National Health Grants and Public Health Services

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THE content of public health programs has steadily expanded in response to changing need and expanding knowledge.

So long as our country was dominantly rural, urban centres small, and the movement of population comparatively limited, public health received only casual attention. But with the greater movement of population, facilitated by improvements in transportation, and the trend towards urbanization that accompanied industrial and commercial development, public health services became of crucial importance. One response to this need may be noted in the substantial progress that has been made in the provision of environmental services directed towards clean water, adequate sewerage, garbage disposal, and so on.

At the same time public health programs have had to keep pace with advances in medical science. The discovery of the microbic origin of disease in 1870 by Pasteur, Koch's description of the tubercle bacillus in 1882, and in more recent years the development of antibiotics such as penicillin and streptomycin which opened the way to significant advances in the treatment of a number of infectious diseases are illustrations. With new scientific developments, control programs for tuberculosis, venereal disease and other communicable diseases were developed to protect the public.

It will be noted, also, that the negative role of combatting disease solely by enforcing regulations, such as those concerning isolation and quarantine, has been supplemented by positive programs for preventive health services. This is seen in the development of child and maternal health programs, school medical and nutrition services and mental health programs, to mention only a few fields. Inherent in this positive approach has been the need for greater reliance upon health education.

Emphasis has shifted from the improvement of many of the impersonal environmental health services to a pivot of interest that is personal. It is personal in the sense that public health services are concerned with the individual —the mother, her infant, the school child, the industrial worker, and so on.

Health Expenditure

Increased demands upon public health services have been reflected in the growth of provincial health expenditures, for it is with provincial governments that the main responsibility for public health services rests. Provincial expenditure on health and hospital care has risen from $10.6 million in 1926 to $50.5 million in 1946, or about fivefold in two decades. This upward trend continued throughout 1947 and 1948 so that by 1948 provincial expenditures had reached an estimated $72.6 million.

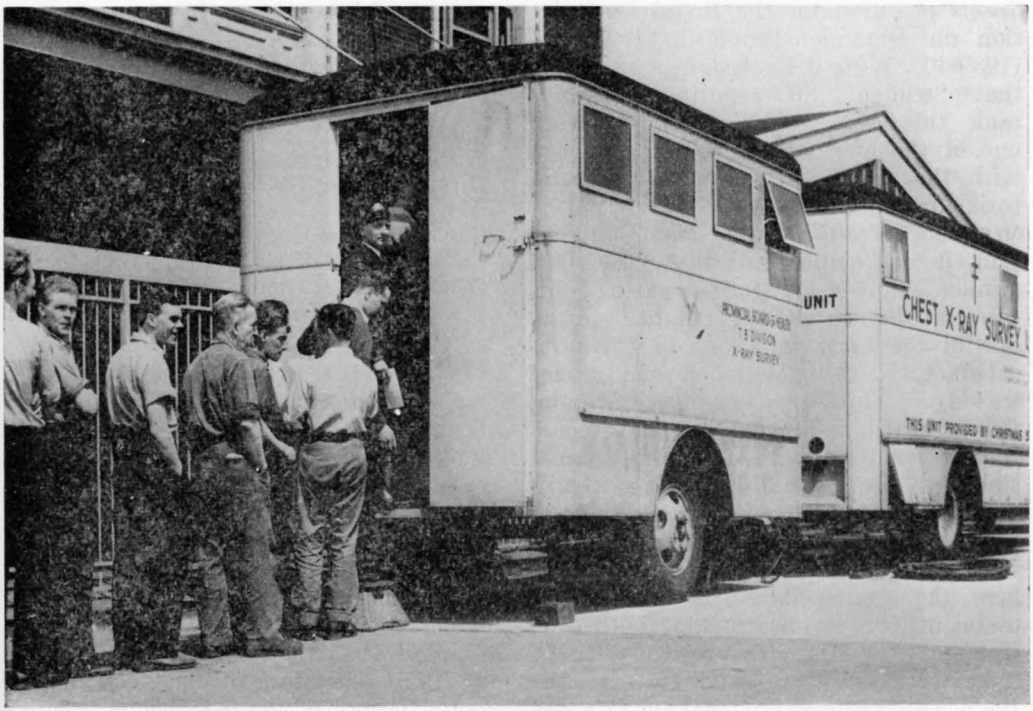
A further extension of provincial health services was foreshadowed by the announcement on May 14, 1948, of the new national health grant program. These federal grants represent the most significant single advance since Confederation in strengthening provincial services. Under this program federal grants, totalling $30,120,000 in the current fiscal year, with proposed increases rising to about $35,000,000 by the fiscal year 1952-53, will financially assist the provinces in the attack against a wide range of diseases and disabilities, in the provision of more adequate hospital accommodation and rural health facilities, and in the conduct of health surveys planning the extension of public health services and the introduction of health insurance.

The financial provisions of the grants have been generously conceived. The relative magnitude of the sums appropriated is easily appraised when comparison is made with previous health expenditures in Canada. Under the new health program, the additional annual appropriation for the Health Branch of the Department of National Health and Welfare will be almost as great as its total expenditure during the previous twenty eight years of its existence and almost as large as the total amount spent on health and hospital care by all governments in Canada a decade and a half ago.

Recognizing the significance of this new program, the American Public Health Association, at its last annual meeting, extended "hearty congratulations to the Government and the people of Canada for a step which makes the year memorable in the annals of public health on this continent."

Development of Grant Program

The use of federal grants-in-aid to strengthen provincial health services is by no means an untried device in Canada. The first federal attempt to aid the provinces financially in an attack against a national health problem was the venereal disease grant of 1919. The movement for such a grant began during the war period, paralleling a similar development in the United States, and the acceptance of the Canadian grant came shortly after the passage of the Chamberlain-Kahn Act of 1918 established a federal grant-in-aid program for venereal disease for that country. In Canada the annual grant has been continued, except for a few years in the mid-thirties, to the present day.



Mass chest X-ray surveys are an essential part of Canada's program for the prevention and control of tuberculosis. In British Columbia, for example, the provincial health agency provides free service through this mobile unit, which handles 102 examination per hour.

In a study of the administration of Canadian conditional grants, Luella Gettys states that "the administrative relationships between the Dominion and the provinces were, on the whole, probably more continuously harmonious during the operation of this grant (venerael disease) than in connection with any other subvention."[1] And in the report on *Dominion-Provincial Subsidies and Grants* prepared for the Royal Commission on Dominion-Provincial Relations (1939-40), Wilfred Eggleston pointed out that "students of conditional grants rank this (venereal disease grant) as one of the more successful experiments with the device."[2] Again, in the editorial foreword to A. E. Grauer's report on *Public Health* for the same Commission, it was emphasized that "the Dominion grant-in-aid for an attack on venereal disease (1920-31) is held up as one of the most (and one of the few) satisfactory examples of a conditional subsidy. This sole experience in the public health field suggests that where specific conditions, fixed by professional standards, can be laid down for a clearly defined object, where the sum involved can be determined in advance, and results can be measured with some exactness, the conditional subsidy may be a useful instrument in attacking both general and special health programs."[3]

In the late thirties and early forties the need for federal financial aid to assist and stimulate provincial health programs became increasingly clear. Expressions of this need came not only from the Rowell-Sirois studies but also from the Dominion Council of Health and representatives of medical and other organizations.

An Advisory Committee on Health Insurance was set up by the federal government in February, 1942, and in its report to the Social Security Committee of the House of Commons, in March, 1943, set out a draft Public Health and Health Insurance Bill. Much of the attention given to health insurance at the time tended to obscure the fact that in this Draft Bill certain proposals were made for federal health grants to the provinces for the extension of provincial public health services. In an estimate[4] of the cost of the Draft Health Insurance Bill, the following amounts were suggested for the grants:

Public Health	$2,872,428
Tuberculosis (Treatment)	1,035,155
Mental Diseases (Treatment)	2,171,485
Venereal Disease	195,325
Professional Training	100,000
Investigational (Public Health)	50,000
Youth (Physical Fitness)	252,774
TOTAL	$6,677,167

In July, 1943, the first of these proposals was put into force with the passing of the *National Physical Fitness Act* under which the sum of $225,000 was made available annually to the provinces for the promotion of physical fitness.

Between March, 1943, and August, 1945, the questions of public health grants and health insurance received further study. In the Dominion Proposals of 1945 to the Dominion-Provincial Conference on Reconstruction the grants proposed in 1943 were greatly extended by the inclusion of new grants for crippled children, public health research and the civilian blind, and by considerably increasing the amounts of the grants previously proposed. The amounts suggested in the proposals were as follows:

General Public Health	$ 4,022,600
Tuberculosis	3,000,000
Mental Health	4,000,000
Venereal Disease	500,000
Crippled Children	500,000

1. Luella Gettys, *The Administration of Canadian Conditional Grants* (Chicago, 1938), p. 110.
2. Wilfred Eggleston and C. T. Kraft, *Dominion-Provincial Subsidies and Grants*, a study prepared for the Royal Commission on Dominion-Provincial Relations (Ottawa, 1939), p. 48.
3. A. E. Grauer, *Public Health*, a study prepared for the Royal Commission on Dominion-Provincial Relations (Ottawa, 1939), editorial foreword.
4. *Report* of the Advisory Committee on Health Insurance to the House of Commons Special Committee on Social Security, March 16, 1943 (Ottawa, 1943), p. 493.

Professional Training	250,000
Public Health Research	100,000
Civilian Blind	1,243,900
Planning and Organization	620,000
TOTAL	$14,236,500

After the ensuing discussions with the provinces, the proposed grant schedule was again substantially liberalized by the introduction of provision for periodic increases in certain grants, amounting in all to an ultimate increase of about $6 million annually in the federal commitment. Provision was made for the general public health grant of 35 cents per capita annually to be increased at the end of two years by 5 cents per capita per year until the grant totalled 50 cents per capita. At the end of two years a supplementary tuberculosis grant of $1 million annually was made available in addition to the $3 million annually already proposed. The $4 million annual mental health grant was increased to $5 million at the end of two years, $6 million at the end of four years, and $7 million at the end of six years.

Public health programs are increasingly *personal* in their emphasis. From immunization against childhood diseases to medical services for aged pensioners—the health of the individual citizen is the pivot of interest to-day.

In 1947 special provision was made

to provide the benefits for the civilian blind, which had been proposed under the grant, by legislation reducing the age at which the blind became eligible for pension and by liberalizing pension conditions. This was followed by a scheme under which the federal government participated with the provinces on a 75:25 basis in paying for operation and medical expenses necessary to restore the sight to blind pensioners. Thus the benefits proposed under the grant have been largely met.

With the implementation of the National Health Grant Program in 1948, the health grants proposed in 1945-46 were again extended and liberalized. A cancer grant of $3.5 million and a hospital construction grant of $13 million were added, the amount of the professional training grant was doubled from $250,000 to $500,000 and provision was made for the public health research grant to be increased gradually from $100,000 to $500,000 at the rate of $100,000 a year and for the general public health grant to increase annually on the basis of population increases.

The growth in the conception of the over-all grant program since the original Grauer suggestions is thus very considerable. To the original grants proposed for tuberculosis, mental hygiene, venereal disease control, cancer and public health, there have been added grants for physical fitness, crippled children, professional training, public health research, hospital construction and health survey. The amount proposed by the Advisory Committee on Health Insurance in 1943 for health grants, excluding health insurance, was about $6.7 million. To-day the amount made available under the health grant program exceeds $30 million.

The 1948 Health Grants

The new federal health grants might be grouped as follows:

1. A grant for provincial health surveys;
2. A grant to encourage hospital construction;
3. A grant to provide professional training for health personnel;
4. A grant to stimulate public health research; and
5. A series of grants directed towards the strengthening of services in specific health areas, including general public health, mental health, tuberculosis, cancer, venereal disease and crippled children services.

Health Surveys. Under the National Health Grant Program, a non-recurring grant of $625,000 has been allocated to the provinces on a per capita basis to assist them in appraising existing health services with a view to developing a comprehensive program for the extension and improvement of public health facilities and services, and planning for hospital and medical care insurance.

Hospital Construction. Various estimates have placed the shortage of hospital accommodation in Canada at between 60 and 65 thousand beds. The trend towards obstetrical care in hospital, normal population growth, the great advance in coverage of hospital insurance plans, the greater appreciation of medical services including hospital treatment, and the financial ability of a larger sector of the population to pay for hospital services have been some of the more important factors contributing to a rise in the demand for hospital care. At the same time the provision of new facilities was retarded during the depression, the war years and the subsequent period of high construction costs.

To meet this pent-up demand for hospital accommodation, the federal government incentive grant for hospital construction makes available $13 million a year for a five-year period, the first part of a ten-year program. The federal grant is distributed to the provinces on a per capita basis; the provincial allotment is made available at the rate

of $1,000 for each active treatment bed, $1,500 for each mental, tuberculosis, chronic and convalescent treatment bed provided the provincial government contributes at least an equal amount.

Professional Training. The shortage of health facilities in Canada is coupled with a shortage of trained health workers, and in many sectors the over-all shortage of personnel has been accentuated by maldistribution. In order to alleviate this situation, particularly with respect to key persons in some of the specialties, and thereby prepare the way for the new services to be provided under the grant program, a professional training grant of $500,000 a year has been made available. In addition to this grant, the training of personnel for work in tuberculosis, cancer, mental health and other fields covered by specific health grants may be financed through these grants.

Public Health Research. The importance of research to medical progress cannot be overestimated. The knowledge and skills research has given us in the past have played fundamental roles in the control of many diseases and the promotion of better health.

In order to encourage and stimulate public health research, as contrasted with medical research in the narrower sense, provision has been made for grants amounting to $100,000 for the current fiscal year. It is proposed to increase this grant at the rate of $100,000 annually until a maximum of $500,000 is reached. Some of the projects for which this year's appropriation is being used include investigations into the polio virus, preventive dentistry for children, the effect of different types of soil on the nutritive value of milk, and the use of radio-active isotypes to study well contamination from septic tanks.

General Public Health. The general public health grant will develop provincial public health services in the areas of greatest need. The emphasis in response to this need will undoubtedly vary from province to province. Translated into health services, the $4.4 million grant will mean: a strengthening of public health education programs; the establishment of new county and district health units and the expansion of existing units; the addition of new mobile clinics, particularly for sparsely settled areas; a further development of public health laboratory services; more vigorous efforts in the fight against crippling diseases such as polio, arthritis, and rheumatism; encouragement of preventive action against blindness; the extension of child and maternal health services; and support for communicable disease control programs.

Mental Health. No field of health in Canada merits more attention at the present time than mental health. Canada has some 50,000 persons in mental institutions and each year about 10,000 more are committed for first treatment. In addition many people suffering from mental illness who require hospitalization are not receiving this care. Psychoneurosis also presents itself as an important factor in many other types of illness. A considerable proportion of persons receiving treatment at out-patient clinics and public dispensaries are suffering from psychoneurosis as one of the underlying causes of their illness.

The seriousness and magnitude of the problem were recognized by the provision of a $4 million federal grant in the current fiscal year, with a proposed maximum of $7 million annually to be reached over a period of years. This federal grant will place substantial resources at the disposal of the provincial governments to train qualified personnel, to develop preventive services and extend the area of free treatment. The professional training grant also may be used to supplement the mental health grant in training psychiatric personnel. At the same time a portion of the hospital construction grant will subsidize the building of provincial mental hospitals.

Tuberculosis. Considerable progress has already been made by the provincial governments and the Canadian Tuberculosis Association in the control of tuberculosis. In 1947, free treatment was provided for 96 per cent of all tuberculosis patients compared with 73.4 per cent in 1938. In the same period the death rate declined from 54.7 to 47.2 per hundred thousand population. But much remains to be done. In 1947, the total of deaths attributed to tuberculosis was 5,453 or 4.6 per cent of all deaths. It is disconcerting, too, that in 1946 one-third of those dying and nearly 40 per cent of admissions were persons under 25 ears of age.

The new federal tuberculosis grant will permit increased emphasis on early detection through the provision and the maintenance of diagnostic facilities and at the same time will open up opportunities for the development and expansion of rehabilitation services.

Cancer. The cancer death rate has been steadily rising from 82.3 per hundred thousand population in 1927 to 108.5 in 1937 and 123.5 in 1947. While this increase may be partially due to a more accurate diagnosis of the cause of death in recent years as a result of greater knowledge of the disease, the incidence has unquestionably risen.

Efforts of most provincial governments in the field of cancer compare rather poorly with their tuberculosis control programs. In many provinces cancer services are relatively under-developed; in a few, diagnostic services are provided, while in two provinces free diagnostic and treatment services have been established. The federal cancer grant is designed to encourage the expansion of provincial participation as well as to provide federal aid and therefore is conditional upon being matched by provincial funds. Together with these provincial supplements, it will enable coverage for free diagnosis and treatment to be progressively extended. If the provinces take full advantage of this cancer grant, $7 million annually will be available for the establishment and maintenance of clinics and facilities for diagnosis and treatment.

Venereal Disease Control. The new federal grant program provides $500,000 annually for provincial venereal disease control services, an increase of $275,000 over the previous year's appropriation. Although free treatment has been widely established, there is still need for additional active clinics and the emphasis of the new expenditure will probably be on an expansion of educational activities and an increase in personnel engaged in preventive work.

Crippled Children. Crippled children have engaged the interest of governmental and voluntary agencies for many years, but no province has developed a comprehensive program on a province-wide basis. Under the new federal health grant in this field, half a million dollars annually is now available to provide some assistance to the provinces in the the development of a program of medical, surgical, and after-care services for the physical restoration and social adjustment of crippled children. With the federal funds now available, the provinces will be in a better position to develop an integrated program—a program under which the resources of government and voluntary agencies can be united in reducing the incidence of disabling illness in childhood, as well as providing an adequate rehabilitation process for crippled children.

Future of the Grants

The grant program has been approached in a spirit of co-operation between federal and provincial governments. There is evidence already that the program is not only succeeding in its objective of raising the level of health services across Canada, but is becoming a symbol of how, through mutual discussion and planning, a co-operative federal-provincial program can be carried out to produce a result far beyond any that could arise from isolated fed-

eral or provincial action. This close collaboration by governments is being buttressed by the support accorded the program by the several professional health groups.

As in other Canadian grant-in-aid programs the success of the health grants rests largely with the provinces. The enterprise and initiative that are being shown by the provincial governments speak well for the future of the grants. The program has now been in operation for several months and projects for more than $13 million have been approved. While the expenditures for the first fiscal year will probably be somewhat lower than this figure, they will represent a significant advance for the initial months of such a comprehensive health grant program.

Research in Social Sciences in Canadian Universities

B. S. KEIRSTEAD

IT is frequently said that the function of the university is threefold: to conserve and pass on to new generations the accumulated experience and wisdom of the past, to extend knowledge by research and discovery, and to make this new knowledge available in a useful way for the solution of the problems of society. The first of these functions is discharged ordinarily in undergraduate teaching. The second and third functions are fulfilled by the research of teachers and graduate students. It is perfectly possible for teachers wholly occupied with undergraduate teaching to engage in valuable research, but it is difficult for them to do so. Usually contributions to knowledge emerge more readily when a scholar's time is not fully occupied with undergraduate teaching, and when he has to face the challenge of graduate students engaged in investigations similar to his own. Indeed good research is the product of a teacher whose own thinking has revealed the nature of the new problems to be studied, and of students mature enough to investigate these problems and to stimulate the teacher to attempt new syntheses and to raise new difficulties.

The undergraduate teaching in Canadian universities in the social sciences is generally believed by Canadians to be good. I doubt if it is as good as we think it is, but in this paper I am not concerned with that problem. I propose, instead to discuss what we are doing in the way of research and graduate study. For the most part Canadian social scientists have been dominated by the idea that they must make useful knowledge available to the community for the solution of "practical" problems. There are several reasons for this. In a young country, with all the problems of growth and development, there has been terrific pressure from government and business for this type of research. That has been one reason, and a strong one. Another reason has been that most of our universities are small, staff is limited, and it is very much more possible to do *ad hoc* jobs of research into immediate problems which require only the application of existing knowledge than to embark on projects of basic research to expand knowledge, projects which sometimes require staff and library facilities not available in small universities. A third reason is, of course, that Canadian university professors are not well paid. Scientific research in Canada is not rewarded. The scholar finds that research costs him money, because usually he has to pay out of his own pocket for books, for travel, for secretarial assistance, and even, before the days of the Canadian Social Science Research Council, for publication. A job for industry,