estimated 1.4 million persons, or one adult drinker in 10, suffer from an alcoholic-related handicap.

Data indicate that in 1978 alcohol consumption was the direct cause of 2,520 deaths and the indirect cause of 5,668 others such as in traffic accidents and falls. There is evidence that alcohol may have been a factor in 10,142 other deaths with medical diagnosis such as coronary and respiratory diseases and various types of cancers. Thus a total of more than 18,000 deaths in 1978, or 10.9% of all deaths in Canada have been linked with alcohol consumption (*Special report on alcohol statistics,* National Health and Welfare and Supply and Services Canada, 1981).

Notifiable diseases are commmunicable diseases which physicians are required by law to report so that public health officials are aware of possible epidemics and may determine the effectiveness of public health programs such as immunization. These data are limited: they represent cases, not individuals; they do not include the impact on an individual, except for the mortality figures; and reporting practices vary from physician to physician and province to province.

The five most frequently reported in 1982 were venereal diseases, salmonella, tuberculosis, hepatitis and measles (Table 3.8).

Venereal disease rates have increased in recent years to over 200 cases per 100,000 people, twice the rate of the 1950s and 1960s. But deaths due to venereal diseases have declined steadily since the introduction of antibiotics after World War II. Not included in these figures, but also of concern to public health officials, is the spread of herpes II virus.

Deaths from notifiable diseases decreased as a proportion of all deaths from 0.8% in 1959 to 0.6% in 1978. This indicates in part the effectiveness of public health programs in treating and controlling communicable diseases. The decline in both the incidence and number of deaths associated with tuberculosis in the last 50 years is one of the success stories of public health. Yet tuberculosis is still the leading cause of death among the notifiable diseases.

3.2 Canadian health system

3.2.1 Government responsibility

Governmental involvement in health care services in 1867, at Confederation, was minimal. For the most part, the individual was compelled to rely on his own resources and those of his family group, and hospitals were administered and financed by private charities and religious organizations.

The only specific references to health matters in the distribution of legislative powers under the Constitution Act, 1867 (formerly named the British North America Act, 1867) allocated to the federal Parliament jurisdiction over quarantine and the establishment and maintenance of marine hospitals and to the provincial legislatures jurisdiction over the establishment, maintenance and management of hospitals, asylums, charities and charitable institutions in and for the province, other than marine hospitals. This probably was meant to cover most health care services. Since the provinces were also assigned jurisdiction over all matters generally of a local or private nature in the province, it is probable that this power covers health care, while the provincial power over municipal institutions provided a convenient means for dealing with such matters.

In addition to the powers of the federal Parliament to legislate in certain areas, the constitution gave it the power to spend the consolidated revenue fund on any object, providing the legislation authorizing the expenditures did not amount to a regulatory scheme falling within provincial powers. The spending power of the federal Parliament enabled it to make payments to provinces and persons in fields where it had little or no regulatory authority: for example, hospital and medical care insurance programs, health resources fund, health grants programs, and fitness and amateur sport. It also enabled the federal government to undertake research and to provide information and consultative services.

Responsibility for health in Canada is thus shared between the federal and provincial governments. At the federal level Health and Welfare Canada is the principal agency for health matters. Its main objectives are to maintain and improve the quality of life of the Canadian people, including their physical, economic and social well-being. These objectives are pursued in conjunction with other federal agencies and with provincial and local governments. The provision of most health care services has been traditionally acknowledged as primarily a provincial responsibility and provincial governments are directly responsible for provision of these services.

Federal-provincial co-operation. Since the federal and provincial governments share responsibilty for health, a formal structure has been established for federal-provincial co-operation. It comprises the following: conference of ministers of health; conference of deputy ministers of health; and federal-provincial advisory committees on institutional and medical services, community care services, international health affairs, health promotion and lifestyle, health manpower and environmental and occupational health. The conferences of ministers and deputy ministers of health convene periodically to discuss matters of promotion, protection, maintenance and restoration of the health of Canadians. For instance, federal, provincial and territorial ministers met in 1982 to discuss proposals to lead to a new health act, to replace the Hospital Insurance and Diagnostic Services Act and the Medical Care Act. The advisory committees and the conferences of ministers and deputy ministers may set up ad hoc working groups to deal with particular subjects requiring more detailed study.