Report on the Bonne Bay Cottage Hospital

For the Provincial Historic Commemorations Program

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Significance of the Cottage Hospital System in Newfoundland Development

The establishment of the Cottage Hospital and Medical Care Plan in 1935, or Cottage Hospital System, was the most important step taken by the Commission of Government in improving outport Newfoundlanders’ access to quality health care. Before the System, there were only eight hospitals in the country outside the capital of St. John’s: three Grenfell Mission hospitals (St. Anthony, Cartwright and North West River); two community-owned hospitals (Grand Bank and Twillingate); two pulp and paper company hospitals (Corner Brook and Grand Falls) and a small mining company hospital (Buchans).1 The health care available to residents in areas not covered by those eight hospitals consisted primarily of individual physicians in private practice.2 However, there were never enough physicians throughout the island to sufficiently meet the needs of the people. According to Harris Munden Mosdell, Secretary for the Commission of Government’s Department of Public Health and Welfare, in 1935:

Less than fifty medical doctors [were] in practice amongst the population outside the City of St. John’s. The ratio [was], therefore, one doctor to every five thousand persons. How inadequate this medical service [was] to our scattered population [was] obvious from the fact that less than forty per cent of mortality returns [were] made by doctors. The inference, of course, [was] that close on seventy per cent of deaths [occurred] from illnesses untreated by registered practitioners.3

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1 The pulp and paper and mining company hospitals focused their services on employees and their families, although they sometimes admitted non-employees at government expense. At that time, the Grenfell Mission also operated a small hospital at Harrington Harbour, on the north shore of Quebec. See Gordon W. Thomas, From Sled to Satellite: My Years with the Grenfell Mission, (Canada: Irwin Publishing, 1987) and Newfoundland Royal Commission 1933: Report, hereafter Amulree Report, (St John’s: King’s Printer, 1933), Chapter X, para. 592. The Royal Commission listed the Note Dame Bay Memorial Hospital at Twillingate as being maintained by the Grenfell Mission. However, the hospital was never formally a Grenfell facility, although “it did initially fall within Grenfell's sphere of influence” and Grenfell was instrumental in securing funding for its construction. See J.T.H. Connor, “Twillingate: Socialized Medicine, Rural Doctors and the CIA,” Newfoundland Quarterly, vol. 100 no.1 (2007).

2 The exception to this was the Northern Peninsula and the coast of Labrador, where the Grenfell Mission had established extensive health care network based on nursing stations and regular contact with the Grenfell hospitals and physicians.

3 Provincial Archives of Newfoundland and Labrador (PANL), GN 38, Box S6-1-1, File 37. “Report to Commissioner for Public Health & Welfare on Hospital, Medical and Nursing Services and Necessities of Newfoundland,” by H.M. Mosdell, 8 February 1935, p.2.
Furthermore, the majority of those fifty physicians practiced on the east coast; there were only seventeen physicians along the expansive south and west coasts of the island. The *Report of the Newfoundland Royal Commission* (Amulree Report) of 1933 also noted that the overall number of private practice physicians in Newfoundland had declined by approximately twenty-five percent since 1911.\(^4\) Ostensibly, the widespread economic problems brought about by the depression made it more difficult for physicians to maintain a viable private practice, especially since residents in outport communities usually relied on a resource-based economy and had limited financial resources. As Leonard Miller summarized in his history of the Cottage Hospital plan, by the early 1930s, “the attractions of medical practice in the real outports of Newfoundland had begun to disappear. The delayed impact of the world depression on a precariously balanced economy reduced living to a struggle and communities which managed to support medical practitioners in better years were now unable to do so.”\(^5\)

While residents in the more populated areas of the country usually had some access to hospitals and/or private practice physicians, those living in the smaller outport communities, almost half of Newfoundland’s population, had few if any health care services.\(^6\) In an effort to reach those Newfoundlanders without access to a nearby hospital or physician, a group of concerned citizens led by Lady Harris (wife of Governor Sir C. Alexander Harris) established the Outport Nursing Committee (ONC) in 1920. This committee organized the recruitment and employment of trained nurses and nurse-midwives in more isolated areas of Newfoundland. These nurses provided a crucial social and medical service and met a tremendous health care

\(^4\) Amulree Report, Chapter X, para. 593.
\(^6\) The population of Newfoundland in 1935 was approximately 290,000. See Dominion Bureau of Statistics, “Province of Newfoundland, Statistical Background, 1949,” p. 4 (Table 4).
need in the communities in which they were stationed. However, the ONC faced the same financial difficulties in maintaining its service as the private practice physicians. The outport nursing scheme was based on the doctrine of self-help – the government provided an annual grant towards the organization’s expenses, but the greater part of the nurses’ salaries were expected to be provided by the people living in the districts where the nurses worked.\footnote{Amulree Report, Chapter X, para. 601. See also Lady Harris, “Outport Nursing,” *Newfoundland Quarterly*, vol. XXI no. 1, (July 1921): 1.} But again, few outport Newfoundlander had the financial means to pay for health services of any kind and as a result, the ONC struggled with finances.\footnote{For example, the Committee could never provide the entire $1000/year salary that was promised to nurses in their original contracts. See Joyce Nevitt, *White Caps and Black Bands: Nursing in Newfoundland to 1934*, (St. John’s: Jesperson Press, 1978), p. 140.} In an attempt to maintain its nursing services, the ONC introduced an industrial program in which local volunteers would knit and weave products for sale, the proceeds of which contributed to the nurse’s salary.\footnote{Nevitt, p. 143.} The ONC incorporated with its industrial branch in 1924 with the creation of the Newfoundland Outport Nursing and Industrial Association (NONIA). But even this creative attempt to fund health services foundered during the depression and by 1934 the number of nursing centres located throughout the island had declined from twenty-five to four.\footnote{Newfoundland Royal Commission, Chapter X, para. 594. Although she was no longer on salary, nurse Myra Bennett continued to practice nursing on a volunteer basis in her adopted home of Daniel’s Harbour. In 1934, the Commission of Government’s Department of Public Health and Welfare offered her a part-time position as nurse in the community. See Nevitt, p. 141.}

Maintaining even the most basic health services in outport Newfoundland during the early twentieth-century proved to be a significant economic and logistical challenge. But the people desperately needed improved health care services. Maternity services and child health were particular areas of vulnerability for Newfoundlander, and indeed maternity accounted for
most of the health-related services provided by physicians and nurses in outport communities.\footnote{Maternity accounted for the vast majority of medical cases at the Grenfell Mission nursing stations. As a result, the Mission purposely recruited British-trained midwives for the stations. See Heidi Coombs-Thorne, “Nursing with the Grenfell Mission in Northern Newfoundland and Labrador, 1939-1981,” (PhD Dissertation, University of New Brunswick, 2010), pp. 207-215.}

However, it was the high infant mortality rate (death of children under one year of age) in Newfoundland that was truly alarming. In 1934, on the eve of the Cottage Hospital System, the infant mortality rate was 102.8 per 1000 births and accounted for 19.3\% of all registered deaths in Newfoundland that year.\footnote{That was actually the second lowest infant mortality rate on record. The highest infant mortality rate was recorded in 1913 at 166.9 per 1000 births. See Newfoundland, \textit{Annual Report on the Births, Marriages and Deaths in Newfoundland}, 1949, Table 24, p. 47. See also, Newfoundland, \textit{Annual Report of the Registrar General of Births, Marriages and Deaths}, 1935, Table 44, p. 35.} This was 4.2\% higher than the death rate from tuberculosis – the leading cause of death among adult Newfoundlanders at that time.\footnote{Newfoundland, \textit{Annual Report of the Registrar General of Births, Marriages and Deaths}, 1934, Table 43, p. 25.} And the infant mortality rate was considerably higher in Newfoundland than in the Canadian provinces (see Table 1). Clearly, infant mortality in Newfoundland was a serious problem.

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|c|}
\hline
 & 1931-35 & 1936-40 & 1941-45 \\
\hline
Newfoundland & 117 & 98 & 92 \\
Prince Edward Island & 67 & 69 & 52 \\
Nova Scotia & 73 & 65 & 58 \\
New Brunswick & 82 & 82 & 74 \\
Quebec & 98 & 82 & 68 \\
Ontario & 61 & 50 & 42 \\
Manitoba & 61 & 57 & 51 \\
Saskatchewan & 62 & 55 & 47 \\
Alberta & 60 & 53 & 44 \\
British Columbia & 46 & 44 & 39 \\
\hline
\end{tabular}
\caption{Average Infant Mortality Rate in Newfoundland and Canada, 1931-1945}
\end{table}

In addition to maternity services and child health, deficiency and infectious diseases were a significant cause for concern. Deficiency diseases like beriberi, rickets, and scurvy were widespread throughout the country, caused by a nutritionally inadequate staple diet. Many Newfoundlanders, especially those in the outports, did not have ready access to fruits and vegetables. Instead, according to the Newfoundland Tuberculosis Public Service, ‘‘[b]read and tea’ seemed to be the only diet. … [The people] seldom [saw or tasted] fresh meat, very little milk, or any of the principal necessities.’’ In addition, malnutrition was a risk factor for infection and made many Newfoundlanders vulnerable to infectious diseases, like tuberculosis. While tuberculosis was not directly caused by poor nutrition, people who were undernourished had greater difficulty fighting the disease. Without a healthy body and strong immune system, someone affected by tuberculosis could often suffer a slow decline and eventual death. During the first half of the twentieth-century, tuberculosis was the scourge of Newfoundlanders; its incident rate in the country was greater than any of the provinces of Canada (see Table 2). And until the 1940s, tuberculosis was overwhelmingly the leading cause of death among the adult population; accounting for approximately 15.1% of all deaths in Newfoundland in 1934 (the second leading cause of death that year was cancer, at 6.7%).

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14 Deficiency diseases became the subject of a variety of nutritional surveys in Newfoundland and Labrador during the first half of the twentieth century. These academic studies and government reports found compelling evidence relating deficiency diseases to the poor local diet. See for example, W.R. Aykroyd, “Beriberi and Other Food-Deficiency Diseases in Newfoundland and Labrador,” *The Journal of Hygiene*, August 30.3 (1930): 357-86; and D. Steven and G. Wald, “Vitamin A Deficiency: A Field Study in Newfoundland and Labrador,” *Journal of Nutrition*, 21.5 (1941): 461-76.


<table>
<thead>
<tr>
<th>Province</th>
<th>Per 1,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland</td>
<td>1.80</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>1.10</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>0.86</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>0.69</td>
</tr>
<tr>
<td>Quebec</td>
<td>0.93</td>
</tr>
<tr>
<td>Ontario</td>
<td>0.39</td>
</tr>
<tr>
<td>Manitoba</td>
<td>0.55</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>0.43</td>
</tr>
<tr>
<td>Alberta</td>
<td>0.40</td>
</tr>
<tr>
<td>British Columbia</td>
<td>0.77</td>
</tr>
<tr>
<td>Canada</td>
<td>0.62</td>
</tr>
</tbody>
</table>


From maternal and child health to deficiency and infectious diseases, Newfoundlanders needed improvements to their health and increased health care services. And during the political and economic turbulence of the early 1930s, it took the British-appointed Commission of Government to institute an adequate and widespread system of health care.

**Creation of the Cottage Hospital System**

When the Commission of Government took office in 1934, it immediately recognized that Newfoundlanders needed increased and improved health care services. The Commissioner for Public Health and Welfare, Sir John C. Puddester, and the department’s Secretary, Mosdell, became the driving force behind health care reform. Mosdell in particular had accumulated a wealth of knowledge on the health care situation in Newfoundland as chairman of the Royal Commission on Health and Public Charities (January 1929). He also studied the health care

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19 Mosdell also received funding from the Rockefeller Foundation in New York to undertake a survey of public health initiatives in Canada and the United States. See Newfoundland, *First Interim Report of the Royal Commission on Health and Public Charities, June 1930*, (St. John’s: King’s Printer, 1930), p. 6.
practices of other countries and claimed to be particularly inspired by the Highlands and Islands Medical Service in Scotland as a model solution for Newfoundland. Scotland faced similar logistical and economic challenges to health care services: in both places, “the expense of placing medical services at the disposal of patients very frequently [cost] much more than the actual professional charge for these services.” Based on his knowledge and research, Mosdell argued for a large reorganization of health care in Newfoundland which included the improvement and increase of patient accommodations at the St. John’s government hospitals, the organization of a travelling clinic along the island’s southwest coast, and the creation of a decentralized district provision of health services – a “cottage hospital” system.

Mosdell’s vision became the basis of the health care recommendations contained within the Amulree Report and the blueprint for the Commission of Government’s action on improving and increasing health care in Newfoundland. The Cottage Hospital System was part of a national health insurance plan in which local families paid a fee of (initially) $5/year which permitted them access to medical care and hospital facilities (maternity services, dental extractions, and outpatient medications usually cost extra). For those who could not afford the fee, the plan allowed families to pay whatever they could afford in the form of cash or commodity, such as fish, firewood, or produce. In this way, the plan was particularly sensitive to local traditions and created a flexible means of access for people with limited resources. The System focused on bringing health care services closer to the people who needed them. This included expanding and incorporating the existing outport nursing service across the island – in the first year of its

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20 First Interim Report, p. 10.
21 PANL, “Report to Commissioner for Public Health & Welfare,” pp. 2, 14. For a history of the south coast clinic, see Nigel Rusted, It’s Devil Deep Down There: 50 Years Ago on the M.V. Lady Anderson, a Mobile Clinic o the S.W. Coast of Newfoundland, (St. John’s: Faculty of Medicine, Memorial University of Newfoundland, 1985).
administration, the Commission of Government increased the number of nurses engaged in outport nursing from eight to twenty-six.\textsuperscript{23} And these nursing services were supplemented by the rapid construction of new cottage hospitals in districts that did not have a resident nurse. Mosdell originally proposed the construction of twelve hospitals across the island; however, by 1949, the government had opened a total of fifteen cottage hospitals, including seven in 1936 alone (see Table 3). And the medical services provided by the hospitals were in such demand that many of them admitted their first patients well before the building was officially opened.

**Table 3: Cottage Hospitals in Newfoundland, by Date of Official Opening**

<table>
<thead>
<tr>
<th>Location</th>
<th>Official Opening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Old Perlican</td>
<td>January 1936</td>
</tr>
<tr>
<td>Markland</td>
<td>March 1936</td>
</tr>
<tr>
<td>Argentia</td>
<td>April 1936</td>
</tr>
<tr>
<td>Burgeo</td>
<td>May 1936</td>
</tr>
<tr>
<td>Harbour Breton</td>
<td>May 1936</td>
</tr>
<tr>
<td>Come By Chance</td>
<td>June 1936</td>
</tr>
<tr>
<td>Burin</td>
<td>August 1936</td>
</tr>
<tr>
<td>Stephenville Crossing</td>
<td>February 1937</td>
</tr>
<tr>
<td>Bonavista</td>
<td>July 1940</td>
</tr>
<tr>
<td>Bonne Bay</td>
<td>July 1940</td>
</tr>
<tr>
<td>Grand Bank</td>
<td>May 1941</td>
</tr>
<tr>
<td>Placentia (replaced Argentia)</td>
<td>November 1942</td>
</tr>
<tr>
<td>Brookfield</td>
<td>January 1944</td>
</tr>
<tr>
<td>Gander</td>
<td>April 1946</td>
</tr>
<tr>
<td>Botwood</td>
<td>August 1946</td>
</tr>
<tr>
<td>Channel-Port aux Basques</td>
<td>June 1952</td>
</tr>
<tr>
<td>Springdale</td>
<td>November 1952</td>
</tr>
<tr>
<td>Fogo</td>
<td>August 1953</td>
</tr>
<tr>
<td>St. Lawrence</td>
<td>June 1954</td>
</tr>
</tbody>
</table>


The cottage hospitals ranged in size from ten to thirty-two beds. The general floor plans of the hospitals were similar, with “two wards to accommodate male and female patients, one or two single rooms, used variously as private, semi-private, isolation or ante-mortem cases, an operating room which doubled as a delivery room (or vice versa) and an out-patient clinic usually too small for the large numbers attending.”  

Each hospital had a resident physician, a nursing staff and housekeeping staff – all of whom lived in the top floor of the building (although the physician was often permitted to live off-site but near the hospital). Activities conducted at the hospitals included deliveries, dental extractions, out-patient clinics, and minor surgeries. Patients requiring specialized surgery were usually transported to the government hospital in St. John’s. The hospitals also provided headquarters for nurses to conduct public health in the communities, to promote healthy diets, and to campaign against diseases like tuberculosis. But perhaps the greatest overall advantage provided by the Cottage Hospital System was that it brought hospital facilities more directly to the people, “readily available at any time of the year with a minimum of inconvenience to any patient and the minimum of expense to all concerned.”

**Importance of the Bonne Bay Hospital in the System**

At the time of its construction, the Bonne Bay Cottage Hospital at Norris Point stood out as the best designed facility within the entire Cottage Hospital System. Indeed, after concluding a tour of the building prior to its opening, Mosdell reported: “[f]or design, workmanship and accommodation it is by long odds the best of all our outport institutions. … It is a pity this plan

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24 Miller, p. 25.

was not instituted for the Bonavista institution.”

The Bonne Bay Cottage Hospital officially opened in July 1940, although it admitted its first patient in December 1939. It was one of the largest of the cottage hospitals in operation, containing twenty-three beds, two cots for babies, x-ray facilities as of 1943 (for which the community fundraised), and a hospital staff of ten. It was also one of the only cottage hospitals which contained a dental clinic for school children.

But not only was the hospital an impressive building in terms of its design, facilities, and accommodations; it was also an impressive product of community pride and support. Norris Point was not on Mosdell’s original list of twelve potential sites for a cottage hospital. When the system was proposed in 1935, Bonne Bay had a resident physician and nurses stationed at Port Saunders and Daniel’s Harbour. Therefore, other communities without a physician or nearby nurses took priority for hospital construction.

However, by 1938, Bonne Bay no longer had its resident physician; and a group of concerned citizens requested the government consider their community for a cottage hospital.

In November 1938, Mosdell met with local delegates (representatives of the region extending from Chimney Cove to Cow Head), after which he informed Puddester:

They requested me to represent to you the outstanding need for hospital and for medical and nursing services in their district. There is now a nurse at Trout River and another at Cow Head. There is no doctor at Bonne Bay, where a medical practitioner usually serves approximately 2500 people residing in about 25 settlements. A Cottage Hospital located at Norris Point would provide facilities

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27 The first patient was Stan Maynard for a dental extraction. See Amy Nicolle, *Then and Now: 50th Anniversary of the Bonne Bay Hospital*, (Bonne Bay Hospital Auxiliary, 1990), p. 8.

28 PANL, GN 38, S6-5-3, “Cottage Hospital Statistical Report, October 1st, 1942 to September 30th, 1943.”


for a population of 3600. It would obviate the long, difficult and expensive journey of patients to Corner Brook, particularly in the winter season, when the people concerned are so badly isolated. It would, of course, reduce very materially the necessity for using the Corner Brook hospital facilities with their exceptionally high costs to the Department.  

At the meeting, the delegates proactively nominated a local Board of Health for the government’s approval, consisting of the following personnel: Magistrate C.M. Lane (Bonne Bay) as chairman; William A. Preble (Bonne Bay) as Secretary-Treasurer; A.B. Harding and John Tucker (Norris Point); John Shears (Rocky Harbour); George Brake (Trout River); and Daniel Hutchings (Cow Head). These individuals were eager to secure cottage hospital facilities and worked tirelessly towards that goal. Preble donated the land on which the hospital was built and Shears became “builder, foreman, and troubleshooter all rolled into one.” And under the leadership of the Board of Health, the local residents became 

unstinted in their co-operation with the Department. Seven thousand hours of free labor [sic] were given to the job, as well as the bulk of the rough and dressed lumber used on the job. Mr. John Shears, of Rocky Harbour, placed a complete milling outfit on the spot. With this the necessary dressed lumber, mouldings and other trim were produced as needed. …Mr. W. Halfyard … kindly volunteered to help with the plumbing and heating installation…. The Bonne Bay hospital [was] in all respects a credit to all concerned. 

Within thirteen months of the delegates’ meeting with Mosdell, the Bonne Bay Cottage Hospital was in operation. 

The original staff at the Bonne Bay Cottage Hospital included Robert Dove as physician (graduate of Dalhousie Medical School 1936), Mary Green and Laura Hicks as nurses, Rita Hollohan as aid, and Mildred Rumbolt as cook – each of whom contributed in different ways to  

32 “Report from Mosdell,” p. 11. 
33 Crellin, p. 20. 
34 PANL, GN 38, Box S6-1-2, File 14, Harris Mosdell to John Puddester, 13 November 1939.
the health and well-being of the hospital’s patients. Martin Bugden, who has been described as “janitor extraordinaire,” was responsible for the overall maintenance of the hospital, its grounds, and its out-lying buildings, including the generator house, the morgue, and the garage/ice house. According to Noel Murphy, physician at the hospital from 1945-1954, Bugden was “a remarkable person. He kept every part of the hospital operating from maintaining the electrical supply to looking after the coal furnace, the plumbing, the requirements in the wards, the driving of the truck, the bringing in of patients, supplies and mail, and 101 other activities.”

Together, these individuals, and many more over the years, contributed to the success of the Bonne Bay Cottage Hospital in meeting the health needs of the people and in creating a hospital with a strong sense of community.

**Context of the System in the Development of Medicare in Canada**

The Cottage Hospital and Medical Care Plan in Newfoundland was a publically funded hospital and medical service for the rural population and represented one of the earliest such efforts in North America. While it did not cover the entire population of the country (health care in larger centres still relied on larger hospitals and private practice physicians), it was a significant step towards increased government involvement in health care. No province of Canada at that time had the same level of government support for medical/hospital care as Newfoundland. In rural areas of Canada, which faced similar economic and logistical challenges to maintaining a health services, health care became the domain of philanthropic organizations and local municipalities. The Victorian Order of Nurses and the Canadian Red Cross were

35 Crellin, p. 5. See also, *Then and Now*, p. 4.
particularly active in establishing small “outpost” hospitals and nursing stations. These institutions operated mostly through patient fees, with some financing also provided by private donations and municipal/provincial grants for the treatment of indigent patients. However, government funding was consistently meagre – in 1945, patient fees accounted for approximately 83.3% of income for Red Cross Outposts in Ontario, municipal/provincial grants for 10.5%, and private donations for 6.2%. Municipalities were more involved in health care in western Canada, particularly in Saskatchewan. In 1916, pressure from women’s groups in that province led to the creation of a “municipal doctor system” in which a municipality would retain a physician on salary to provide general practitioner services. Saskatchewan also pioneered a “union hospital system” in 1917, which provided for the combination of towns and rural municipalities into union hospital districts for the purposes of establishing and maintaining hospitals.

During the first half of the twentieth-century, people living in rural areas, whether in a Canadian province or in Newfoundland, did not have the same access to health services as people in urban areas. In the absence of a large medical infrastructure in rural areas, community and/or local government involvement became essential to increasing and improving people’s access to health care. In the Canadian provinces, philanthropic organizations and municipal governments became much more involved in establishing and maintaining health services than the provincial or federal governments. However, Newfoundland took a different path. Since the country did not have the same level of municipal organization as the Canadian provinces, it


became essential that Newfoundland’s national government take the lead in improving health services to the outports. As a result, Newfoundland’s Cottage Hospital and Medical Care Plan was established a full twelve years before any plan with a similar level of government support was established in any Canadian province.39 By establishing the Cottage Hospital System, Newfoundland demonstrated the positive impact national involvement could have on the provision of health care services.

Conclusion

In 1934, people living in outport Newfoundland had limited access to quality health care. The population was scattered throughout 1300 small, often isolated communities that hugged a rugged and expansive coastline. Transportation to larger centres with health facilities was expensive, slow, often difficult and sometimes dangerous. Several attempts were made to bring health services closer to the people, particularly through private practice physicians and ONC/NONIA nurses stationed in certain communities. However, both of these forms of health service declined during the early years of the depression. When the Commission of Government took office in 1935, it made country-wide health reform a priority. And under the leadership of Puddester and the vision of Mosdell, the Department of Public Health and Welfare launched its Cottage Hospital and Medical Care Plan – the Cottage Hospital System.

The Cottage Hospital System brought health services more directly to the people. The hospitals themselves employed resident physicians who could assess people’s symptoms, provide maternity care, treat minor wounds and sicknesses, and refer more serious cases to a larger hospital for specialized care. The hospitals also served as strategic bases from which

39 The first provincial-wide plan in Canada was Saskatchewan’s Hospital Service Plan of 1947. It differed from Newfoundland’s plan in that it was compulsory and province-wide. See Government of Canada, Royal Commission on Health Services, (Queen’s Printer, 1964), p. 392.
nurses could provide health education and conduct public health activities. And the results paid off – during the first fifteen years of the Cottage Hospital System, people generally became healthier and more conscious of the importance of healthy living. On the eve of Confederation, the infant mortality rate had declined from 102.8 per 1000 births in 1934 to 53.4 in 1949 – the lowest on record. And the tuberculosis death rate showed a similar pattern of decline, from 192 per 100,000 people in 1934 to 82 in 1949 – also the lowest on record.40 (See Appendix) The fifteen government-owned and operated cottage hospitals that were in operation at the time would have certainly contributed to the tremendous improvement in people’s health. However, the cottage hospitals provided more than pragmatic solutions to the provision of health care in outport Newfoundland. The people themselves felt a sense of pride and ownership with the hospitals, which often became beloved fixtures of the communities they served.

40 Newfoundland, Annual Report on the Births, Marriages ad Deaths in Newfoundland, 1949, Table 24, p. 47; and Table 20, p. 43.
Appendix

**Chart 1: Infant Mortality Rate in Newfoundland, 1919-1949**


**Chart 2: Tuberculosis Death Rate (per 100,000)**

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