

World War II and Expansion

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Elizabeth L. Smellie

Service to VON and First Female Military Colonel

Elizabeth Laurie Smellie was born in 1884 in Port Arthur, Ontario. After attending the Johns Hopkins Training School for Nurses in Baltimore, she signed up as a Nursing Sister during WWI with the Royal Canadian Medical Corps. In 1924, she joined the Victorian Order of Nurses and was appointed Chief Superintendent shortly after, helping to expand the Victorian Order of Nurses across Canada. In 1940, Ms. Smellie rejoined the Canadian army in World War II and helped organize the Canadian Women’s Army Corps (CWACs). The CWACs performed a variety of war-time duties, from clerical and administrative to driving, sail-making, as supply assistants and teletype operators. Ms. Smellie was placed in command of the CWAC division in 1942 and promoted to Colonel in 1944, the first woman to reach this rank in the Canadian army.

—suite101.com

The Second World War created unprecedented growth in the labour force and the rate of industrialization in Canada. Raw materials, farm products, and manufactured goods were needed to fight the war. In addition to significant increases in capital investment and technological

advances, a predominantly rural country became an urban one during the 1940s. Women were essential in keeping the farms and the economy running during the war and their rate of full-time labour force participation doubled between 1939 and 1944, many doing what was traditionally considered “men’s work.” Technological advances put hospitals and medical specialists centre stage as industrialization continued to transform Canadian society, while labour and left-wing political forces called for greater social equity. The end of Second World War brought the promise of progressive change, growth and prosperity to Canada, although there was also growing anxiety about the accelerating pace of change and the looming atomic shadow of the Cold War.¹

During World War II, many of the country’s most talented medical and public health personnel joined the armed forces. A *Canadian Public Health Journal* editorial on public health in wartime warned that while the ultimate scope and cost of the war was still unknown, it was clear that demands had “already gone out for curtailment of public expenditures and redirection of effort.... Gains must be consolidated. The last war left its lessons. There can be no reduction in public expenditures, and no lessening of public effort, for the safeguarding of health.”² CPHA continued to press for federal funds for full-time health units and provincial tuberculosis control programs. In every province, public expenditures for tuberculosis control and sanatorium care

1 http://www.warmuseum.ca/cwm/exhibitions/newspapers/canadawar/homefront_e.shtml
2 “Public Health in Wartime,” *Canadian Public Health Journal* 31 (January 1940): 35–36

“closely approximates or even exceeds the expenditure of the Health Department for all other services,” leaving very little to support preventive services.³

Nutrition and Food Safety

During and after the war, many Canadians had problems accessing and affording good quality food. The war brought a new focus on



Cockfield, Brown & Company Limited

Safe milk supply

nutrition for the civilian and the military populations, as recent surveys revealed malnutrition among a significant proportion of the population. Bread was of particular interest to help improve nutrition levels by shifting popular preferences away from white bread to more nutritious whole wheat breads, although the addition of a synthetically-derived vitamin B₁ to white bread was seen as an improvement. Nutrition surveys revealed deficiencies in calcium, with children in lower income families receiving only half the calcium they needed—their diets

lacking in milk and cheese due to economic hardship or lack of appreciation for the nutritive value of milk. As a *Canadian Public Health Journal* editorial stressed, “in a predominantly agricultural country, frequently embarrassed by surplus crops, a large number of our children are not securing healthful meals.”⁴

3 “The Need for Federal Government Assistance in Public Health,” *Canadian Public Health Journal* 32 (September 1941): 478–79

4 E.W. McHenry, “Nutrition in Canada,” *Canadian Public Health Journal* 30 (September 1939): 431–34; “Improving the Staff of Life,” *Canadian Public Health Journal* 31 (September 1940): 441; Dietary Calcium Deficiencies in Canada,” *Canadian Public Health Journal* 32 (April 1941): 227–28



Josephine DeBrincat

Developed Public Health Nursing in Manitoba

Josephine DeBrincat’s career is closely linked with the development of public health nursing services in Manitoba. She was born on the island of Malta and graduated from nursing training at the Winnipeg General Hospital in 1925. She went on to earn the Royal Sanitary Inspector’s Certificate and the Public Health Nursing diploma. Ms. DeBrincat specialized in industrial nursing and during and after the Second World War served as Public Health Nurse Supervisor for the United Nations Rehabilitation and Relief Administration in Italy. Upon her return to Manitoba in 1946, she took up her responsibilities as Industrial Nursing Consultant, Public Health Nursing Consultant, and Civil Defence Consultant to the Department of Health and Public Welfare.

—*Canadian Journal of Public Health*, Vol. 61, 1970

Better nutrition was seen as necessary for the young and for adults, particularly those employed in war industries. A Division of Nutrition was created within the Department of Pensions and National Health in 1941 to improve Canadian nutrition standards and work with nutritional committees set up in each province. Canada’s first national food guide, then called the Official Food Rules, was introduced in 1942 to help prevent nutritional deficiencies during wartime food rationing. The Division launched a comprehensive national nutrition program with assistance from the Wartime Information Board and the Association of Canadian Advertisers “to awaken Canadians to the need for adequate

nutrition for the maintenance of health and physical efficiency.”⁵

Recovery from wartime food shortages during the early post-war period was slow. Import restrictions and the high price of fresh



Health Canada

Canada’s first food guide



Chester B. Stewart

Researcher, Administrator and Dean of Medicine, Dalhousie University

Chester Bryant Stewart was born in Prince Edward Island. Following graduation as Gold Medalist in Medicine in 1938, he was appointed Assistant Secretary of the Associate Committee on Medical Research of the National Research Council in Ottawa, under the chairmanship of Sir Frederick Banting. He was involved in the first program of research in aviation medicine in Canada and from early 1940 to mid-1945, pursued aviation research activities in the Canadian Armed Forces, retiring with the rank of Wing Commander. After postgraduate training in public health and epidemiology, he was appointed Professor of Epidemiology in the Faculty of Medicine, Dalhousie University in 1946 and later Dean of Medicine.

—*Canadian Journal of Public Health*, Vol. 67, May/June 1976

5 “The Canadian Nutrition Program,” *Canadian Journal of Public Health* 34 (January 1943): 38–39

fruits and vegetables were significant and in 1948, the Dominion Council of Health noted that “housewives were expressing concern that their families were being deprived of needed nutrients.” The Council advised the federal health department to provide advice about suitable substitutes for items in short supply and how to stretch the food dollar. The Dominion Council of Health also considered the regulation of salt suppliers, as provincial health departments were being pressured to address iodide deficiencies causing goitre. Vitamin D deficiencies among children prompted the Dominion-Provincial Nutrition Committee to press for the preparation of new and updated educational material on nutrition.⁶

For families forced to look for fat substitutes, the 1886 ban on the manufacture of margarine was difficult to understand. The dairy industry was unable to meet the demand for butter and shortages finally resulted in the lifting of the ban in 1948. Many thought the nutritional value of margarine was poor, but the chief of the federal Nutrition Division was confident that “from the economic and nutritional aspects, good margarine is superior to butter.”⁷

Canadian Public Health Journal, 34 (November 1943)



launched mid-way through the war. As with World War I, large numbers of young men called up for military service had to be rejected because of their lack of physical fitness. The House of Commons reported that some 43% of new recruits had to be rejected in 1941, a figure that rose to more than 50% by 1944 and many were accepted despite having remedial defects of eyes, teeth, hernias and orthopedic conditions, among others. In 1943, the federal government implemented the *National Physical Fitness Act*, established the National Council on Physical Fitness and provided grants to the provinces for local health education initiatives. As one *Canadian Public Health Journal* editorial stressed, “war teaches valuable lessons but it should not be necessary to have a war to make people realize that the health and physical fitness of children and of young people are of paramount importance to the country.”⁸

Tobacco Use

Despite the persistent opposition by the Women’s Christian Temperance Union since World War I, tobacco use continued to grow in popularity in Canada. Raymond Pearl published actuarial life tables in a 1938 issue of *Science* that clearly showed more frequent



Public Health Journal, 15 (June 1924)

Dent. of National Defense, Library and Archives Canada, PA-065375



Soldiers exercising, RCAF, Hamilton, ON, 1944

Physical Fitness

Along with the nutrition initiatives, a broad national health education and physical fitness initiative was

6 Minutes, Dominion Council of Health, May 14–16, 1947, October 15–17, 1947, May 10–12, 1948
 7 Minutes, Dominion Council of Health, October 15–17, 1947; “Margarine,” *Canadian Journal of Public Health* 40 (June 1949): 275–76

8 “Health Training in Schools,” *Canadian Public Health Journal* 33 (April 1942): 178–79; “Military Rejections and the Public Health,” *Canadian Public Health Journal* 35 (September 1944): 367–68



June Lawson

Canada's First Female Sanitary Inspector

June Lawson was the first woman to receive the Certificate in Sanitary Inspection (Canada). Born in Scotland in 1907, Ms. Wilson moved to Winnipeg and graduated from Success Business College in 1930. She worked as a clerk for the T. Eaton Company, later for the City of Winnipeg Tax Office, and later for the City Health Department Food and Dairy Division as well as the Sanitation and Housing Division. While with the City Health Department, Ms. Lawson trained to become a Sanitary Inspector and received Certificate # 254 in 1942.

—Tim Roark, Historian, Canadian Institute of Public Health Inspectors, 2009

early death among smokers than non-smokers, but this and other evidence of the harmful effects of tobacco use apparently had no impact on the public. The habit was glamorized in the Hollywood movies of this decade, further boosting smoking's popularity, including among a growing number of women. Cigarettes were custom-packaged for the soldiers and provided by tobacco companies in the rations. The number of cigarettes consumed annually in Canada increased tenfold between 1921 and 1949, reaching 28 billion. A 1947 survey showed that 49% of Montreal women smoked, while other surveys showed that about three-quarters of men and 50% of women in their 20s and 30s were smokers.⁹

9 N. Collishaw, *History of Tobacco Control in Canada* (2009), Ottawa, ON

Venereal Disease and Penicillin

The war expedited the development and large scale supply of penicillin—one of the most dramatically successful medical drug treatments to emerge since insulin. Discovered in London by Alexander Fleming in 1929, penicillin's antibiotic effects prompted intense research efforts during the early 1940s by Howard Florey, Ernst Chain



Claude Ernest Dolman

Distinguished Microbiologist, Researcher and Recognized Botulism Expert

Dr. Claude Ernest Dolman was a distinguished microbiologist and well known for his contributions to both public health and academic aspects of bacteriology. Born in England in 1906, he came to Canada in 1931 as Research Assistant at Connaught Laboratories. He went on to become Professor and Head of the Department of Bacteriology and Preventive Medicine at the University of British Columbia. Dr. Dolman made more than 100 contributions to the medical literature, including 36 to the *Canadian Journal of Public Health*. These papers cover a wide range of topics, such as brucellosis, gonorrhoea, typhoid fever, cholera vaccine, diphtheria, influenza and rat-bite fever. He gained a world-wide reputation for his work on botulism and put forward the epidemiologically significant hypothesis that *Clostridium botulinum* type E is not a marine organism but of terrestrial origin.

—*Canadian Journal of Public Health*, Vol. 64, March/April 1973

and others in Oxford to produce it on a large scale. It was increasingly clear that penicillin would have a significant impact on the treatment and management of pneumonia, meningitis, gonorrhoea and syphilis and the Canadian Forces used it with supplies largely provided by Connaught Laboratories.

The federal government re-established its Venereal Disease Control Division in 1943, under the joint authority of the Department of Pensions and National Health and the Department of National Defence. There was a lower incidence of VD among military personnel than had been expected and this was attributed to health education, treatment, contact tracing, and condoms and prophylactic packages provided to soldiers prior to leaves. On the home front, federal health grants enabled provinces to provide antibiotic treatment for free, contributing to a 72.2% reduction in syphilis rates and a 35.6% reduction for gonorrhoea between 1944 and 1951.¹⁰

Sanofi Pasteur Limited, Connaught
Campus Archives



Immunization and Infectious Diseases

Measles, hepatitis, a resurgence of rabies and of the importation

of malaria via soldiers returning from Korea added to public health concerns about diseases such as typhoid fever entering the country with

10 Gordon Bates, "Venereal Disease Control," *Canadian Public Health Journal* 32 (July 1941): 339–49; "The Importance of the Moral Factor in the Control of Venereal Diseases," *Canadian Public Health Journal* 32 (July 1941): 366–67; "An Essential Consideration in Venereal Disease Control," *Canadian Public Health Journal* 33 (October 1942): 502–03; "A Coordinated Program for Venereal Disease Control in Canada," *Canadian Journal of Public Health* 34 (May 1943): 246–47



Allan Reid Morton

*Able and Hardworking
Developer of Public Health
in Halifax*

Dr. Allan Reid Morton became the first full-time Medical Officer of Health for Halifax in 1940 and also accepted an appointment as Associate Professor of Preventive Medicine at Dalhousie University. Diphtheria was a prime concern in the early 1940s, especially as Halifax was an embarkation and assembly point for troops during WWII. During the war, Dr. Morton served as Chairman of the Medical Committee for the armed services of the area and after the war, guided the development of a mental health program, and a maternal and child health program. He supervised the Salk Poliomyelitis Vaccine Trial program in Halifax in 1954, the first area in Canada to use the vaccine. Dr. Morton waged a personal battle with tuberculosis, which interrupted his career on a number of occasions but each time he returned with renewed vigour.

—*Canadian Journal of Public Health*,
Vol. 55, June 1964

new immigrants. Immunization efforts were hampered by apathy and complacency among parents and many within the medical profession. Lapses in diphtheria immunization for preschool children and limited uptake among nurses, physicians, medical students and hospital staff members fuelled persistent diphtheria incidence and Canada, which had been a global leader in bringing diphtheria under control, had fallen behind the United States, England and Wales by the mid 1940s.

Sanofi Pasteur Limited, Connaught
Campus, Archives



A severe case of smallpox



Three siblings, two vaccinated; middle child unvaccinated

J.J. Heagerty, Smallpox and
Vaccination, Ottawa, 1925

Provincial health departments renewed efforts to raise awareness of free toxoid inoculations but follow-up doses of toxoid were often not given. Nova Scotia experienced a diphtheria epidemic among civilians and the military and Halifax's poor public health management history prompted the city government to launch an independent survey of health conditions, carried out by the International Health Division of the Rockefeller Foundation. The survey criticized the city government's laissez-faire attitude towards its public health responsibilities, evident in a high incidence of preventable diseases, tuberculosis and infant mortality rates.¹¹

When a virulent smallpox outbreak in Seattle, Washington in 1946 resulted in 51 cases and 16 deaths, British Columbia's provincial officer of health issued a strong statement through the press, advising all citizens to be vaccinated. The public responded quickly, prompting emergency calls to Connaught Laboratories for rush supplies of vaccine while Vancouver and Victoria health departments held vaccination clinics that were open for 12 to 14 hours a day to accommodate the steady lines of people. Once the vaccine supply was sufficient, vaccination clinics were arranged across the province and proof of vaccination

11 "National Immunization Week, November 14–21," *Canadian Journal of Public Health* 34 (October 1943): 476–77; "The Halifax Health Survey," *Canadian Journal of Public Health* 34 (March 1943): 140–41; "The Occurrence of Diphtheria in Halifax from October 1, 1940 to January 31, 1941: An Interim Report to the Dominion Council of Health," *Canadian Public Health Journal* 32 (August 1941): 404–09

was required to cross the Canada–United States border. By the time the crisis had passed, a total of 300,000 people were vaccinated in the Vancouver and coastal areas of the province, with no significant complications reported and no noticeable anti-vaccination activity. The importance of routine vaccination of children during their first year of life was re-emphasized, while at CPHA's Annual Meeting in 1946 a resolution was passed urging "the adoption of a more vigorous policy of health departments in regard to re-immunization."¹²

Health Services for Aboriginal People

As concerned individuals continued to urge better federal responses to tuberculosis among Indigenous communities, Dr. J. D. Galbraith wrote a seven-page letter describing TB in Bella Coola and urging British Columbia's provincial secretary to take some action to address the "utter lack of measures to deal with treatment of existing cases or prevention of spread of this disease" in 1940.¹³ He noted that still, "the Canadian Indian is the only person in Canada who is excluded entirely from the nationwide organization to cope with the disease of tuberculosis." Death rates in the 1940s remained in excess of 700 deaths per 100,000 Indigenous Canadians—among the highest ever reported in a human population, due to poverty, poor nutrition, overcrowding and co-morbidity with other diseases. In contrast, the national rate of TB mortality began a rapid decline in the 1940s,

12 "Resolutions Adopted at the 34th Annual Meeting of the Canadian Public Health Association, Toronto, May 6–8, 1946," *Canadian Journal of Public Health* 37 (June 1946): 254

13 J.D. Galbraith. Letter to G.M. Weir, February 15, 1940.

now believed to primarily be due to a cohort effect resulting from the death and aging of a vulnerable generation.

The health of Indigenous peoples in the North was determined to be a federal responsibility under a 1939 Supreme Court of Canada ruling. The Inuit (generally called Eskimos at this time) were to be included with Indians, in terms of federal jurisdiction for their health care, but not extending to the provisions of the *Indian Act*. A unified Indian and Eskimo health service was created in 1945 under the new Department of Health and Welfare. Military activity during and



Andrew J. Rhodes

Applied Electron Microscopy to Virus Identification

Born in 1911, Dr. Andrew Rhodes was a research scientist for nearly four decades in his chosen field of microbiology, particularly virology. He led in the application of electron microscopy to virus identification, in the *in vitro* cultivation of poliovirus in tissue culture and in studies of other viruses. He had over 140 papers accepted for publication and in cooperation with C.E. Van Rooyen, he authored two of the definitive textbooks on virus diseases, both of which went on through multiple editions. At various times he was Director of the Research Institute, Hospital for Sick Children, Director of the School of Hygiene, and Medical Director of the Laboratory Services Branch of the Ontario Ministry of Health.

—*Canadian Journal of Public Health*, Vol. 66, March/April 1975



Polio in the north of Canada, 1940s

after the war and subsequent economic development in the territories brought infectious disease threats that proved especially dangerous to Inuit communities, including polio, influenza and a number of other virus diseases.

Polio continued to spread among the whole population in the 1940s in the absence of an effective vaccine. The federal health research grants program supported a comprehensive polio virus research program at Connaught Medical Research Laboratories, launched in 1947 under the direction of Dr. Andrew J. Rhodes. During the winter of 1948–49, he heard of an outbreak among the Inuit population on the western coast of Hudson’s Bay from the Indian Health Services Medical Officer of Health for the Eastern Arctic region, Dr. J.P. Moody. Moody was one of 27 full-time medical officers of the Indian Health Services division of the Department of National Health and Welfare, seven of whom were stationed in the eastern Arctic area. There were also some 700 doctors providing medical services on a part-time basis to Aboriginal communities, in addition to 24 field nurses scattered across the country and a medical group stationed on the Eastern Arctic Patrol onboard the *HMS Nascopie*.¹⁴ By the end of February, some 25 cases and



14 P.E. Moore, “Indian Health Services,” *Canadian Journal of Public Health* 37 (April 1946): 140–42



Joseph Henry Gilbert Page

Development of Vital Statistics and Public Health in Canada

Joseph Henry Gilbert Page was born in Chalk River, Ontario in 1909. In 1942, he accepted an appointment in the Statistics Department of the Health and Welfare Division and played a leading role in developing, in collaboration with the provinces, the National Birth Index—the cornerstone of the National Family Allowances Program. He was appointed Chief of the Vital Statistics Section in 1947—a position he held with distinction until his retirement in 1974. He participated in planning five Canadian censuses and in laying the groundwork for the 8th and 9th Revision of the *International Classification of Diseases*. Through dialogue and communication with the provinces, Mr. Page built confidence and understanding that led to the evolution of Canada’s vital statistics system.

—*Canadian Journal of Public Health*,
Vol. 65, March/April 1974

deaths had occurred and a team of six doctors was flown into the area by the Air Force to diagnose and treat the outbreak. On February 20, Moody imposed an unprecedented regional quarantine, covering some 40,000 square miles.¹⁵

Around the same time as the Arctic polio epidemic to the east, an unusually virulent outbreak of influenza struck the entire Inuit population of 90 people who lived in the southern regions of Victoria Island in the



John Thornton Marshall

*Distinguished Statistician
Made Significant
Contributions to Public Health*

John Thornton Marshall was born in Buckingham, England and came to Canada as a boy, settling in Victoria. He took up employment with the Vital Statistics Division of the British Columbia Board of Health and from 1916 to 1941, rose from clerk to director of the Vital Statistics Division and supervisor of Medical Records. He invented and introduced a number of systems for the registration of births, marriages and deaths and he established registries for adoption and divorce. As well, he set up recording systems for hospitals, welfare agencies and public health nursing services. In 1941, Mr. Marshall moved to Ottawa and served as assistant Dominion Statistician. His pioneer work resulted in the establishment of the Vital Statistics Council of Canada, dedicated to standardization and improvement.

—*Canadian Journal of Public Health*,
Vol. 56, 1965

four

Lawrence family, Provincial Archives of Alberta, A2088



*Mackenzie Delta Eskimos, Aklavick,
Arctic Circle, 19—?*

northern Northwest Territories, near Cambridge Bay, resulting in 18 deaths. Among the non-Inuit population of approximately 50 men living in the area, very few were affected and medical attention was needed in only one case. There were concerted efforts to identify the strains responsible for the outbreaks and it was clear that there was “the need for immunizing Eskimos against infection introduced from without with similar inoculation of white persons entering these Arctic Territories.”¹⁶ Influenza was a significant factor in many areas of Canada that winter, especially in parts of Ontario, Quebec, New Brunswick, Saskatchewan and Alberta, but its effects among the non-Aboriginal population were generally mild.

Federal Expansion and Post-War Promise

A federal-provincial conference was held in 1941 to discuss the Rowell-Sirois Commission’s recommendations, but most of these, including a proposed health insurance plan, did not proceed in the face of opposition from the provinces from what was seen as federal intrusion into provincial domains. However, pensions and welfare provision were transferred from provincial jurisdiction and the federal government turned its attention to improving the country’s standard of living. A new Department of National Health and Welfare had replaced the Department of Pensions and National Health in 1944.



Dr. George
Donald West
Cameron



Paul Martin Sr.

A federal health grants program was announced in August 1945 but fizzled out when Ontario and Quebec did not agree with the plan’s financial arrangements. A renewed federal focus on expanding national public health services began in 1946 with the appointment of Dr. George Donald West Cameron as Deputy

Minister of National Health and of Paul Martin Sr. as Minister of National Health and Welfare. Martin had a strong interest in health issues, much of it drawn from personal experience. A few

months before his appointment, a serious polio outbreak in the Windsor, Ontario area touched Martin’s eight-year-old son, Paul Jr., among many others. Martin Sr. was Secretary of State at the time and in a cabinet meeting when he received a frantic call from his wife asking him to rush home. (In 1907, Martin Senior himself had suffered from an attack of polio, which left a number of physical scars.) He was given access to a government plane for the trip and found his son in an isolation ward, paralyzed in the throat and unable to speak. Fortunately, the crisis passed and Paul Jr. recovered, although it would take most of a year.¹⁷

The division of child and maternal hygiene in 1947 filled the gap created when the child welfare division was closed in 1943. A new division for epidemiology and new quarters for the Laboratory of Hygiene, the Food and Drugs Laboratory and an Industrial Hygiene Laboratory, modeled after the National Institutes

16 C.E. Van Rooyen, L. McClelland and E.K. Campbell, “Influenza in Canada During 1949, Including Studies on Eskimos,” *Canadian Journal of Public Health* 40 (November 1949): 447–56; F.P. Naglet, C.E. Van Rooyen and J.H. Sturdy, “An Influenza Virus Epidemic at Victoria Island, N.W.T., Canada,” *Canadian Journal of Public Health* 40 (November 1949): 457–65

17 Paul Martin, *A Very Public Life: Volume I, Far From Home*, (Ottawa: Deneau Publishers, 1983), pp. 459–60

of Health in Washington, were other signs of federal public health expansion.

Martin announced his national health program in May 1948 at the annual meeting of the Canadian Public Health Association in Vancouver. He stressed the “greatly accelerated progress” that was now possible based on “vastly increased expenditures” being committed by the federal government to “put into effect this far-reaching plan for national health.”



John J. Heagerty

Developed Federal Health Insurance Legislation

Dr. John J. Heagerty was Canada’s first chief officer of health of the federal Department of Health. In 1928, Dr. Heagerty wrote: “We have seen our health departments develop from a part-time physician, who was the sole staff, to armies of workers and an expenditure of many thousands of dollars. We have seen the death rate drop from 40 per thousand to as low as 7.5 per thousand, in some parts of the country. To all who have been engaged in fighting disease from generation to generation it has been a long and tiresome journey.” His exhaustive *Report on Public Health in Canada* formed the basis of the draft health insurance bill presented to a parliamentary committee in 1943. He led a comprehensive federal effort to develop the bill, introduced in 1945. He created his own memorial in his *Four Centuries of Medical History in Canada*.

—*Canadian Medical Association Journal*, August 10, 1968

Frederick W. Jackson

Developed and Introduced Renowned Manitoba Health Plan

Dr. Jackson entered the Department of Health and Welfare of Manitoba as Director of the Division of Disease Prevention in 1928 and from 1931 to 1948 he served as Manitoba’s Deputy Minister of Health and Public Welfare. In this position, he developed the renowned Manitoba Health Plan that was introduced in 1945. Due to his vision and untiring efforts, Manitoba developed a unique and highly effective health program, integrating hospital services, public health, laboratory and diagnostic services. He went on to assist the Department of National Health and Welfare in establishing health insurance studies.

—*Canadian Public Health Journal*, Vol. 48, 1957

The program was focused on three types of grant programs for provincial health services: \$625,000 for provincial planning to survey existing health needs; \$13 million a year for five years to construct hospitals; and eight national health grants totalling \$17 million in the first year, expected to rise to \$22 million annually for an indefinite period and distributed to each province on a per capita basis. The health grants focused on the control of tuberculosis, cancer and venereal disease, mental health care, support for crippled children, professional training, general public health, and public health research.

New federal welfare allowances were created to help support families, the aged and blind, provide insurance for the unemployed, financial support for housing, and assistance for farmers and fishermen. The new federal philosophy was that “social well-being is an essential and basic

consideration of healthful living,” and this defined the foundation of the Department of National Health and Welfare. According to Martin, “Canada is among those countries where public health is shifting its emphasis and broadening its outlook to embrace all that affects human life.”¹⁸

Martin and Cameron decided not to let provincial resistance stand in the way and planning proceeded for a national health insurance scheme. Saskatchewan pioneered North America’s first province-wide hospitalization prepayment plan in 1947, based on an annual per capita fee of five dollars. British Columbia, Alberta and Newfoundland (which joined Confederation in 1949) also offered partial coverage.

A Mixed Blessing for Public Health

The Canadian Public Health Association appointed its first full-time executive director, Dr. J.H. Ballie, who began his new job at the end of 1945 by directing several public health surveys requested by provincial health authorities and launching a new initiative to establish provincial public health associations. CPHA conducted surveys of public health practice and salary schedules, but a legacy of undervaluing public health work continued to limit salary growth, despite increasing demands and shortages of qualified public health personnel.¹⁹

18 Paul Martin, “A National Health Program for Canada,” *Canadian Journal of Public Health* 39 (June 1948): 219–26

19 “Qualifications and Salaries of Public Health Personnel,” *Canadian Journal of Public Health* 37 (May 1946): 209; “The Salary Survey,” *Canadian Journal of Public Health* 38 (January 1947): 58–59; “The Canadian Public Health Association, 1946–1947: Report of the Executive Director,” *Canadian Journal of Public Health* 38 (May 1947): 249–52; “The Shortage of Nurses,” *Canadian Journal of Public Health* 38 (November 1947): 558–49; “Survey of Public Health Practices in Canada,” *Canadian Journal of Public Health* 39 (February 1948): 84–85



Gregoire Fere Amyot

Public Health Contributions to Canada and the United States

After graduating in medicine at the University of Toronto, Dr. Amyot joined the Department of Public Health in Saskatchewan and worked in the northern regions of the province, often travelling by canoe. He later became Assistant Provincial Health Officer and Advisor on Hospital Services for the Province of British Columbia as well as a Professor of Public Health Administration at the University of Minnesota’s Department of Public Health and Preventive Medicine. In 1946, Dr. Amyot became the first Deputy Minister of Health for British Columbia’s Department of Health and Welfare.

—*Canadian Journal of Public Health*,
June 1963

The professionalization of public health continued, and it was officially recognized as a designated specialty of medicine by the Royal College of Physicians and Surgeons of Canada in 1947. Qualifying for this specialization status was a challenge, owing to the public nature of public health services in contrast to the personal relationships inherent in private medical practice. It also paid considerably more to be a general practitioner or to pursue a career in any of the other growing medical specialties, other than public health.²⁰

20 “Qualification Requirements and Minimum Salaries for Public Health Personnel in Canada,” *Canadian Journal of Public Health* 40 (April 1949): 186–87; “The Shortage of Public Health Personnel,” *Canadian Journal of Public Health* 41 (January 1950): 44–45; “Public Health – A Specialty in Medicine,” *Canadian Journal of Public Health* 41 (March 1950): 133–34



G. Brock Chisholm

First Director General of the World Health Organization

When Dr. Chisholm retired from the World Health Organization, an editorial in an international journal at the time said: “Dr. Chisholm’s retirement after nearly two years with the Interim Commission and five years as Director General of the World Health Organization closes a notable chapter in the history of public health and of international collaboration. His dealings with individuals were directed by the skill of an experienced psychiatrist; and his vision and courage in program planning were characteristic of a leader of inherent and essential greatness.” Dr. Chisholm entered the field of psychiatry after spending some years in private practice. During WWII, he served as Director of Personnel Selection, as Deputy Adjutant General and later, as Director General of Medical Services. When he was appointed Deputy Minister of National Health in 1944, it was said that he exhibited extraordinary skill in the post-war expansion of the Department. In 1946, Dr. Chisholm directed the Interim Commission of the World Health Organization and became its first Director General two years later.

—*Canadian Public Health Journal*,
Vol. 49, 1958

Despite grants for professional development, there had been significant shortages in public health personnel since the end of the war, mostly due to a lack of financial incentives for physicians to specialize in public health. The public health nursing shortages were acute and expanding health services and hospital construction in the United States drew many young Canadian physicians and nurses south. The *Canadian*



Lyle M. Creelman

Developments of Nursing and Public Health in Canada and Around the World

“In fourteen years as Chief Nursing Officer, World Health Organization, Lyle Creelman probably achieved more for nursing throughout the world than any other nurse of her time,” said the *Journal of the International Council of Nurses* in 1968. Lyle Creelman was born and educated in Nova Scotia and in 1938 was granted a Rockefeller Fellowship to attend Columbia University, where she completed a master’s degree, specializing in public health nursing administration. Her work on the international level began immediately after WWII when she was appointed Chief Nurse for the United Nations Relief and Rehabilitation Administration in the British zone of occupation in Germany. On her return to Vancouver in 1947, she conducted an intensive study and evaluation of public health practice in collaboration with Dr. J.H. Baillie, with recommendations that made a decided improvement in the practice. Two years later she joined the World Health Organization as nursing consultant in maternal and child health and was appointed Chief Nursing Officer five years later.

—*Canadian Journal of Public Health*,
Vol. 63, 1972

Journal of Public Health added an Employment Services section to advertise the growing number of public health positions that were increasingly difficult to fill.

World Health Organization

Despite the field's challenges at home, Canada made a significant contribution to the creation of the World Health Organization (WHO) in 1948. Deputy Minister of National Health and Welfare, Dr. Brock Chisholm, played a central role in the development of the WHO after the war and is credited with defining the international organization's objective of the attainment by all people of the highest possible level of health.

Chisholm served as the first Director General of the WHO, from 1948 to 1953. The Organization's statement that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"²¹ would help define the broader mission of the Canadian public health community in the next decade.

21 S.W.A. Gunn, "The Canadian Contribution to the World Health Organization," *Canadian Medical Association Journal* 99 (December 7, 1968): 1080–88