharmacists in the Atlantic Provinces, there be established a school of pharmacy at Memorial University, St. John's, Newfoundland, at the same time as the medical school we have recommended and as a department thereof.[1]

203. That annual Professional Training Grants of $2,000 each be made available to graduate pharmacists pursuing post-graduate studies in pharmacy.

2. Paramedical Personnel

204. That there be established in each province a Paramedical Education Planning Committee, advisory to the provincial Health Planning Councils, to plan and direct the orderly development of the education and training of paramedical personnel. The Committee should be representative of the various provincial paramedical associations, university(ies), the Health Services Commission and the Department of Education, and advise the Health Planning Council of those paramedical fields in which shortages of personnel exist, training facilities needing expansion, training programmes and other matters concerned with the supply of and demand for paramedical personnel.

205. That, to encourage suitable personnel to enter and remain in these occupations, salaries commensurate with their training and responsibilities and similar to those in comparable fields be paid by federal and provincial agencies and by hospitals.

206. That financial assistance under the Hospital Insurance and Diagnostic Services Act, and under the Technical and Vocational Training Assistance Act be expanded immediately to support any qualified applicants enrolling in courses of training prescribed for those paramedical fields in which shortages exist. On the national level we foresee shortages particularly in the following occupations: medical record librarians, physiotherapists, occupational therapists, speech therapists and audiological therapists, and medical social workers.

207. That financial assistance be provided to set up Departments of Rehabilitation in the medical schools at l'Université de Sherbrooke

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[1] *See* Volume I, Chapter 2, Recommendation 141, p. 71.

and at the University of Ottawa and such other universities as may be able to provide adequate training for paramedical personnel in this field.

208. That training facilities for speech therapy and audiological therapy be established in association with the medical schools of Dalhousie University, University of British Columbia within its Health Sciences Centre, and with one of the medical schools located in the Prairie Provinces.

209. That training facilities for physiotherapy and occupational therapy be provided in association with those medical schools which do not already possess such facilities.

210. That, in order to provide a continuous and uninterrupted supply of qualified paramedical personnel, more efforts be made to attract men into certain health occupations by ensuring working conditions, and especially salaries, competitive with other comparable occupations.

3. Opticians

211. That legislation regarding the qualification and licensing of dispensing opticians be enacted in all provinces and territories.

212. That legislation be enacted restricting the sale of contact lenses by anyone, except on prescription by an ophthalmologist.

4. Professional Titles

213. That legislation be enacted to provide that no practitioner of any healing art without a doctoral degree granted by a recognized university be permitted to designate himself as "Doctor", or to use any letter following his name indicating the same, or to advertise himself as such.

5. Radiography

214. That provincial legislation provide, to the extent that this is not already done, for the licensing of X-ray equipment, technicians, and operators, according to accepted uniform standards and ensuring that such standards are maintained after the initial licensing.

215. That provincial legislation be enacted to restrict the advertisement of diagnostic X-ray facilities.

216. That the proper scientific agencies continue the intensive study and observation of the consequences of radiation, including that resulting from diagnostic radiography.

217. That the reading and interpretation of radiographs be undertaken only by recognized personnel.

6. Ambulance Services

218. That, in order to ensure that ambulance services are of a high quality, legislation be enacted in all provinces and territories establishing standards for the training and qualifications of ambulance staff, and for the equipment used, and that these be subject to licensing.

219. That, to ensure that such services are readily available, the provincial Health Planning Councils establish guide lines for the efficient organization of ambulance services on a regional or community basis, and, where required, of air ambulances and other emergency transport.

7. Health Research

220. That, in the provision of educational facilities for health professional personnel at research institutions, medical schools, dental schools, schools of public health and schools of nursing, adequate library facilities be provided to be financed from the Health Facilities Development Fund and the Health Professions University Grant.

221. That, over the period 1966-1971, the grants made by the Federal Government towards the operating budget of the Health Sciences Research Council be progressively increased by $3 million a year.

222. That, where funds are not available from other sources to offset the decline in research funds from the National Institutes of Health, or if sufficient funds are not forthcoming from voluntary organizations and foundations to meet the projected needs in 1971, the deficiency be met by a further expansion of federal grants to the Health Sciences Research Council.

8. Voluntary Organizations

223. That agencies concerned with the prevention of accidents participate in the work of the Health Planning Councils at the various levels and in particular with regard to measures to prevent highway accidents.

224. That voluntary agencies have an integral place in any comprehensive health care programme and that they participate actively in the work of the various planning councils.

225. That all voluntary health organizations submit an Annual Financial Report to the Department of National Health and Welfare, describing their functions as well as showing assets and liabilities, income by source and expenditures under appropriate headings, duly audited in accordance with accepted auditing practices.

226. That the Department of National Revenue take cognizance of the organizations so reporting, when recognizing donations as charitable exemptions under the Income Tax Act.

9. Federal Department of Health

227. That, in view of the growing responsibilities of the Department of National Health and Welfare in both the health and the welfare fields, and particularly in view of the increased responsibilities that would be placed on the Department with the implementation of the Health Services Programmes, and taking account of the advisability of administering health services separately from welfare services, the Health Branch be restored to the status of a separate Department of Health.

10. General Practitioners

228. That the Association of Canadian Medical Colleges, in consultation with the College of General Practice of Canada and others concerned give immediate attention to the question of setting up administrative Departments of General Practice in the teaching hospitals and subsequently, Chairs of General Practice in the Faculties of Medicine.

229. That, as part of a seven-year crash programme, special Professional Training Grants of $5,000 per year be allocated to medical graduates undertaking post-graduate study to qualify for the teaching of general practice in the Faculties of Medicine.

11. Rehabilitation

230. That the Vocational Rehabilitation of Disabled Persons Act, 1961, be amended by removal of its restriction to *vocational* rehabilitation and that the terms "disabled person" and "vocational rehabilitation" be revised and redefined accordingly.

231. That a new rehabilitation agency of the Federal Government be established, with representation from the Federal Department of Health, the Department of Welfare, the Department of Labour, the Department of Veterans Affairs, and the Unemployment Insurance Commission reporting to Parliament through the Minister of Labour.

232. That the National Advisory Council on the Rehabilitation of Disabled Persons, with representation from the federal departments concerned, provincial governments, voluntary agencies, medical professions, universities, and employer and employee organizations, act in advisory capacity to the new rehabilitation agency.

12. Health Services Administrators

233. That the Health Professions University Grant be available for the establishment of undergraduate and post-graduate courses in health services administration at selected Canadian universities.

234. That, as part of a seven-year crash programme, special Professional Training Grants of $3,500 per year be made available to graduate students proceeding to a higher degree in such courses.

13. Northern Health Service Plan

235. That every possible support be given to the Northern Health Service of the Department of National Health and Welfare to speed the implementation of the five-year plans to provide adequate health services for the Yukon and the Northwest Territories, and that the implementation be telescoped into a shorter period of time as resources become available.

236. That the Northern Health Service implement by 1967 its proposed comprehensive flying health service system linking the various communities with their health service base.[1]

237. That, as far as possible, such transportation services be integrated with the needs of other agencies; and that at each of the communities covered, suitable landing strips and other facilities be prepared and maintained to serve aircraft and, where feasible, helicopters in all seasons.

238. That an integrated telecommunication system be established to provide a 24-hour service for voice communication and that a visual system be implemented when this becomes practical; such communication systems for the purposes of the health services to be integrated with the needs of other agencies in a community.

239. That provisions be made for regular periodic visits to northern stations by medical specialists for consultation and seminars.

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[1] *See* pp. 268 and 269.

240. That provisions be made for regular periodic visits to northern stations by dentists and dental auxiliary personnel.

241. That training, refresher courses, manuals and the necessary equipment be provided to maintain a high degree of effectiveness among lay dispensers.

242. That the provision of "family medical packs" to isolated families and small groups be speeded up and that the necessary instruction manuals be made available.

243. That, while the present five-year plans for the improvement of health services in the Yukon and the Northwest Territories are implemented, more far-reaching plans for a further five-year period be formulated in order to ensure the future development and improvement of health services in the Territories.

244. That the budgetary requirements of the Northern Health Service of the Department of National Health and Welfare be considered within the framework of the territorial budgets rather than as part of the departmental budget.

245. That every effort be made towards the training of indigenous residents of the Territories by intensifying the ongoing training of nursing assistants and progressively for more advanced education and training of professional and technical health personnel.

246. That, as part of a seven-year crash programme, grants be made available from the Professional Training Grant, to cover the cost of such education or training.

247. That, on the coming into operation of a medical school at Memorial University at St. John's, Newfoundland,[1] part of the curriculum and training be directed towards the needs of health services in Canada's North and other sparsely settled areas.

248. That Memorial University at St. John's, Newfoundland, establish in connection with its future medical school, specialized courses for the training of other health personnel in the specific knowledge and skills required for the practice in the North and other sparsely settled areas.

249. That financial assistance be made available from the Professional Training Grant to enable personnel in training for health service in the North to do their field work in the Yukon or the Northwest Territories.

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[1] *See* Volume I, Chapter 2, pp. 70 and 71.

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    (a) competitive and attractive salaries and allowances to compensate for cost differentials,
    (b) upgrading of positions,
    (c) leave of absence provisions to provide for
        (i) regular periodic vacations with transportation for the personnel and their family paid to and from a predetermined home base;
        (ii) compassionate leave for the personnel in cases of serious illness in the family, and transportation paid to and from the nearest centre in the South for personnel and/or their family in the case of serious illness or death among their nearest relatives in the South;
        (iii) educational leave to facilitate continuing education and self-improvement;[1]
    (d) financial aid towards the education and maintenance of children where service in the North entails separation from their parents,
    (e) suitable housing accommodation.

251. That the selection of health personnel for service in the North be exercised with great care with regard to professional qualification as well as personal suitability and aptitude required under the circumstances.

252. That all residents of the Territories requiring medical attention not available in their home areas be flown out for such attention and returned on discharge as part of the Medical Services Benefit.

253. That the Health Sciences Research Council provide funds for the conduct of applied research into specific health and health service problems in the North.

254. That the existing agencies for the co-ordination of the activities in the Territories of federal government departments be strengthened, with adequate representation for the health services, both at departmental headquarters and at the regional and local levels.

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[1] For example, physicians may be granted one year's study leave in the middle of a 5-year term of office.

255. That intensive efforts be made for general community services to be developed simultaneously with the health services.

256. That the Centennial Commission as a centennial project survey the possibility of adopting the implementation of a demonstration project, in two far northern locations, of community development including adequate housing, proper sanitation services and essential education, health and other facilities.

ADDENDA TO RECOMMENDATIONS IN VOLUME I

In reviewing our Recommendations made in Volume I we find it desirable, for the sake of clarity and completeness, to round out these Recommendations in a few specific instances, listed below:

RECOMMENDATION 59 requires, in the provision of the drug benefit, a contributory payment of $1.00 by the purchaser for each prescription. The provision for a contributory payment shall not apply in the Yukon and the Northwest Territories.[1]

RECOMMENDATION 61 provides for the enlargement of the Drug Advisory Committee to the Department of National Health and Welfare.[2] We now suggest that among the expanded membership of that Committee there should be added representatives of the dental profession.

RECOMMENDATION 62 provides, among other matters, for the establishment of an information service which would issue periodic bulletins providing the latest information on drugs and drug therapy to physicians, pharmacists and hospitals.[3] Among the recipients of the bulletins, there should be added the members of the dental profession.

RECOMMENDATION 80 deals with the expansion of research grants by the Health Sciences Research Council.[4] The term "non-professional" in this paragraph should read "professional".

RECOMMENDATION 109 suggests that depreciation allowances on the value of buildings and fixed equipment, less the amount paid by federal and provincial grants, be recognized as shareable costs.[5] The introduction to Recommendation 109 speaks of interest and depreciation as shareable costs; hence, this Recommendation should be expanded to include interest as well as depreciation allowances as shareable cost.

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[1] *See* Volume I, Chapter 2, p. 41.
[2] *Ibid.*, p. 41.
[3] *Ibid.*, p. 42.
[4] *Ibid.*, p. 44.
[5] *Ibid.*, pp. 56 and 57.

RECOMMENDATION 195 requires reinterpretation in the light of the changing federal-provincial fiscal relationships and particularly the arrangements being developed permitting provinces to opt out of certain federal-provincial shared programmes.[1] In so far as a province elects to operate outside the grants-in-aid system through the opting-out device, such a province should be permitted to operate its health care programmes along the lines recommended in this Report with its share of financial assistance obtained through the collection of revenues from tax fields vacated by the Federal Government, equivalent to the amount it would have received from the Federal Government under a grants-in-aid system.

[1] *Ibid.*, p. 88.

ALL OF WHICH WE RESPECTFULLY SUBMIT
FOR YOUR EXCELLENCY'S CONSIDERATION

Everett M. Hall

Chairman

Commissioners

Alice Guiard

D. M. Bargen.*

O. J. Emerson

C. L. Strachan

Arthur F. Van Wart

B. K. Blicken.

Director of Research

December 7, 1964.

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* *See* addendum on following page.

ADDENDUM BY DR. D. M. BALTZAN

While fully agreeing with the views of my fellow Commissioners as expressed in the recommendations contained in Volumes I and II, I wish to add the following personal observation. When a patient chooses to obtain services from a physician practising independently of the Medical Services Programme and pays that physician an amount agreed upon, the patient should be entitled to be reimbursed by the Health Services Commission of his province the amount the Commission would have paid a physician practising under the Programme for the same service.

January 8, 1965.

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ERRATA TO VOLUME I

Page 232, para. 2, line 3: 1,150 *should read* 116.7.

Page 509, para. 1, line 3: may outweigh *should read* may not outweigh.

Page 826, Table 20-12, last column: 27.9 *should read* 24.9.

Page 849, para. 3, lines 3 and 4: $8.27 and $9.31 *should read* $7.09 and $8.25.

Page 850, Table 20-25, last column: 8.27 and 9.31 *should read* 7.09 and 8.25.