CANADA

THE DEPARTMENT OF NATIONAL HEALTH AND WELFARE

ANNUAL REPORT

FOR THE FISCAL YEAR ENDED MARCH 31

1956

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To His Excellency the Right Honourable Vincent Massey, C.H., Governor General and Commander-in-Chief of Canada.

MAY IT PLEASE YOUR EXCELLENCY:

The undersigned has the honour to present to Your Excellency the Annual Report of the Department of National Health and Welfare for the fiscal year ended March 31, 1956.

Respectfully submitted,

PAUL MARTIN,

Minister of National Health and Welfare.

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To the Honourable Paul Martin, Q.C., M.P., LL.M., LLD., D.C.L., Minister of National Health and Welfare, Ottawa.

SIR:

With the responsibilities of the Department of National Health and Welfare continuing to grow, the past year was marked by new or accelerated activities in a number of fields, all of which will have a significant and lasting effect upon the health and welfare of the Canadian people.

On January 26th the Prime Minister announced to the House of Commons the federal Government's proposal to the Provinces covering hospital insurance and laboratory, radiological and other diagnostic services. By the year-end two Provinces had indicated readiness to accept the federal proposal and elsewhere it was under study.

The year also saw the first widespread application of poliomyelitis vaccine which was released for provincial use following rigid safety and potency testing carried out by both the Connaught Laboratories and the department's Laboratory of Hygiene. From a trial procedure it became recognized as a useful public health measure, and the progressive extension of immunization programs gave promise of the effective control of paralytic poliomyelitis.

During the year the Department continued its role in the supervision of radioactive isotopes and gave advice on many health aspects of the use of radiation. In addition, resulting from the increasing interest in the biological effects of radiation, the Department initiated a program for studying the genetic and short-term effects of radiation and began routine analysis of radioactive strontium in food substances.

On the welfare side the year was most strikingly marked by the federal government's offer to share with the Provinces the cost of Unemployment Assistance. By the end of the year five Provinces had signed agreements. The same period saw the completion of the first full year's operation of the Disabled Persons Act.

The department's expenditures during 1955-56 rose to $840.9 million, an increase of $36.7 million over the previous year. The increase was almost entirely accounted for by higher statutory expenditures under the Family Allowances Act, the Old Age Security Act, and the Disabled Persons Act, and by an increase in payments under the National Health Program of $1.9 million.

In concluding this letter of transmittal we again draw your attention to the generally high standard of competence and integrity of the staff. The degree to which the Department has been able to retain the services of certain key people in the face of increasing outside financial inducement reflects commendable loyalty to the public service. In other circumstances many of the achievements recorded in this report would not have been possible.

Respectfully submitted,

G. D. W. CAMERON,
Deputy Minister of National Health and Welfare (Health)

G. F. DAVIDSON,
Deputy Minister of National Health and Welfare (Welfare)

OTTAWA, Canada.

INDIAN AND NORTHERN HEALTH SERVICES

Development and Functions

Five milestones in the development of Indian Health Services were reached in 1955. Exactly two hundred years ago the Imperial Government appointed Sir William Johnstone, of the Mohawk Valley, New York, as the first Superintendent General of Indian Affairs. From this event may be traced the development of all branches of government now engaged in any phase of Indian administration both in Canada and the United States. Seventy-five years ago the Canadian Department of Indian Affairs was formed, and under its aegis were appointed the first part-time physicians to the Indians of Eastern Canada. Fifty years ago a Superintendency of Medical Services was set up within the Department of Indian Affairs. This early venture did not prove too successful but the golden jubilee of the first attempt to organize a medical program underlines the long-standing interest of Government in the health, as distinct from the general welfare, of the native population.

A most important date in the development of the Directorate was November 1, 1945. On that day the control and supervision of the administration of medical services for Indians and Eskimos was transferred to the Department of National Health and Welfare as Indian Health Services. The Directorate, as now set up, is just ten years old and, from the point of view of rapidity of expansion and widening of interests, these have been most fruitful years. The progress was climaxed in 1955 by the addition of a new wing to the Service. Northern Health Services came into being, and fused with its older partner to form the combined Directorate of Indian and Northern Health Services.

INDIAN HEALTH SERVICES

To put the relationship between this Service and the Indian population of the country into its proper perspective it must first be emphasized that the Indian is not entitled by law to free medical care. It is the intention of the Government to help these people reach full social, economic and educational equality with their white neighbours and to assist them, if they choose, to become full partners in the Canadian community. However, they have not been made wards of the State, nor has the State even assumed the responsibility of providing free medical attention to all, irrespective of their legal status or ability to pay. On the other hand, the government votes a certain amount of money to be spent each year for the provision of basic health and treatment services to the Indians and Eskimos. This is done on humanitarian grounds, for the isolation of many of these people is such that even the most primitive facilities would not otherwise be available.

The Directorate functions primarily as a public health service and this basic service is provided to all Indian and Eskimo communities. By contract, the eligibility for medical care of any given individual is determined by three considerations. First, he must be an Indian within the meaning of the Indian Act. Next, he must be following the Indian way of life, which for practical purposes in most parts of the country means that he must be living on an Indian reserve or have been away from that reserve for a period of less than a year. Finally, it must be established that the individual is financially unable to arrange appropriate care for himself. If he is able, he is expected to do so.

At the latest census in 1954 the Indian population was shown to be 151,500 as compared with 136,500 in 1949. This represents an increase of 11 percent over the five year period—a rate appreciably in excess of the natural increase in the non-Indian

population. The death rate is somewhat higher than average; in 1954 the crude rate for all Canada was 8.2 per 1000 while that of the Indian was 9.8. The birthrate is much higher; again quoting the 1954 figures, which are the most recent available, the rate in Indians was 40.8 as compared with 28.4 in the non-Indian population. Projecting these rates into 1955 and making due allowance for approximately 1,000 Indians who are accepted each year for legal enfranchisement, the 1955 population is estimated at 154,000. The same influences are apparent in the Eskimo group whose population in 1955 was about 9,500.

Administration of all aspects of Indian Affairs other than health is the responsibility of the Department of Citizenship and Immigration while the Northern Administration and Lands Branch of the Department of Northern Affairs and National Resources has the same role in relation to the Eskimo.

NORTHERN HEALTH SERVICES

Northern Health Services has a dual function. Basically it has the duty of carrying out all responsibilities of the federal government in the field of health in the Northwest Territories and the Yukon, except where it might be advisable for the armed forces to operate health facilities within military establishments. In addition, it is prepared to undertake certain of the responsibilities of the territorial governments, provided suitable agreements in respect of each Territory are made with the appropriate authorities.

It was recognized from the beginning that the first task lay in collecting facts in order to assess the needs of the various communities scattered across the huge mass of Northern Canada. This was begun by a series of surveys through the area, by increased liaison with the governments concerned and with the Department of Northern Affairs and National Resources. It was fully realized that the medical and public health standards of the Territories could best be raised by coming to know and understand the points of view of their citizens and by bringing to bear, on their behalf, the technical resources not only of Indian and Northern Health Services but of the Department as a whole.

During 1955 Northern Health Service personnel were in the thick of this slow process. In all spheres in which the activities of the two Services overlapped they acted as a single unit whose functioning was co-ordinated at all levels by a common Directorate. Hence, the remainder of this Report except where the context makes the distinction clear will make no attempt to describe their activities separately. To do so might imply a divergence of policy or of authority which did not in fact exist.

FACILITIES AND STAFF

For administrative purposes the country has been divided into five Regions with headquarters at Vancouver, Edmonton, Regina, Winnipeg and Ottawa. Each is headed by a Medical Regional Superintendent who represents the Director and who is assisted in his planning by a nursing consultant and a senior administrative officer. In the three Regions whose territory extends North of provincial boundaries this team acts in a dual capacity, representing the interests of both Indian and Northern Health Services. All Regions are further subdivided into Zones, each of which is administered by a Medical Zone Superintendent. This officer frequently has his headquarters in one of the larger departmental hospitals and may be assisted by a team similar to that operating from the Regional office. Within each of these Zones is a variable number of field installations. When circumstances do not justify the establishment of a separate unit the native groups are cared for under arrangements made with local agencies. In the more isolated districts, where constant professional surveillance may be impossible to arrange, the network is rounded out by the help volunteered by scores of missionaries, teachers, traders and officers of all government departments who dispense simple drugs, provide such

first-aid assistance as lies within their abilities and act as sentries who contact the nearest administrative centre at the first sign of emergency.

Services to Suit

Facilities of the Service are scattered across all Provinces and Territories and are tailored, as far as possible, to the needs of the groups they serve. Their functions and size vary widely. However, in the conviction that only through a progressive public health approach can the most urgent problems be met, the field program has been built around the Public Health Nurse. The typical unit from which she works consists of a dwelling and an office and is known as a Health Centre. From this centre she extends her influence into the lives of the people, teaching the fundamentals of good health habits and ensuring that modern protective procedures are employed. Most of these Health Centres are located in rural communities and some are extremely isolated. In addition, fourteen clinics are based on departmental hospitals. From there a team of one or two medical officers, assisted by one or more graduate nurses, provides a combined health and treatment program. Thirteen similar clinics are set up in centres of relatively high population density in various parts of the country. In all, 86 field units of one or other of the above types were in operation during 1955.

When provision is made for the care of less seriously ill patients by the addition of a few beds the field unit becomes known as a Nursing Station. It is usually staffed by a nurse, a nursing assistant and a fireman-labourer. These Nursing Stations are mainly located in remote districts and medical advice, when needed, may have to be obtained by radio. In emergency a physician is flown in or the patient evacuated by air. The amount of bed care required is so consistently high that preventive public health work has had to be somewhat curtailed, but progress has been made towards establishing a proper balance. One hundred and eighty-five beds in 40 such Nursing Stations were operated in 1955, and a breakdown of the work done is given in Table 12 at end of the Directorate's report.

Table 11 summarizes the distribution of all field facilities by type and by province, and in Table 13 is shown some of the professional staff needed to operate the program in all its aspects. It will be noted that the work of the physicians and nurses was supplemented by a team of ten Dental Surgeons who attempted to concentrate on prophylactic care and dental health education in the younger age groups.

Hospital Care

The eighteen hospitals operated by the Directorate are almost exclusively in the West. The most easterly is that at Moose Factory, Ont., at the foot of James Bay, and the most westerly at Miller Bay near Prince Rupert, B.C. They vary in size from 20 to 500 beds and have a total rated capacity of 2,193 beds and 110 bassinets. The larger of these function primarily as sanatoria for the treatment of tuberculosis but even these, and to a greater extent the smaller hospitals, are equipped to serve as community general hospitals. Table 14 provides statistics of patient movement in each of these institutions during 1955. The figures refer to in-patients, by which is meant those who were receiving medical care and who were occupying patient beds. Out-patients, newborn children and persons awaiting transportation are, therefore, excluded. The table includes both general and tuberculosis patients, and combines both Indians and Eskimos. The average occupancy of the 2,193 beds was 87.7 percent and the professional establishment included 40 medical officers and 286 graduate nurses.

The total number of full-time staff employed by the Directorate was 1,722. Amongst these were 197 Indians and Eskimos. To supplement their efforts, and to ensure that even the most remote bands should have access to professional help, it was found neces-

sary to employ more than 60 part-time physicians and to receive accounts from more than 1,200 doctors and 120 dentists in all parts of the country. In addition, Indians and Eskimos were treated in over 600 non-Departmental hospitals, which accounted for more than one-half of the 1,747,884 patient days of care given under the auspices of the Directorate during the year.

Data on patients treated in hospital, whether departmental or non-departmental, are given in Table 15. This table is both a synopsis and a breakdown: it summarizes and combines information on each of the three principal elements—race, condition and type of hospital—which enter into the patient-movement statistics maintained by the Directorate. As indicated by this table, there were no mental patients in departmental institutions. Moreover, the British Columbia Health Insurance Services (B.C.H.I.S.) concern only General patients and only Indians, as there are no Eskimos in that province. In all categories the patient days of separations include not only those days accumulated by patients actually discharged but also those accumulated by patients who have died or been transferred; many of the individuals who contributed to the last group were still in hospital at the end of the year. Therefore, the average length of stay of persons discharged, particularly in the tuberculosis category, was somewhat greater than might be inferred from the table

It will be noted that there was a substantial increase in patient load. This was most marked in the General category, where 1,687 individuals were under treatment on January 1, 1956, as compared with 1,050 on the same date in 1955.

FIELD ACTIVITIES

Reduced to its simplest terms the question which the Service is trying to answer is how to overcome the difficulties inherent in arranging a modern health service for 2,000 small groups, often isolated and sometimes primitive, scattered over half a continent. Under these circumstances a project undertaken after weeks of careful planning may have to be postponed because of a change in the wind or a premature thaw. An X-ray survey may be held up by a broken crankshaft. A relatively simple problem may prove difficult to solve if raised over the radio by a worried trader in an Arctic settlement. In many outposts field officers must possess, above all, the qualities of ingenuity and resourcefulness and may sometimes be called upon to face a degree of personal risk. By contrast, officers in the more settled parts of the country may be able to operate their units in much the same fashion as do their provincial counterparts.

The problem is further complicated by the comparatively high incidence of illness found amongst the native peoples. Most striking at first glance is the prevalence of those communicable diseases which always follow in the train of poor sanitation and inadequate housing. Of particular importance in this respect is gastroenteritis of infants, which still takes far too high a toll of Indian lives each year. Such conditions as tularaemia and hydatid disease, relatively uncommon in the non-Indian population, are well recognized amongst Indians. The Eskimos, in particular, appear to have a very low degree of resistance to the more common communicable diseases and their exposure for the first time to measles or pertussis may be followed by a severe epidemic, sometimes involving the entire settlement and attended by a high incidence of complications. Underlying these striking manifestations in some groups are such less obvious problems as inadequate nutrition. Most basic of all, many have to face the psychological difficulties which must be met by any population which is trying to span, in one lifetime, the cultural gap of centuries.

EDUCATION AND IMMUNIZATION

With this background it was necessary to maintain an active program on many fronts during 1955. In all areas increasing emphasis was laid on health education. Many

visual aids were employed, including filmstrips prepared by the Department, supplemented by material borrowed from the National Film Board library. For the first time an intensive effort was made to bring this type of teaching to the Eskimo. However, it was realized that these aids alone would not achieve lasting results except inasmuch as they were used to supplement the type of continuing education provided by the public health nursing program. It was felt that the progress that could be expected in any community would be in direct proportion to the degree of confidence the people had in their nurse. Home visiting was stressed, and in many areas first aid and home nursing classes were held.

Two poster competitions were held in an attempt to stimulate the interest of the school children. The first dealt with tuberculosis control and was confined to the province of British Columbia; the other covered the remainder of the country and stressed the importance of good nutrition. In both cases prizes were given to the successful entrants.

An intensive immunization program was continued in all areas, using the triple diphtheria, pertussis and tetanus antigen. B.C.G. immunization was again encouraged and an attempt made to give this protection to every newborn Indian child. In those districts where the risk was thought to be high T.A.B. courses were given. A complicating factor in such campaigns is that many native groups can only be assembled at irregular intervals and it is sometimes impossible to complete the course that has been initiated. The protection of the Salk vaccine was made available to the Indians and Eskimos for the first time during 1955. Those Indians resident within provincial boundaries were included in the campaigns organized by the local authorities. The distribution of vaccine in the Northwest Territories was organized by the Directorate and a total of 2,700 doses was administered by officers of the Service to the Indians of this area and to the Eskimos in all three sectors of the Arctic.

Worthy of special mention amongst the many field activities during 1955 was the success achieved by the survey parties in the Eastern Arctic. Five separate teams were involved, each responsible for a certain sector of the coast. The "saturation" approach was attempted for the first time with striking results. This involved a closely coordinated, highly organized program for each settlement whereby the greatest amount of benefit could be obtained by the population in the short time available. Each member of the survey team had certain clearly specified duties. The success of the venture can be gauged by the fact that almost 80 percent of the total population from Northwest River, Labrador, to Craig Harbour, Ellesmere Island, was X-rayed, physically examined, immunized against diphtheria, pertussis, tetanus and poliomyelitis, and given a dental check-up.

The immunological studies commenced in 1954 in co-operation with the Laboratory of Hygiene were continued during 1955. Additional valuable information on Eskimos was gained from specimens obtained by the Arctic survey parties. The investigation on the incidence of carcinoma of the cervix amongst Indian women, also commenced during 1954, is still proceeding and by the end of 1955 almost 1,000 specimens had been examined.

TUBERCULOSIS

Deaths

For the past several years the outstanding highlight of this section of the Report has been the precipitous drop in Indian tuberculosis mortality. Official figures for 1955 are not yet available but early information indicates that the death rate will not be much lower than that recorded for 1954. This finding is not altogether unexpected; many of the deaths were in the older age groups and represented the postponed ending of lives prolonged by intensive treatment. A summary of the mortality rates over the past ten years is given in Table 16. It may also be of interest to note that in 1954, the last year

for which final figures have been received ,tuberculosis had dropped to eighth place as a cause of Indian mortality. This contrasts with the position it held in the four previous years–first in 1950, second in 1951, third in 1952 and sixth in 1953.

Case-finding

The most gratifying aspect of the anti-tuberculosis activities of the Directorate during 1955 was the increased coverage which was provided in the case-finding program. On field surveys alone a total of 86,652 X-rays were taken which represents an increase of 8,512 over the previous year. In addition, 11,635 plates of Indian and Eskimo school children were examined. These figures do not include the many thousands taken in hospitals, those referred by outside agencies or the examinations carried out on persons of non-native status. Much of this extra activity was undertaken in the far North. It is estimated that field and school surveys reached 70 percent of the total Eskimo population, and that this percentage was exceeded in the Eastern Artic. New active cases in the Eskimo group numbered just over 400 giving the extremely high overall incidence of 6 percent. Practically every known active case has been evacuated and is now under treatment; hence a marked improvement in this figure should be noted within the next two or three years.

Allowing for duplication of plates, the 91,099 examinations of Indians on survey represents a coverage of about 50 percent of the total population. There was some variation in the incidence of new cases in different areas, but over all the figure averaged approximately one percent. On survey examinations alone, counting all groups, one active case of tuberculosis, either new or reactivated, is being turned up for every 54 patients examined. Data on selected aspects of the case-finding program is presented in Table 17.

B.C.G. Vaccination

This phase of the work gathered further momentum in 1955. Six thousand, one hundred and twelve Indians were vaccinated for the first time and 693 repeat procedures were done. This represents an increase of over 1,000 as compared with the 1954 figures. From the point of view of long-term planning an important step was taken by having Doctor Armand Frappier, accompanied by Doctor Lise Davignon of the Institute of Hygiene and Microbiology of the University of Montreal, visit each of the Regions. Intensive courses in theory and technique were conducted at four centres for groups of field doctors and nurses.

Hospital Activities

As may be seen in Table 15 over 1,000,000 days of patient care were given to tuberculous Indians and Eskimos during 1955. The average length of stay for those actually discharged has not yet been calculated, but it is estimated that the final figure will be well over 400 days.

There has been no fall-off in the patient load. On January 1, 1956, 2,982 tuberculous patients were under treatment as compared with 2,941 on January 1, 1955. However, it is encouraging that there is now little or no delay in getting an active case under treatment.

EXTENSION OF SERVICES AND FACILITIES

Staff

The Director of Indian and Northern Health Services was designated as Canadian member of the Executive Board of the World Health Organization and headed the Canadian delegation to the World Health Assembly in Mexico in 1955.

A senior medical administrative officer was appointed to the Directorate as consultant in Northern Health. Also on Northern Health strength, a medical zone superintendent was appointed for the MacKenzie and Yukon areas and a full-time physician and nurse established at Fort Smith, N.W.T. to co-operate with the Indian Health Service personnel already working there.

Significant advances were made in the sphere of public health nursing during 1955. Seven supervisory positions were set up and there was an increase of nine in the public health staff nursing establishment. Improvements were also effected on the administrative side. A senior administrative officer was appointed by the Eastern Regional office at Ottawa and trained hospital administrators commenced duties at three hospitals—Sioux Lookout, Ont.; Miller Bay, B.C.; and North Battleford, Sask. A Requirements Control Officer was appointed to Head Office to develop and introduce standards and scales of issue and to ensure economical supply to all units.

Professional Improvement

Two medical officers were successful in obtaining the Diploma in Public Health during the year, and four nurses completed a course in Public Health nursing.

A Pembine-type conference, in which three hospitals presented a series of consecutive tuberculosis discharges from a predetermined and arbitrarily-selected date, was held by the Directorate at Brandon Sanatorium on June 12, 1955. This was the first time that such a meeting had been held on this scale in Canada. Twenty Departmental medical officers attended, and an equal number of guests, from seven provinces, were present.

On the administrative side, the Assistant Director attended a one month training course for senior government officers during the summer, and two field officers were enrolled in an extension course in hospital administration. In March, 1956 an Executive Development Course was held in Ottawa by the Directorate. Fifteen administrative officers from all regions attended the meetings, which lasted for three weeks. National and local conventions of medical, nursing and hospital organizations were attended by various officers, and some received short courses of extra training.

Facilities

Further improvements were effected at Charles Camsell Hospital, Edmonton, and the workshops and garage were renovated at Norway House Hospital, Man. Six new nursing stations were set up at Fort Good Hope, N.W.T.; Split Lake, Man.; Pelican Narrows, Sask.; Sandy Lake, Ont.; Frobisher Bay, Eastern Arctic; and Goodfish Lake, Alta. Two new health centres were put into operation at Manowan, Que., and Fort Chipewyan, N.W.T.

CO-OPERATION WITH OTHER AGENCIES

The extensive use made of local professional and treatment services has already been mentioned. In many areas provincial authorities have co-operated with the Service in case finding and other public health endeavours. A fine working relationship exists with other government departments operating in areas inhabited by Indians and Eskimos, and special tribute must be paid to the help repeatedly given by the Royal Canadian Mounted Police and the Royal Canadian Air Force. In all parts of the country, but particularly in the far North, the Directorate leans heavily on the goodwill of religious groups of all denominations and on the continuing assistance given by many trading and commercial concerns. Most intimate of all has been the association between officers of the Service and the administrators of Indian Affairs in the Department of Citizenship and Immigration and the administrators of Eskimo Affairs in the Department of Northern Affairs and National Resources. To both these agencies must be given the highest praise for their outstanding work on behalf of the native peoples.

TABLE 11

(Indian and Northern Health Services)

DEPARTMENTAL FACILITIES

December 31, 1955

AREA	Registered Indians* and Eskimos†	Hospitals	Nursing Stations	Health Centres	Clinics
Maritimes	5,841	—	2	4	1
Quebec	19,836	—	5	14	1
Ontario	37,249	3	7	12	5
Manitoba	19,684	6	8	2	4
Saskatchewan	18,786	2	5	5	3
Alberta	15,767	4	6	4	4
British Columbia	31,086	3	—	11	6
Yukon and N.W.T.	12,071	—	7	7	3
Labrador	1,117	—	—	—	—
TOTALS	163,500‡	18	40	59	27

* 1954.
† 1951.
‡ Estimated for 1955.

TABLE 12

(Indian and Northern Health Services)

NURSING STATION ACTIVITIES

CALENDAR YEAR 1955

PROVINCE	Number of Nursing Stations	Rated Bed Capacity	Patient Movement				Patient Days
			Admissions	Separations			
				Discharges	Transfers	Deaths	
Nova Scotia	1	4	19	15	7	.....	119
New Brunswick	1	6	66	55	8	1	315
Quebec	5	20	200	152	43	.....	1,341
Ontario	7	38	576	496	79	9	4,526
Manitoba	8	32	420	358	60	5	1,777
Saskatchewan	5	20	603	469	124	5	3,098
Alberta	6	37	625	570	47	6	4,350
Yukon and Northwest Territories	7	28	65	55	8	.....	451
TOTALS	40	185	2,574	2,170	376	26	15,977

TABLE 13

(Indian and Northern Health Services)

PROFESSIONAL POSITIONS

AT JANUARY 1, 1956

PROVINCE	MEDICAL OFFICERS			GRADUATE NURSES			Dental Surgeons	Physicians Part-time	Administrative Officers
	Admin.	Hosp.	Field	Admin.	Hosp.	Field			
Maritimes	.....	.....	1	1	.....	5	1	8	.....
Quebec	1	.....	1	1	12	12	1	6	.....
Ontario	1	9	6	2	60	24	2	19	2
Manitoba	1	2	5	1	16	16	1	4	2
Saskatchewan	1	5	3	1	23	11	1	1	3
Alberta	1	13	5	1	91	13	2	2	3
British Columbia	1	11	7	1	96	20	1	21	4
N.W.T. and Y.T.	1	.....	8	0	0	8	1	1	.....
Headquarters	5	.....	.....	1	.....	.....	.....	.....	3
TOTALS	12	40	36	9	286	109	10	62	17

TABLE 14

(Indian and Northern Health Services)

HOSPITAL ACTIVITIES

CALENDAR YEAR 1955

PROVINCE	Hospital	RATED CAPACITY		Average No. of Beds Occupied	PATIENT MOVEMENT				Patient Days
		Beds	Bass.		Admissions	SEPARATIONS		Deaths	
						Discharges	Transfers		
ONTARIO	Lady Willingdon	44	10	29.6	850	816	21	22	10,804
	Moose Factory	142	18	175.9	1,063	735	311	8	64,189
	Sioux Lookout	70	8	63.2	795	686	65	15	23,066
MANITOBA	*Brandon	240	16	244.9	192	169	26	7	89,387
	*Clearwater Lake	150	4	148.3	207	152	68	3	54,131
	*Dynevor	40	10	47.8	70	50	17	1	17,461
	Fisher River	32	4	18.1	609	581	19	14	6,606
	Fort Alexander	20	5	12.0	537	493	35	6	4,390
	Norway House	34	4	38.0	709	678	38	10	13,865
SASKATCHEWAN	Fort Qu'Appelle	112	6	108.9	702	680	23	10	39,742
	North Battleford	55	6	54.6	1,273	1,194	54	23	19,934
ALBERTA	Blackfoot	37	4	11.5	490	466	22	6	4,206
	Blood	46	5	29.1	1,084	1,078	13	13	10,625
	Charles Camsell	568	6	438.0	1,024	1,031	7	19	159,873
	Hobbema	27	4	17.8	819	797	27	9	6,512
BRITISH COLUMBIA	Coqualeetza	190	.....	148.0	371	255	68	3	54,036
	Miller Bay	171	.....	143.4	178	186	34	6	52,353
	Nanaimo	215	.....	194.3	210	163	50	6	70,938
TOTALS	.....	2,193	110	1,923.6	11,183	10,210	898	181	702,118

* Operated for the Department by the Sanatorium Board of Manitoba.

TABLE 15

(Indian and Northern Health Services)

TOTAL PATIENT MOVEMENT

CALENDAR YEAR 1955

	GENERAL									
	UNDER CARE			SEPARATIONS				In at End	DAYS OF CARE	
	In	Adm*	Tot.	Dis.	Tr.	Died	Tot.		P.D.	P.D.S.
INDIAN										
Dept. Hosp. and N.S.	446	11,373	11,819	10,535	609	175	11,319	500	186,746	165,856
Non-Dept. Hosp.—excluding B.C.H.I.S.	526	19,643	20,169	18,597	309	220	19,126	1,043	242,934	230,399
—B.C.H.I.S.	†	†	†	†	†	†	†	†	90,622	†
TOTAL INDIAN	972	31,016	31,988	29,132	918	395	30,445	1,543	520,302	396,255
ESKIMO										
Dept. Hosp. and N.S.	44	248	292	173	59	3	235	57	15,936	11,769
Non-Dept. Hosp.	34	519	553	440	26	.....	466	87	21,582	19,215
TOTAL ESKIMO	78	767	845	613	85	3	701	144	37,518	30,984
INDIAN AND ESKIMO										
Dept. Hosp. and N.S.	490	11,621	12,111	10,708	668	178	11,554	557	202,682	177,625
Non-Dept. Hosp.—excluding B.C.H.I.S.	560	20,162	20,722	19,037	335	220	19,592	1,130	264,516	249,614
—B.C.H.I.S.	†	†	†	†	†	†	†	†	90,622	†
TOTAL INDIAN AND ESKIMO	1,050	31,783	32,833	29,745	1,003	398	31,146	1,687	557,820	427,239

* Includes Transfers In.

† Not Available.

TABLE 15 (Continued)

(Indian and Northern Health Services)

TOTAL PATIENT MOVEMENT

CALENDAR YEAR 1955

	TUBERCULOSIS									
	UNDER CARE			SEPARATIONS				In at End	DAYS OF CARE	
	In	Adm.*	Tot.	Dis.	Tr.	Died	Tot.		P.D.	P.D.S.
INDIAN										
Dept. Hosp. and N.S.	1,368	1,811	3,179	1,561	473	25	2,059	1,120	450,597	613,638
Non-Dept. Hosp.	1,167	1,532	2,699	1,292	206	37	1,535	1,164	428,857	393,991
TOTAL INDIAN	2,535	3,343	5,878	2,853	679	62	3,594	2,284	879,454	1,007,629
ESKIMO										
Dept. Hosp. and N.S.	158	325	483	111	133	4	248	235	64,816	65,157
Non-Dept. Hosp.	248	625	873	276	125	9	410	463	118,520	93,317
TOTAL ESKIMO	406	950	1,356	387	258	13	658	698	183,336	158,474
INDIAN AND ESKIMO										
Dept. Hosp. and N.S.	1,526	2,136	3,662	1,672	606	29	2,307	1,355	515,413	678,795
Non-Dept. Hosp.	1,415	2,157	3,572	1,568	331	46	1,945	1,627	547,377	487,308
TOTAL INDIAN AND ESKIMO	2,941	4,293	7,234	3,240	937	75	4,252	2,982	1,062,790	1,166,103

* Includes Transfers In.

TABLE 15 (Continued)

(Indian and Northern Health Services)

TOTAL PATIENT MOVEMENT

CALENDAR YEAR 1955

	MENTAL									
	UNDER CARE			SEPARATIONS				In at End	DAYS OF CARE	
	In	.Adm*	Tot.	Dis.	Tr.	Died	Tot.		P.D.	P.D.S.
INDIAN										
Dept. Hosp. and N.S.										
Non-Dept. Hosp.	330	140	470	92	4	21	117	353	123,346	91,365
TOTAL INDIAN	330	140	470	92	4	21	117	353	123,346	91,365
ESKIMO										
Dept. Hosp. and N.S.										
Non-Dept. Hosp.	10	3	13	1			1	12	3,888	10
TOTAL ESKIMO	10	3	13	1			1	12	3,888	10
INDIAN AND ESKIMO										
Dept. Hosp. and N.S.										
Non-Dept. Hosp.	340	143	483	93	4	21	118	365	127,234	91,375
TOTAL INDIAN AND ESKIMO	340	143	483	93	4	21	118	365	127,234	91,375

* Includes Transfers In.

TABLE 15 (Concluded)

(Indian and Northern Health Services)

TOTAL PATIENT MOVEMENT

CALENDAR YEAR 1955

——	GENERAL, T. B., AND MENTAL									
	UNDER CARE			SEPARATIONS				In at End	DAYS OF CARE	
	In	Adm*	Tot.	Dis.	Tr.	Died	Tot.		P.D.	P.D.S.
INDIAN										
Dept. Hosp. and N.S.	1,814	13,184	14,998	12,096	1,082	200	13,378	1,620	637,343	779,494
Non-Dept. Hosp.—excluding B.C.H.I.S.	2,023	21,315	23,338	19,981	519	278	20,778	2,560	795,137	715,755
—B.C.H.I.S.	†	†	†	†	†	†	†	†	90,662	†
TOTAL INDIAN	3,837	34,499	38,336	32,077	1,601	478	34,156	4,180	1,523,142	1,495,249
ESKIMO										
Dept. Hosp. and N.S.	202	573	775	284	192	7	483	292	80,752	76,926
Non-Dept. Hosp.	292	1,147	1,439	717	151	9	877	562	143,990	112,542
TOTAL ESKIMO	494	1,720	2,214	1,001	343	16	1,360	854	224,742	189,468
INDIAN AND ESKIMO										
Dept. Hosp. and N.S.	2,016	13,757	15,773	12,380	1,274	207	13,861	1,912	718,095	856,420
Non-Dept. Hosp.—excluding B.C.H.I.S.	2,315	22,462	24,777	20,698	670	287	21,655	3,122	939,127	828,297
—B.C.H.I.S.	†	†	†	†	†	†	†	†	90,662	†
TOTAL INDIAN AND ESKIMO	4,331	36,219	40,550	33,078	1,944	494	35,516	5,034	1,747,884	1,684,717

* Includes Transfers In.

† Not Available.

TABLE 16

(Indian and Northern Health Services)

T. B. DEATH RATES PER 100,000 POPULATION

——	1946	1947	1948	1949†	1950	1951	1952	1953	1954	1955
All Canada	47.4	43.4	37.1	30.4	25.9	24.4	17.1	12.3	10.3	.....
Indian	579.1	549.1	488.5	399.6	298.8	262.2	167.5	100.3*	60.2	48.8‡
White	41.9	41.9	32.5	26.7	22.0	20.7	14.7	11.4	9.8	.....

* For the first time includes those of Indian status only.

† Includes Newfoundland.

‡ Provisional.

TABLE 17

(Indian and Northern Health Services)

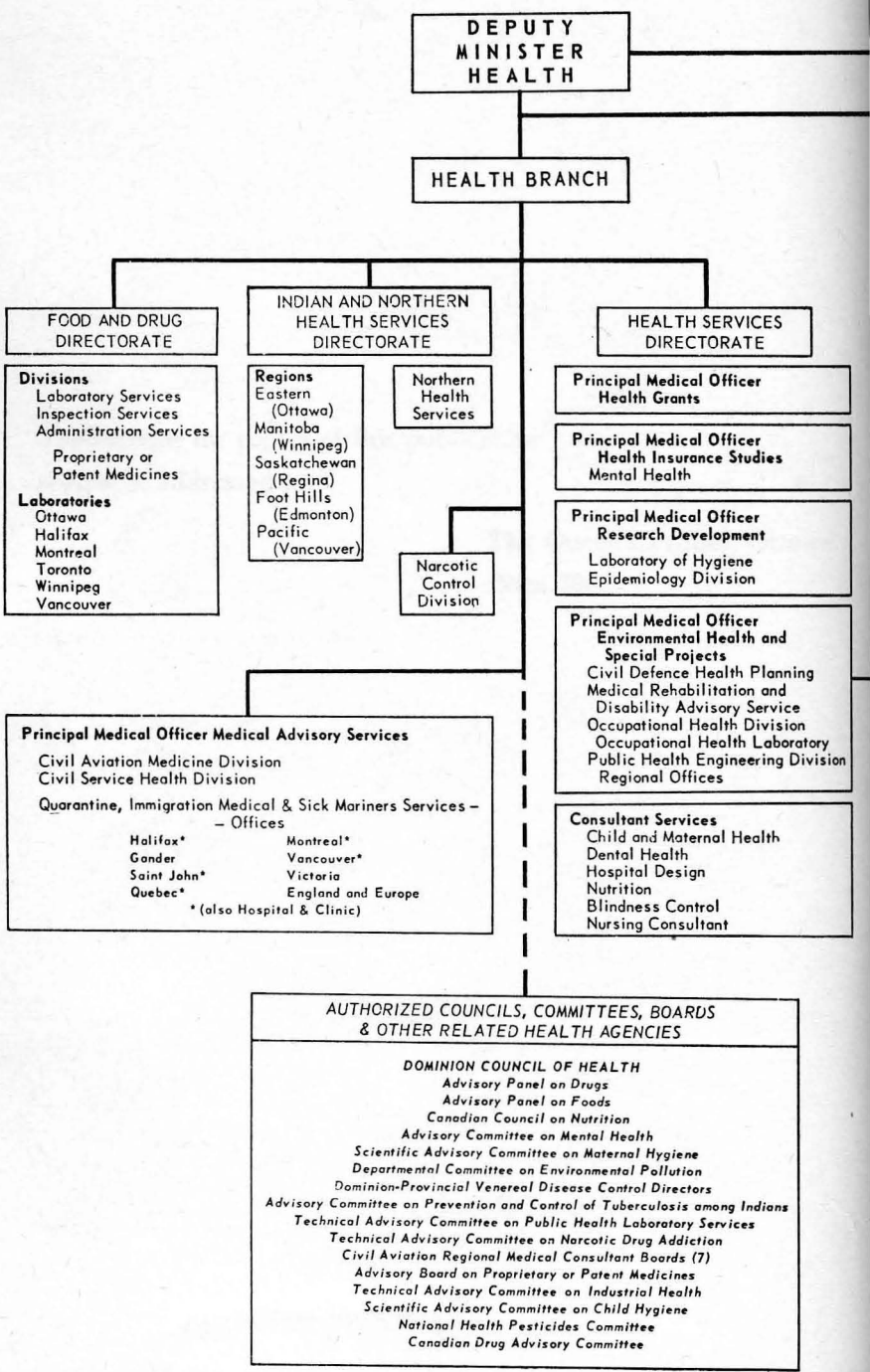
SELECTED ASPECTS OF TUBERCULOSIS CASE FINDING PROGRAM

CALENDAR YEAR 1955

	REGION					
	Eastern	Central	Sask.	Foothills	Pacific	Total
Native Population						
A. Indian	50,202	30,214	18,750	21,807	30,585	151,558
B. Eskimo	5,200	1,832	.....	2,461	.....	9,493
Number of X-Rays Taken on Field Surveys						
A. Indian	16,206	18,604	12,610	15,285	17,135	79,840
B. Eskimo	4,166	1,131	.....	1,515	.....	6,812
C. Others	302	2,443	2,947	8,240	757	14,689
Number of X-Rays Taken on School Surveys						
A. Indians	2,440	2,498	2,111	4,210	Included	11,259
B. Eskimo	7	.....	.....	369	under field	376
C. Others	79	323	199	1,140	Surveys	1,741
Number of Active Cases						
A. Diagnosed for the first time	881	165	141	17	65	1,329
B. Previously known						
i. known to be active	243	16	327	2	.....	588
ii. Re-activation	85	75	26	24	.....	210
Number of Active cases discovered by means other than field and school surveys	204	73	(*)	140	86	503
Number of active cases discovered on Surveys hospitalized by January 1, 1956	651	185	(*)	93	132	1,061

(*) Not Available.

DEPARTMENT O



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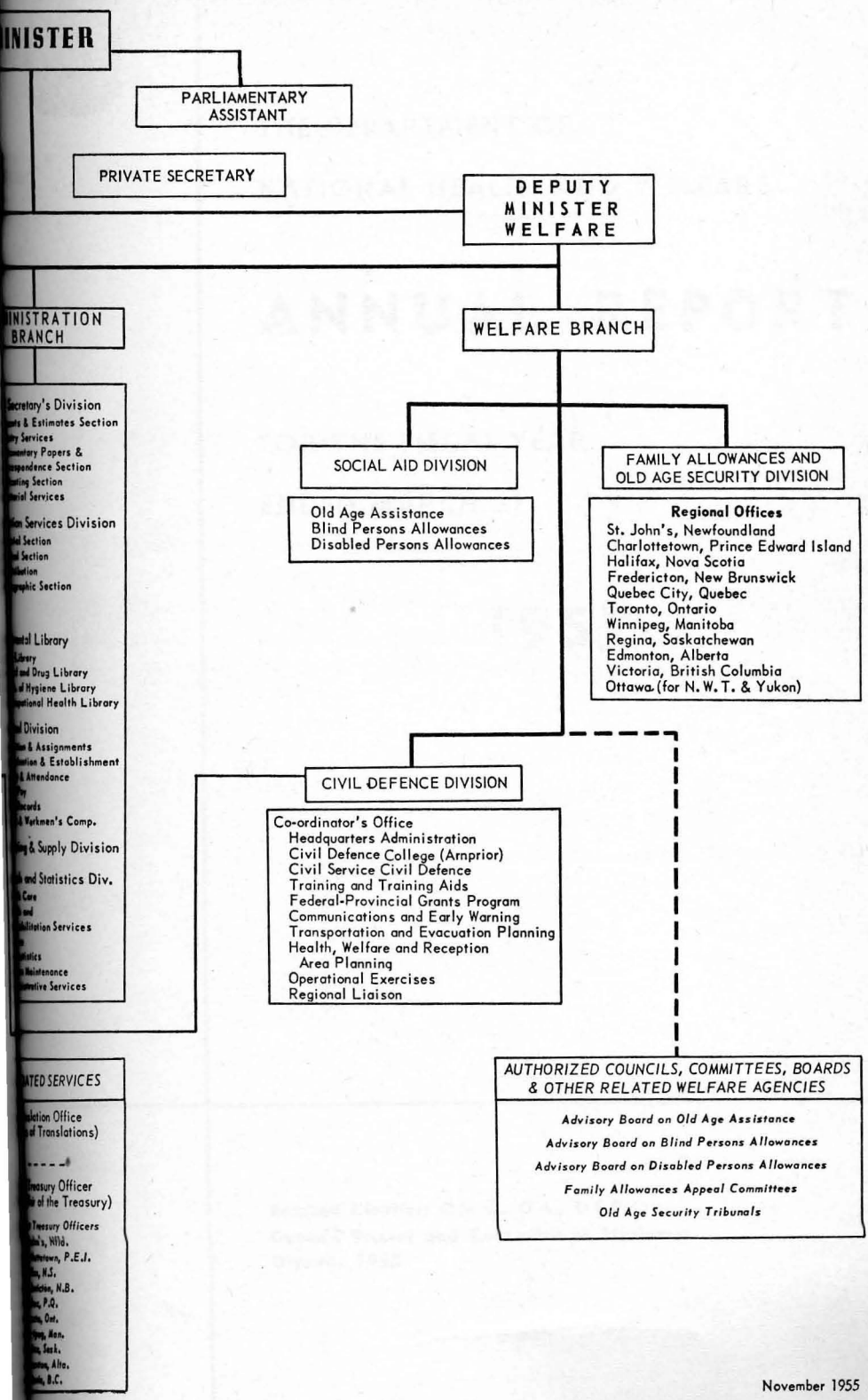

November 1955