

## This is Public Health: A Canadian History

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# Social Transformation and Health Services

The 1960s were a period of rapid social change in Canada, and especially in Quebec where 16 years of Conservative rule ended and the province launched its “Quiet Revolution” with ambitious economic and social reforms that touched every level of society. Traditional governmental roles also changed radically and Canadians enjoyed greater access to medical care with the introduction of public medical insurance. Longer life expectancies brought greater attention to the challenges of chronic disease. Tobacco, alcohol and drug use became bigger concerns and the incidence of sexually transmitted infections increased. The public became more aware of the potential negative impacts of synthetic chemicals, prescription drugs and technological advances, while concerns about the impact of processing on food nutrition prompted research studies and calls for better education strategies. On the whole, however, public health seemed to be taken for granted and there was resistance to official messages about vaccination, tobacco, water fluoridation and automobile safety.

## CPHA at Fifty

In order to renew CPHA’s 1912 federal charter, a private member’s bill to update the *Canadian Public Health Association Act* was introduced in February 1960, received unanimous support in the Senate and the House of Commons, and was given Royal Assent on March 31. The Association appointed Dr. Edward J. Young as full-time Executive Director, after nearly a decade without one and an advisory board for the *Canadian Journal*.



[click to enlarge image](#)

*Public Health circular distributed to homes, 1961, Vol. 47, No. 1, p. 16*

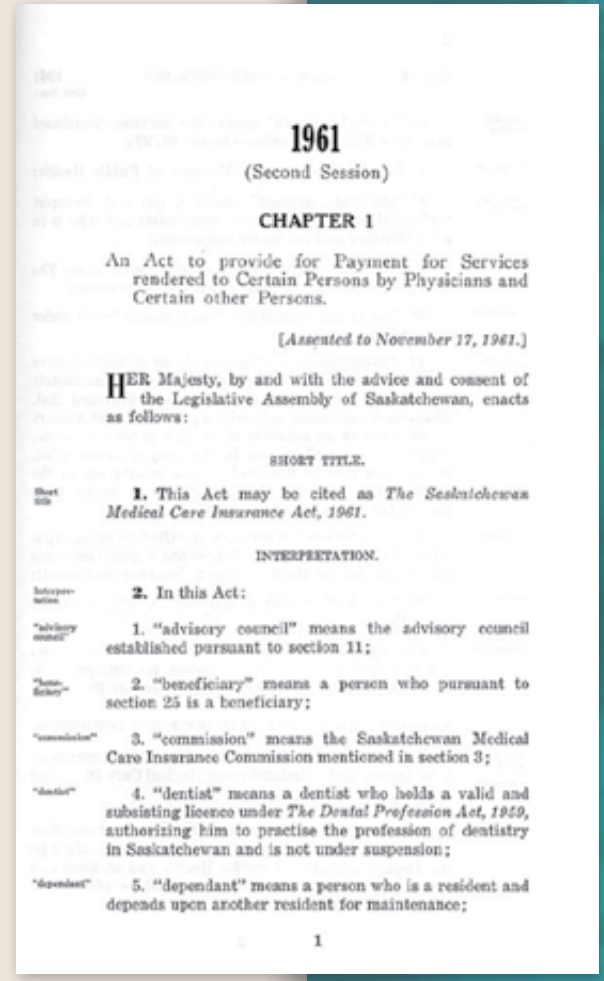
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*of Public Health* was also appointed, made up of representatives from each provincial association, as well as an associate editor from Quebec in an effort to attract a larger number of submissions from that province.

The public health field struggled to redefine itself as the bulk of government health spending was devoted to a national system of hospital-based health care. In a March 1960 issue of the *Canadian Journal of Public Health*, CPHA President Dr. Jules Gilbert stressed the need for more work in public health education, professional training, research, and the provision of preventive services. In the same journal issue, Department of National Health and Welfare director of health services, Dr. K.C. Charron, outlined five main priorities for public health: administration and organization; mental health; medical rehabilitation and chronic disease control; and health radiation and emergency health services.<sup>1</sup>

### Hospitals and the Future of Public Health

A March 1960 editorial in the *Canadian Journal of Public Health* noted the “almost overwhelming” need for more hospital beds and nurses. The federal and provincial governments continued to expand hospital infrastructures while public medical insurance plans were being developed. The creation of Canada’s system of public medical insurance began in Saskatchewan in 1960 with the re-election of **Tommy Douglas**’ Co-operative Commonwealth Federation (CCF) government. Fear of government interference with professional freedoms and objections to the compulsory nature of the plan led to a provincial doctor’s strike during the summer of 1962, but when the province agreed to remove or change any sections in the legislation that the Saskatchewan College of Physicians and Surgeons viewed as “hazardous to professional freedoms,” the doctors’ strike ended.<sup>2</sup>




[click to enlarge image](#)

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U of S Archives, V.E.A. Tollefson Papers MG2651, H. Personal

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Voluntary medical insurance plans had been introduced in British Columbia, Alberta and Ontario and in 1961, the federal government launched a Royal Commission chaired by Saskatchewan Chief Justice Emmett Hall, “to inquire into and report on the existing facilities and future need for health services for the people of Canada and the resources to provide such services and to recommend such measures, consistent with the constitutional division of legislative powers in Canada.”<sup>3</sup>

The Canadian Public Health Association urged the Commission to focus on issues of quality, availability and the effective use and co-ordination of health services. CPHA recommended in a 1962 brief that, “Canada should adopt a more positive philosophy towards health,” and noted that “services for prevention and public health need a great deal more support.” Long-term planning and evaluation, the control of chronic diseases, comprehensive rehabilitation facilities, a more progressive and integrated approach to mental health services, and greater support for public health research and training were among the Association’s recommendations.<sup>4</sup>

### Unaddressed Public Health Concerns

When the Commission’s preliminary report was released in 1964, the emphasis on “a planned and coordinated approach to the development and maintenance of health services on a nation-wide basis” was welcomed but the field was disappointed by the lack of attention to public health issues. The suggestion of “radical changes” in the National Health Grants program was also disconcerting and the Commission apparently did not appreciate the historical importance of the grants in assisting establishing and expanding



### Thomas Clement Douglas

*The Father of Canadian Medicare*

While doing post-graduate work in sociology at the University of Chicago during the Depression and observing the suffering

of those who had lost their jobs, Tommy Douglas became determined to do what he could to help “the poor, the weak, and the dispossessed.” Born in Scotland in 1904 and raised in Winnipeg, Mr. Douglas became the leader of the Saskatchewan Co-operative Commonwealth Federation (CCF) in 1942 and when in power, Saskatchewan earned the reputation of the social laboratory of North America. His early achievements included free cancer treatment, free hospitalization for the mentally ill, a universal public hospitalization plan, and the *Saskatchewan Bill of Rights*. Under his leadership, the Saskatchewan CCF laid the foundation for North America’s first universal, public medical insurance plan enacted in 1962.

—CPHA Health Digest, Vol. 8, No. 3,  
June 1984

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provincial public health services. “It is the opinion of [CPHA] that it would be unfortunate if it were concluded from the recommendations of the Royal Commission that these needs have been substantially met.”<sup>5</sup>

Among the major needs not yet met was injury prevention. Public health nurses and sanitary inspectors were urged to use their enthusiasm, ingenuity and patience in highlighting specific preventable injury hazards during their home visits, bringing them to the attention of homeowners and keeping track of their correction. Mortality due to drowning, motor vehicle crashes and house fires within British Columbia First Nations communities was reported at five times higher than among non-Indigenous people. In 1964, more than 4,600 Canadians were killed in automobile crashes and public attention to and interest in vehicle safety intensified after American consumer advocate Ralph Nader published *Unsafe at Any Speed* in 1965, documenting the resistance of car manufacturers to address occupant safety issues.<sup>6</sup>

**Developing Public Health Tools**

Better research methods and tools were also among the public health needs that were still being addressed in the 1960s. CPHA appointed a research committee in 1962 to improve the training of researchers and health workers in research methods. There was a preliminary recognition of the need for information about the health status and services for Indigenous people. The collection of this information was hampered by a 1962 decision by the federal Medical Services Branch to include Aboriginal health services with those for public servants, civil aviation personnel, immigrants, mariners and people needing to be quarantined. Injury and disease rates were best documented for status Indians but little was known about the health status of those living off-reserve or other Indigenous peoples.<sup>7</sup>

**Hester Kernen**

*Inspired Development of Community Health*

Hester Kernen graduated from the Regina General Hospital of Nursing and obtained a certificate in Public Health Nursing from McGill University and bachelor and master’s degrees in nursing education from Columbia University in New York. With this preparation, Ms. Kernen accepted a position as Professor of Public Health Nursing at the University of Saskatchewan, a role she held for the next 27 years before her promotion in 1973 as Dean of the College of Nursing. For the next seven years, Ms. Kernen demonstrated her abilities to lead, organize and administer while filling special assignments at the national and provincial level in both the education and service aspects of nursing. Ms. Kernen was the first woman elected as president in any of the CPHA branches (1956–58).

—CPHA *Health Digest*, Vol. 5, No. 2, April 1981

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A provincial study comparing the nutritional intake of Aboriginal and non-Aboriginal children in British Columbia was initiated in response to the lack of information on the subject. Indeed, a recognition of the paucity of information on a variety of Aboriginal public health issues and the lack of bridges between Aboriginal and non-Aboriginal services generated initiatives to build public health capacity within Aboriginal communities.<sup>8</sup>

In 1969, Minister of Indian Affairs Jean Chrétien introduced the White Paper on Indian Policy, which proposed to integrate Indigenous people into the same government structures that served other Canadians, repeal the *Indian Act*, and transfer control of Indigenous lands to Aboriginal communities. The philosophy behind the paper was that separate legal status had kept Indigenous peoples apart from and behind the benefits enjoyed by other Canadians but the proposals were widely opposed by Aboriginal leaders as assimilationist. The government shelved the document as most Aboriginal Canadians appeared to reject it in favour of continuing to fight for better service delivery from the federal government, including health services, while assuming a growing role as service providers in their own communities.



### Persistent Challenges: Polio, Tuberculosis and VD

Uneven immunization rates against polio, especially among adults, continued to frustrate public health authorities. A 1961 survey in Victoria, British Columbia found that only 31% of all adults had been vaccinated and when asked, most said they believed “that polio is a child’s disease and that vaccine is available only to those under 40.” In addition to being misinformed about the disease, it appeared that the public had lost its fear of polio.<sup>9</sup>



### Jean C. Leask

*VON Director-in-Chief  
Served over 30 Years  
in the Field of Nursing*

Jean C. Leask was born in Moose Jaw, Saskatchewan in 1912 and received her Bachelor of Arts at the

University of Toronto before entering the School of Nursing. Ms. Leask joined the Victorian Order of Nurses as a Staff Nurse in the Toronto Branch and later accepted a post as Nurse in Charge at the Regina Branch. With a fellowship from the Rockefeller Foundation, she travelled in the United States and Canada, observing official agency programs in 1941. She continued her education at the University of Chicago, majoring in Public Health Nursing Administration, and rejoined the Victorian Order of Nurses as Director in Chief for Canada in 1960. Ms. Leask was active on many national and international committees related to nursing.

—*Canadian Journal of Public Health*, 1969

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### A New Polio Vaccine

A live, weakened strain of the polio virus was used to develop an orally administered vaccine in the expectation that it would multiply in the digestive tract in the same way that the wild (naturally occurring) virus did, displacing the stronger wild strain as it spread. Using strains developed by Dr. Albert Sabin, Connaught Medical Research Laboratories developed an oral polio virus (OPV), paid for by joint federal-provincial funding in 1962. Four million doses were distributed in eight provinces, but when four cases of paralytic polio were reported among individuals who had received OPV, the federal government curtailed the program for a few months. A technical committee concluded there was a probable link between these cases and the vaccine. The risk was small but higher among adults who never received a polio immunization previously. By 1965, provincial vaccine programs had reduced the incidence of paralytic polio in Canada to zero.<sup>a</sup>



Sanofi Pasteur Limited, Connaught Campus, Archives

Tuberculosis, however, would prove to be far more persistent than polio in Canada. In 1965, there was a 5.6% increase in newly active cases and an 11.4% increase in the number of new cases reported in children under 10. The high rate of TB infection among Indigenous people had left “the Indian population as a whole with reservoirs of quiescent or inactive disease ready to blossom with the first sign of lowered resistance.” Tuberculosis sanatorium treatment had finally been expanded to include Indigenous people, but this often resulted in family tragedy, especially in the North. The Eastern Arctic Patrol, developed by Indian and Northern Health Services director Dr. Percy Moore, used the icebreaker *HMS Nascopie* and later the *C.D. Howe* to take Inuit for TB treatment in southern sanatoriums and many never made it back to their families. The average length of sanatorium treatment for the Inuit was two-and-a-half years, and when patients died, they were often buried without notifying their families. By the end of the decade, the incidence of drug-resistant strains increased considerably, and public health strategies began focusing on improvements in supervision of the treatment of TB cases.<sup>10</sup>

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A surprising increase in reported syphilis and gonorrhoea preceded the widespread use of the birth control pill in Canada. A lack of familiarity with diagnosis, treatment and following up with contacts among younger physicians was a possible factor. An increasing incidence of venereal diseases among teenagers and children younger than 13 was linked to “changed moral standards and greater independence and unsupervised freedom young people have today.” The Department of Health promoted its free VD treatment services and supplied updated films for high school and community group distribution upon request and a 1965 *Canadian Journal of Public Health* news item reported that “a renewed educational effort is taking shape.”<sup>11</sup>

A British Medical Association committee investigating VD among young people in 1964 advised the public health community of the need to better understand the social factors involved. A *British Medical Journal* editorial commented that “impatience of the young with older generations was said to have a sharper edge than formerly, the beliefs and social responsibilities of the past being replaced by cynical and hard-boiled self-indulgence with equal mistrust for both religion and ‘science.’” A *Canadian Journal of Public Health* article noted that, “We know a great deal about VD as a communicable disease, but to eradicate or control it, we need to know a great deal more about ourselves and apply this knowledge. This is the challenge for VD education and youth is eager for our response.”<sup>12</sup>

### Environment and DDT

Environmental concerns came to the fore when marine biologist Rachel Carson published *Silent Spring* in 1962, documenting the harm being done through the indiscriminate and poorly understood use of chemical pesticides, especially DDT. This pesticide, which is now known to cause cancer, accumulates in the fatty tissue in increasingly concentrated



### Carol Buck

*An Epidemiologist Ahead of Her Time*

Dr. Carol Buck was considered to be ahead of her times—a talented woman who rose rapidly through the ranks during the 1950s. She

graduated in medicine in 1947, completed a PhD in 1950, received the Diploma in Public Health from the University of London in England while on a Rockefeller Scholarship, and by 1967, was Chair of Community Medicine at the University of Western Ontario. She contributed to the advancement of epidemiology and authored over 80 scientific articles, many of which appeared in the *Canadian Journal of Public Health*. She gained international recognition when elected President of the International Epidemiological Association in 1981. Her work demonstrated “a passionate commitment to advancing the health of the people by identifying and correcting the causes and determinants of ill-health, using the rigorous methods of epidemiology towards this end.”

—CPHA Health Digest, Vol. 11, No. 3, 1987





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amounts up the food chain. DDT is also suspected of causing neurological, respiratory and cardiovascular ailments in humans and it can remain in the soil for more than 30 years. *Silent Spring* is widely credited with launching the environmental movement and increasing attention to the public health risks of science and technology. Scientists began looking into ways to reduce the use of pesticides and their impact on health and the environment.<sup>13</sup>

### Thalidomide and Drug Safety

The unforeseen implications of scientific and technological advances came to the forefront with the tragedy of thalidomide in Canada. Developed in West Germany in the 1950s, this drug had been widely used there to treat a number of ailments since 1957, including to prevent morning sickness among pregnant women. It was approved for use in Canada on April 1, 1961 if prescribed by a physician and was considered a safe alternative to other sedatives, such as barbiturates, as well as in over-the-counter medicines for the treatment of colds, flu, headaches, neuralgia and asthma. Such broad use made it difficult to isolate thalidomide as the cause of severe deformities in newborn babies with unusual anomalies in the arms, legs, hands and feet. As reports of side effects grew, the German manufacturer recalled the drug in November 1961, with British and Swedish producers shortly following suit. Studies published in early 1962 finally convinced the Canadian government to order thalidomide off the market on March 2, 1962. The Minister

### Cultural Changes

Another profound change since the 1950s has been a steady influx of immigrants to Canada, usually of over 100,000 a year. Fewer have come from European countries and more from South and Southeast Asia and China, the Philippines, South and Central America, North Africa, and the Caribbean. Many of these immigrants have been here long enough to have raised children who have reached adult years. Recently available census data suggests that these young adults mainly form marital unions within their own ethnic subculture, but enough marry across cultures to suggest that while the Canadian cultural mosaic remains substantially intact, over time some features of a melting pot socio-demographic pattern may emerge. This influx of immigrants has made Canada one of the most multicultural nations on earth. It also makes Canada a challenging nation in which to provide effective and efficient community-based public health services to meet all needs, perhaps most importantly in such aspects as female reproductive health and increasingly in the future, the care of dependent elderly people. In former times and in their countries of origin, not many survived to reach dependent old age, whereas in affluent modern Canada, many do; but the exigencies of modern occupational mobility may make it difficult for younger family members to care for their dependent elderly, and they do not have an extended family network to fall back on. The task of providing effective and efficient public health services for the complex multicultural population of the Canada of the 2010s and beyond is at least as difficult and challenging as the task of providing effective and efficient educational services.

—John Last

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of Health and Welfare asked the Royal College of Physicians and Surgeons to set up a special committee to conduct an objective review of “the procedures relating to the issuing of new drugs and to make recommendations as it considered appropriate in the public interest.” An estimated 115 children were born in Canada in 1961 and 1962 with congenital malformations associated with the mother’s use of thalidomide in early pregnancy.<sup>14</sup>

Following the Canadian experience, the World Health Organization resolved to “improve the lines of communication among nations and to further the standardization of procedures regarding new drugs, as well as developing an international warning system.” Reporting on a special federal-provincial conference on thalidomide held in August 1962, the *Canadian Journal of Public Health* noted “a new realization of the problems and hazards relating to the development and testing of new drugs. There is assurance in the knowledge that Canada has a capable, effective organization in its Directorate of Food and Drugs to grapple with these difficult problems.”<sup>15</sup>

### Fluoride

Local fluoridation plebiscites and debates were common in the 1960s. Toronto’s director of dental health services, Dr. F.H. Compton, described fluoridation as “a nation-wide issue which periodically agitates Canadians from coast to coast as no other single event in the history of public health.” Fluoridation was widely supported by public health experts for safely and efficiently reducing dental caries among children, but “to others, it represents no more than a thinly veiled intrusion into cherished civil liberties preserved by constitution and tradition.” The public tended to be easily swayed by these loud voices over the advice of local dentists and public health leaders. Some objected to fluoridation of public water supplies on religious and moral grounds, while public health leaders pointed to opposition in the past to public health initiatives such as chlorination, pasteurization and immunization.<sup>16</sup>

### Norton Whittaker

#### *Health Inspector Developed Creative Community Solutions*

In 1961, Norton Whittaker, a health inspector in Pembroke, Ontario developed a recording of female mosquitoes to lure the male mosquito to enter a fog of poisonous spray. By eliminating the male mosquito, the female would not be able to lay fertilized eggs to enlarge the population. Whittaker also created the “Golden Garbage Can Award” to encourage citizens to clean their garbage cans in order to reduce the health hazards related to large numbers of houseflies. The Award was presented weekly to the best maintained can and a number of other cities in North America, Britain and Europe subsequently copied this successful program.

—Klaus Seeger

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### Social and Biological Changes

The second half of the 20<sup>th</sup> century was a period of profound social change in most advanced industrial nations, including Canada. An important change in family structure, function, formation, and dissolution occurred with increased flexibility and variability of marital customs. Among couples born in Canada, average family size has fallen below replacement level, so the population would have declined were it not for immigration. Increasing proportions of couples have bonded, lived together, shared incomes and even raised children in stable albeit common law unions that can be dissolved without formality. Other couples have engaged in what amounts to serial monogamy, sometimes with but often without the legal sanction of formal marriage ties. There has been a large increase in numbers and proportion of single parent led families (mostly mothers, many of whom live in poverty), and in the numbers and proportion of families in which both partners are employed, in contrast to the old tradition in which men were bread-winners and women were primarily occupied in childbearing, child rearing and homemaking. As the 20<sup>th</sup> century progressed, Canadian society adopted more liberal attitudes towards homosexuality, including acceptance of same-sex unions. The proportion of the population who believe in God has declined but among believers, there has been an increase in fundamentalist beliefs, often associated with resistance to greater female reproductive choice. Television became increasingly the dominant form of entertainment, contributing to increased prevalence of juvenile obesity.

Another health-related phenomenon of late 20<sup>th</sup> and early 21<sup>st</sup> century Canada is an increase in children's height, weight and earlier sexual maturity. These trends may be associated with improved nutrition or possibly over-nutrition, because there is also a worrying increased prevalence of obesity and type II diabetes. Another possible causal factor for earlier sexual maturity is the presence of low level environmental endocrine disruptors. The long-term consequences of these trends for the health of the Canadian population are unknown but are unlikely to be desirable.

—John Last

### William Harding Le Riche

*Professor and Researcher in Epidemiology, Nutrition and Maternal and Child Health*

Dr. Le Riche came to Canada in 1952 from Johannesburg, South Africa, stopping at Harvard University along the way for his Masters of Public Health. He started teaching epidemiology at the University of Toronto in 1957 and it is said that his former students are well represented in the public health field across Canada today. Nutrition, maternal and child health, and developing local public health and primary care services were his enduring research interests. His work covered a range of epidemiologic issues, including hospital infections. His pioneering work analyzing the Physician Services Incorporated medical insurance records are landmarks in health-related research in Canada. He has published more than 130 articles and a number of books, including *The Chemical Feast*, written for a general audience in 1982. Dr. William Harding Le Riche served as an expert resource person on numerous national and international projects for both the Ontario and the Canadian Public Health Associations and he received CPHA's highest honour, the R.D. Defries Award, in 1981.

—CPHA Health Digest, Vol. 5, No. 2, April 1981

## Tobacco

As the number of cigarettes sold in Canada exceeded 34 billion, preliminary results of a national survey of Canadian war veterans were presented at the Canadian Public Health Association's annual meeting in 1960. The study revealed a consistent relationship between cigarette smoking and mortality due to lung cancer and heart disease and CPHA was among the first to take on smoking as a priority health issue. The members passed a resolution calling on "all interested agencies to carry on vigorous educational programs designed to acquaint the public with the hazards of smoking... aimed particularly at encouraging young people not to acquire the habit."<sup>17</sup>

CPHA and the Canadian Medical Association each launched anti-smoking campaigns to educate the public and health professionals about the dangers of smoking. In 1962, a physician wrote that, "one can sense an inevitable change in professional and lay reaction at long last in the cigarette controversy, with support of the anti-cigarette claims rapidly rising to a crest this past spring."<sup>18</sup> At the first Canadian Conference on Smoking and Health in 1963, the Minister of National Health and Welfare committed \$600,000 over five years for anti-smoking education and research. In January 1964, the U.S. Surgeon General concluded that smoking caused lung cancer and in 1966, tobacco manufacturers agreed to an advertising code in Canada, while in the U.S., warning labels about the health risks of smoking were also required on cigarette packages.<sup>19</sup>

Targeting tobacco advertisers was a new public health tactic and in the 1960s, new levers were being pulled to promote health and prevent disease. In 1967 and 1968, a number of private members' bills were introduced in the House of Commons regarding cigarette advertising, labelling, and tar and nicotine content. The Standing Committee on Health, Welfare and Social Affairs held hearings but the Canadian Public Health Association was not among the organizations presenting. A 1969 *Canadian Journal of Public Health* Editorial noted that after the 1963 Smoking and Health Conference in Ottawa, CPHA had effectively left the issue to other groups and agencies.<sup>20</sup>

### E.S.O. Smith

#### *Years of Service to Public Health in Alberta*

Dr. Edward Stuart Orford Smith earned 11 academic degrees and fellowships at universities in Canada and abroad. His public health service began in Alberta in 1953 as Medical Officer of Health in the Sturgeon Health Unit and he went on to be the Director of Epidemiology for Alberta Social Services and Community Health. Dr. Smith wrote over 30 publications on areas of concern including rehabilitation, poliomyelitis, rabies, cancer, accidents, hypertension, smoking, alcohol, traffic accidents, venereal disease, heart disease, family planning, epidemiology, reporting and contact tracing methods, and occupational health. He was chairman of CPHA's Task Force on Fluoride.

—*CPHA Health Digest*, Vol. 2, No. 3,  
June 1978

## Birth Control and the Role of the State

Since 1892, birth control had been classified as obscene and made illegal in Canada. Physicians were not permitted to discuss contraception with an individual patient outside of fairly strict parameters. Concern about the global population explosion in the 1960s and the availability of new oral contraceptives increased public pressure for legal birth control and a number of associations urged the federal government to change the laws. In the U.S., the American Public Health Association established a policy in support of family planning services but birth control remained a controversial subject for CPHA. A motion regarding birth control at CPHA's 1964 meeting was "conveniently sent off to a committee for further study."<sup>21</sup>

Meanwhile, family planning clinics were established in several communities through Planned Parenthood, local health units, or in cooperation with hospitals. Because they were established to "further the public good," they were able to skirt the *Criminal Code* and by the late 1960s, there seemed to be little interest in enforcing the letter of the law restricting birth control information.<sup>22</sup>

A federal omnibus bill, introduced in December 1967 by Justice Minister Pierre Trudeau, proposed major changes to the *Criminal Code*, including lifting all restrictions on contraception, allowing therapeutic abortions in hospitals if a committee of doctors decides that continuing the pregnancy may endanger the mother's life or health, and decriminalizing homosexuality. In 1967, Trudeau's statements that, "There's no place for the state in the bedrooms of the nation," and "What's done in private between two consenting adults doesn't concern the *Criminal Code*," crystallized this radical change in governmental approaches to family planning and sexuality and the bill was enacted in 1969.



### Ann Harling

*Devoted Her Career to the Health of Children and Adults in New Brunswick*

Ms. Ann Harling devoted her professional career to the health care of New Brunswickers. She developed a large number of public health programs and services, especially in the field of maternal and child health, and her general and specialized pediatric clinics became models for the delivery of highly specialized medical care to the children of New Brunswick. Ms. Harling gave her time, energy and expertise to a number of regional, provincial, national and international initiatives since her involvement in CPHA in 1972. She accompanied the Hon. Monique Bégin on the first Canadian Health Study Tour of China when they visited medical and nursing schools, hospitals, rehabilitation facilities, and day care centres over a period of five weeks.

—CPHA Health Digest, Vol. 19, No. 2, 1995

## Final Report on Health Services

The final *Report of the Royal Commission on Health Services* in 1966 recommended a national health insurance plan but the lack of attention to disease and injury prevention disappointed the public health field. Dr. **John E.F. Hastings** of the School of Hygiene at the University of Toronto described the report’s oversights, such as the social aspects of health, problems related to aging, non-prescribed drugs, environmental aspects of health, and income maintenance during periods of ill health. The report paid little attention to the importance of preventive medicine and health promotion and community health programs. Hastings noted the report overlooked the need to re-orient health promotion and prevention as central features of medical education while maintaining an outdated concept of public health, restricted to the areas of communicable disease control, environmental sanitation, and facilitating medical care in outlying areas.<sup>23</sup>

There was little recognition of long-standing universal programs in public health nursing, child and maternal health, school health and of the work by health departments in educating, identifying, and following up on cases of tuberculosis, venereal disease and mental illness. Essentially, Hastings wrote, the Commission did not consider public health departments “to have a particularly active role to play in the future development of our health services.” Interest in other medical issues, a lack of time, or “the hostility of some professional and other bodies to public health involvement in anything more than traditional communicable disease and environmental control activities” were likely factors for the virtual eclipse of public health in the report. Hastings added that the field had to shoulder much of the responsibility for its poor showing in the report, because many apparently didn’t want to upset vested interests. “We have forgotten our origins and our predecessors,” who were “crusading, dedicated, militant people who saw community health problems that had to be solved. Come hell or high water they were determined to solve them or perish in the attempt.”<sup>24</sup>



### Jean E.C. Lewis

*Instrumental in Public Health Nursing in Newfoundland and Canada*

Jean E.C. Lewis studied pediatric and general nursing in Liverpool, England and worked at a military hospital there before returning to St. John’s, Newfoundland at the end of WWII. She held the position of Provincial Director of Public Health Nursing for 29 years and was responsible for the province’s entire nursing service—the point of entry into the health care system at that time, with many roles in primary, secondary and tertiary prevention. Ms. Lewis was instrumental in the establishment of CPHA’s Newfoundland and Labrador Branch in the early 1960s and chaired the Association’s Public Health Nursing Section.

—CPHA *Health Digest*, Vol. 17, No. 2, Summer 1993

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### Public Health Challenges

As the decade came to an end, Hastings wrote “Some Plain Thoughts on the State of Public Health.” He noted many significant changes in Ontario, where regional health services were organized in most of the province. Similar reorganizations were taking place in Quebec and the other provinces, characterized by increasing centralization, bureaucratization and government control over health care. Hastings felt that such changes pointed to the urgent need “to view public health as encompassing all matters relating to the health of our population and of the delivery of health services to them.”<sup>25</sup>

The *Canadian Journal of Public Health* reported that at the 1967 annual meeting, CPHA’s “membership unanimously endorsed the proposition that the CPHA as presently constituted is not likely to continue as an effective and relevant organization during the next century. The Association needs a remedy in large doses and Council was single minded in its recommendation to the annual business meeting to appoint a commission to study the whole purpose and structure of the Association with its future in mind.” Questions about CPHA’s future had been raised repeatedly over the previous decade and the Commission’s preliminary report later that year identified once again the need for a full-time professional Executive Director. Significant new multi-year grants from the W.K. Kellogg Foundation and the Canadian Life Insurance Association expedited the appointment of a new Executive Director, C.D. Noble in 1969.<sup>26</sup>

Rebuilding the Canadian Public Health Association would take several years, as less than one-third of those employed full-time in public health activities were members of the CPHA. In addition, “pitifully small” membership dues were inadequate to support the Association and Journal and CPHA did not want to rely on federal funding in order to be an impartial advisor on public health in Canada.



#### Robert Davies Defries

*Led Connaught and Canada’s First School of Hygiene, and Was First Editor of the Canadian Journal of Public Health*

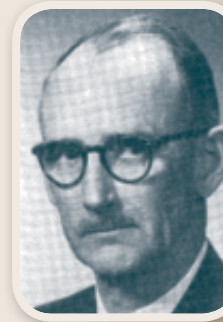
Dr. Robert Davies Defries became the Editor of the

*Canadian Journal of Public Health* when it was purchased by CPHA in 1928. In 1953 he became President of the Association and his stimulation and guidance over many years were said to have contributed immeasurably to the Association’s growth and development. Dr. Defries was appointed Director of Connaught Laboratories and Director of the School of Hygiene in 1940 and accepted the responsibility of the Department of Public Health Administration in 1941. He made numerous contributions to scientific literature in the fields of bacteriology, immunology, epidemiology, and public health administration. In 1965, CPHA instituted the R.D. Defries Award as its highest honour to be awarded annually in the form of a medal and citation for outstanding contributions to the broad field of public health.

—*Canadian Journal of Public Health*, Vol. 55, June 1965

## This is Public Health: A Canadian History

The Association's challenges reflected a broader need for the public health field to act boldly, redefine itself and try to remain relevant into the 1970s. A new political reality of health care was becoming clear. A federal Task Force on the Cost of Health Services had been established by the Department of National Health and Welfare in 1968 by a minority Liberal government facing growing inflationary and budgetary pressures. The task force's work was driven by the need to identify how the federal and provincial governments could provide health services at less rapidly-rising costs, specifically the costs of hospitals and medical care and physician fees.<sup>27</sup>



### George Donald West Cameron

*Long-time Deputy Minister of National Health and First R.D. Defries Medal Recipient*

Dr. George Donald West Cameron fought in France during World

War I and after the war went on to study preventive medicine and public health at the School of Hygiene at the University of Toronto. In 1931, he became responsible for the production and testing of serums and diphtheria toxoid at the farm section of the Connaught Medical Research Laboratories and eight years later was appointed as Chief of the Laboratory of Hygiene in the Department of Pensions and National Health. By 1946, Dr. Cameron was Deputy Minister of National Health where he served with distinction until his retirement in 1965. He represented Canada as Chief Delegate of the Canadian Delegation to the World Health Assembly on numerous occasions and received the first R.D. Defries Medal from CPHA in 1966 for his lifetime of service.

—*Canadian Public Health Journal*,  
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### CPHA's Highest Honour, The Defries Award

In 1964, Dr. Robert D. Defries retired as editor of the *Canadian Public Health Journal*—a position he had held since 1928. In honour of his long service, CPHA created the annual R.D. Defries Award, bestowed annually in the form of a medal produced by the Royal Canadian Mint, in recognition of outstanding contributions to the field of public health. The first Defries Award was given in 1965 to G.D.W.

Cameron, who served as Deputy Minister of National Health from 1946 to 1965.

