

*Unhealthy Policies: The Role of Citizenship in the Federal Government Response to  
Tuberculosis in Indigenous Populations 1945-2015*

by

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## Abstract

At a time when the overall national rates of tuberculosis in Canada are among the lowest in the world, the rates of tuberculosis among the Canadian Indigenous population are ten to twenty times higher than among the Canadian non-Indigenous population. In light of factors such as Canada's universal health care system and advancements in public health and medical interventions over the past century, the question remains as to why this disparity continues to exist. Finding the answer to that question lies at the core of this research project. It involves the analysis of a complex array of factors that lie at the intersection of public policy, politics, and the place in society that the Canadian federal government continues to attribute to Indigenous peoples.

The relationship between federal policies and health and social inequalities in Indigenous communities is examined through the lens of state power and citizenship. It's the federal government who exercises the power to define the scope of its responsibility for 'Indians, and lands reserved for Indians' under Section 91 (24) of the *Constitution Act*. It is the federal government, not Indigenous peoples, who further decides who is an 'Indian' under the *Indian Act* for the purposes of determining who is eligible for federal services. This research project studies the impact of the federal government's position that it does not recognize a treaty or legal obligation for Indigenous health, and that it provides health services as a matter of policy only. Citizenship theories provide the analytical lens with which to review how the federal government chooses to include and exclude certain sub-groups of Indigenous peoples based on their Indian Status, whether they live on or off reserve, and based in which provincial or territorial jurisdiction they reside. The result is an ad-hoc network of service delivery across Canada.

This research project demonstrates that the federal government's own Indigenous health policies play a central role in perpetuating the health and social inequalities that are contributing factors to the elevated rates of tuberculosis that persist in Indigenous communities.

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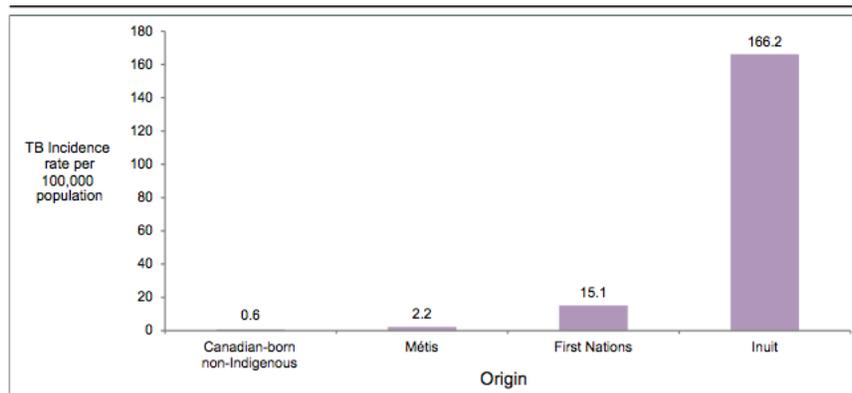
To all my family and friends, I express my heartfelt gratitude for being my greatest cheerleaders. To my husband Bob, who quietly supported me throughout the process, I express my deep appreciation for giving me the space and time to get this work done, and for patiently proofreading draft documents. To my daughter Suzanne, I owe a debt of gratitude – from the start, you were my source of inspiration and you helped me believe that I could achieve my goal. Finally, Diane Watson, what would I have done without your famous ‘red pen’. Your hilarious editing comments helped to cut through the weariness of the drafting process, and kept me smiling along the way.

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## CHAPTER 1 – INTRODUCTION

In 2015, compared to the incidence rate of 0.6 per 100,000 population in the Canadian-born non-Indigenous population, the incidence rate among the Métis (2.2 per 100,000 population) was almost four times higher and the incidence rate among First Nations (15.1 per 100,000 population) was 25 times higher. The highest incidence rate across all origin groups was among the Inuit at 166.2 per 100,000 population, a rate which was over 270 times higher than the rate in the Canadian-born non-Indigenous population.<sup>1</sup>



### I - BACKGROUND

The June 1, 2017 edition of the *Canada Communicable Disease Report* confirms that the rates of tuberculosis remain higher among the Indigenous population as compared to the rates among the Canadian non-Indigenous population. In light of Canada’s universal health care system and the many federal government Indigenous health policies and programs that were implemented over the past century, the question remains as to why this disparity continues to exist.

Finding the answer to that question lies at the core of this research project. It involves the analysis of a complex array of factors that lie at the intersection of public policy, politics, and the

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<sup>1</sup> Victor Gallant et al, “Tuberculosis in Canada - Summary 2015” in *Canada Communicable Disease Report* 2017;43(3):77-82.

place in society that the Canadian federal government continues to attribute to Indigenous peoples. This research project shows that the federal government's own Indigenous health policies play a central role in perpetuating the unequal health, social and economic conditions that have been identified as contributing factors to the elevated rates of tuberculosis, and health disparities in general, that persist in Indigenous communities.<sup>2</sup>

Foucault's hypothesis of state power provides a lens through which to examine the policy instruments that have informed the federal government's response to Indigenous health issues. He argues that state power manifests itself not only in terms of hierarchical, top-down edicts, but also in terms of social control over segments of the population within disciplinary institutions such as schools and hospitals, where the behaviour of these populations is manipulated.<sup>3</sup> In Canada, the federal bureaucracy responsible for the *Indian Act* and the Indian Reserve system forms a disciplinary institutional system where the government exercises social control and power over Indigenous peoples through the use of policy instruments. On matters of health, the outcome of these policy actions is a patchwork system of health resources for Indigenous peoples that are different from those available to the rest of the Canadian population.

In the case of tuberculosis, federal government actions throughout the 20<sup>th</sup> century and into the 21<sup>st</sup> century have progressively:

- offered limited emergency care for tubercular Indigenous patients on reserve for fear that they would travel to, and contaminate, neighbouring settler communities;

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<sup>2</sup> The relationship between the inadequate living conditions such as substandard housing conditions and poor socio-economic living conditions and the elevated rates of tuberculosis among Canada's Indigenous peoples has been acknowledged by the federal government as recently as in the Chief Medical Officer of Health's 2014 Report (Ottawa: Public Health Agency of Canada, 2014).

<sup>3</sup> Michel Foucault, "Governmentality", in *The Foucault Effect*, eds. Graham Burchell, Colin Gordon & Peter Miller (Chicago: The University of Chicago Press, 1999), 87-104.

- admitted some Indigenous patients to provincial hospitals for care, but placed them in segregated areas that separated them from other tuberculosis patients;
- established a network of Indian hospitals and tuberculosis sanatoria, from former abandoned military installations, that served to minimize contact between Indigenous and non-Indigenous patients;
- underfunded both provincial and Indian hospitals and sanatoria for the costs of care associated with Indigenous patients compared to the per-patient rates provided for non-Indigenous patients; and, more recently.
- established a patchwork of tuberculosis programs and services in select communities across Canada that is comprised of a series of inclusions and exclusions based on Indigenous identity and geographical location.<sup>4</sup>

From the beginning of the 20<sup>th</sup> century, there has been an acknowledged link between poor socio-economic conditions and tuberculosis. It was also recognized that “Tuberculosis is a social disease with a medical aspect.”<sup>5</sup> The poverty and the inadequate housing in Indigenous communities, and their link to the incidence of tuberculosis, continued to be well documented by the federal government in the annual reports of National Health and Welfare and Health Canada throughout the latter decades of the 20<sup>th</sup> century and in publications of the Public Health Agency of Canada well into

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<sup>4</sup> For more information on the historical developments in the treatment of Indigenous tuberculosis in the western provinces during the 20<sup>th</sup> century refer to: Maureen Lux, "Care for the 'Racially Careless': Indian Hospitals in the Canadian West, 1920-1950.", 407-434; and, Maureen Lux, Maureen K. *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s*. University of Toronto Press, 2016.

<sup>5</sup> Sir William Osler as cited in Richard Long, “The Canadian Lung Association/Canadian Thoracic Society and Tuberculosis Prevention and Control”, in *Canadian Respiratory Journal*, Volume 14 No 7, October 2007: 427; Department of Indian Affairs. *Annual report of the Department of Indian Affairs for the Year Ended March 31, 1908*. (Ottawa. Sessional Papers of the Dominion of Canada.1908): xxviii-xxiv; Thomas McKeown, *The Origins of Human Disease*, (Oxford, Blackwell Publishing, 1988).

the 21<sup>st</sup> century.<sup>6</sup> These conditions prevailed because of a political ideology that was based on the assumed cultural superiority of European settlers over Indigenous culture.

## II - TUBERCULOSIS AS A CASE STUDY

The federal government's response to dealing with tuberculosis is used as a case study to investigate the political ideology behind the continued persistence of health and social inequalities that exist in the Indigenous population as compared with the non-Indigenous population. At the beginning of the 20<sup>th</sup> century, tuberculosis was at epidemic levels among Canadians. In 1926, 1 in 13 of all reported deaths in Canada was due to tuberculosis.<sup>7</sup> This was followed by a sharp decline in the rates of tuberculosis starting in the late 1940s as a result of improved living conditions and the isolation of infectious cases in sanatoria. The incidence and mortality rates continued to decline with the introduction of effective antibiotic treatment in the mid-20th century that saw the rates nearing zero in the 1980s.<sup>8</sup> This decline is attributed to a combination of factors, including improvements in public health, hygiene regulations, sanitation infrastructures and the introduction of antibiotics as an effective way to treat the bacillus in the 1940s and 1950s.<sup>9</sup>

It is, however, the dramatic resurgence in the rates of tuberculosis starting in the 1990s that is most puzzling. Whereas the rates increased in First Nations and Inuit communities, there was no corresponding rise among non-indigenous Canadians. Equally puzzling is the fact that the elevated

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<sup>6</sup> David Butler-Jones, "Tuberculosis- Past and Present", in *The Chief Public Health Officer's Report on the State of Public Health in Canada: 2010*. Public Health Agency of Canada, 2010; G. Alvarez, "TB in Canada – The Battle is not Over", in *Canada Communicable Disease Report: Volume 41-S2*, March 19, 2015, Public Health Agency of Canada, 2015.

<sup>7</sup> M. Jensen et al, *A population-based study of tuberculosis epidemiology and innovative service delivery in Canada*. International Journal of Tuberculosis and Lung Disease 2012;16(1):43-9.

<sup>8</sup> Jessica Halverson et al, "Epidemiology of Tuberculosis in Canada", in *Canadian tuberculosis standards, 7th Edition* (Ottawa, Minister of Health, 2014): 8.

<sup>9</sup> Ibid.

rates of tuberculosis in the Indigenous population continue to persist in spite of federal efforts and resources specifically targeted to that population, such as the 1992 *National Tuberculosis Elimination Strategy* whose goal was to eliminate tuberculosis by 2010.<sup>10</sup> The epidemiological definition of ‘elimination’ of a disease is a reduction of the incidence of that disease to 1 case per 1 million.<sup>11</sup> As outlined at the beginning of this chapter, Canada is nowhere near approaching this goal in the Indigenous population.

There is a general perception in Canada that tuberculosis is a ‘disease of the past’.<sup>12</sup> Yet, tuberculosis remains a serious global public health issue. It is a highly infectious disease and, according to the World Health Organization (WHO), is one of the top infectious disease killers worldwide. In 2014, 9.6 million people worldwide fell ill with tuberculosis and 1.5 million died from the disease.<sup>13</sup> WHO further reports that over 95% of tuberculosis deaths occur in low-and middle-income countries where it is among the top five causes of death for women aged 15 to 44, and where an estimated 1 million children became ill with tuberculosis, of which 140,000 have subsequently died. In international comparisons, the overall Canadian rate for tuberculosis is one of the lowest in G7 countries. In 2015, Canada had the second lowest rate of new cases of tuberculosis at just over 5 cases per 100,000 population.<sup>14</sup> As a result, the topic has not garnered the attention of the general population in Canada.

The low prevalence of the disease nationally is not, however, equally represented amongst all

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<sup>10</sup> Health Canada. *National Tuberculosis Elimination Strategy* (Ottawa: Medical Services Branch, 1992): 2.

<sup>11</sup> Michael Clark, *Tuberculosis in First Nations Communities 1999*. (Ottawa: Health Canada, 1999): 3.

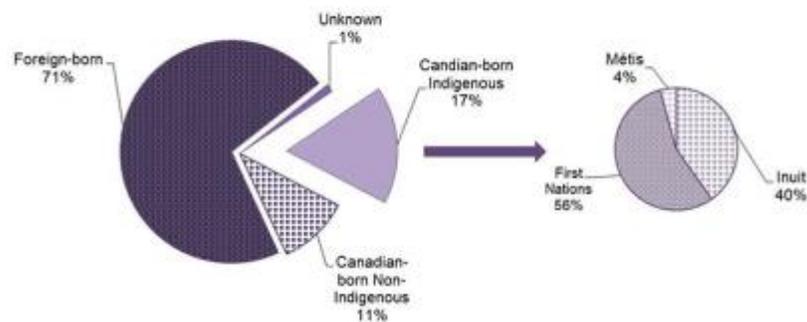
<sup>12</sup> Médecins Sans Frontières, *Tuberculosis*. <http://www.msf.ca/en/tuberculosis>, March 3, 2017; Jeff Reading, *The crisis of chronic disease among Aboriginal peoples: a challenge for public health and social policy* (Victoria: University of Victoria. 2010).

<sup>13</sup> World Health Organization *Tuberculosis Fact Sheet Number 104, updated October 2015*, <http://www.who.int/mediacentre/factsheets/fs104/en/> March 30, 2017.

<sup>14</sup> Public Health Agency of Canada, *Health Status of Canadians 2016* (Ottawa, Public Health Agency of Canada, 2016): 61.

population groups in Canada. There are two demographic groups that carry the burden of the disease: Indigenous peoples and individuals who were born outside of Canada.<sup>15</sup> Although the greatest number of cases is reported among foreign-born individuals, it is the Indigenous population that carries the greatest proportional burden for tuberculosis.

Figure 6: Distribution of active tuberculosis cases (new and re-treatment) by origin, Canada, 2015



Foreign-born individuals and Canadian-born Indigenous people continued to be disproportionately represented among reported cases of TB in 2015 (Figure 6). The foreign-born population, which represented approximately 22% of the total Canadian population in 2015, accounted for 71% (1,169/1,639) of all reported cases corresponding to an incidence rate of 14.8 per 100,000 population. *Canadian-born Indigenous people made up approximately five percent of the total Canadian population in 2015 but accounted for 17% (281/1,639) of all reported cases, with a corresponding incidence rate of 17.1 per 100,000 population.* Canadian-born non-Indigenous people accounted for the lowest percentage of reported cases at 11% (170/1,639), for an incidence rate of 0.6 per 100,000 population.<sup>16</sup> *(italics added for emphasis)*

This is not to understate the efforts of the many health professionals, researchers and Indigenous leaders who are dedicated to addressing the high rates of this disease in the Indigenous population. However, what the persistent disparity in the rates of tuberculosis between Indigenous and non-Indigenous Canadians does underscore is that the issue does not appear to be of the highest

<sup>15</sup> Gonzalo G. Alvarez, et al. Tuberculosis Prevention and Care in First Nations, Inuit and Métis Peoples” in *Canadian Tuberculosis Standards 7th Edition*. (Ottawa, Public Health Agency of Canada, 2014).

<sup>16</sup> Victor Gallant et al, “Tuberculosis in Canada - Summary 2015” in *Canada Communicable Disease Report* 2017;43(3):77-82. (Ottawa, Public Health Agency of Canada, 2017)

priority for federal public policy decision makers.

Health professionals have long known that diseases like tuberculosis persist because fundamental factors in the spread of the disease, health and social inequalities, are not being addressed within the existing medical approach. Sir William Osler's observation in 1902 that "Tuberculosis is a social disease with a medical aspect" regularly frames the academic discourse on this topic.<sup>17</sup> Sir William Osler was a Canadian physician who played an important role in training medical professionals at the beginning of the 20<sup>th</sup> century, and possessed a keen understanding of the complexity of tuberculosis. One hundred years later, this perspective is still present in the list of known risk factors that the Public Health Agency of Canada (PHAC) identified in 2014 which included: living in communities with high rates of tuberculosis; living in a low-income household, in crowded and inadequately ventilated housing; or being homeless.<sup>18</sup>

Yet, these risk factors are not reflected in the federal government's latest policy approach for dealing with tuberculosis. Health Canada is the federal department that is responsible to deal with the problem of the elevated rates of tuberculosis within the Indigenous population. As outlined in the 2012 *Health Canada's Strategy Against Tuberculosis for First Nations On-reserve*, its prime objective is to prevent, diagnose and manage the disease.<sup>19</sup> It fails, however, to present a broad national approach to the problem. First, the policy is limited to those First Nations people who live on reserve, thereby excluding non-status and off-reserve First Nations as well Inuit and Métis. Second, the policy further narrows the scope of federal responsibility to a patchwork of specific communities

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<sup>17</sup> As cited in Richard Long, "The Canadian Lung Association/Canadian Thoracic Society and Tuberculosis Prevention and Control", in *Canadian Respiratory Journal*, Volume 14 No 7, October 2007: 427

<sup>18</sup> Chief Public Health Officer, *Report on the State of Public Health in Canada 2014: Public Health in the Future*, (Ottawa, Minister of Health, 2014): 55

<sup>19</sup> Health Canada, *Health Canada's Strategy Against Tuberculosis for First Nations On-reserve* (Ottawa, Health Canada, 2012).

that they choose to define as being at greatest risk.<sup>20</sup>

Arguably, it is the federal government's complex categorization of Indigenous groups and sub-groups in a network of geographical and jurisdictional inclusions and exclusions that creates inequality in service delivery for health services. These inequalities depend in large part on geographical criteria. With reference to health care services in general, Lavoie maintains that "The current rules still anchor themselves to the geographical location of those served (on- or off-reserve), and as such, fail to accommodate the diversity of living arrangements and mobility."<sup>21</sup> This case study looks at the impact of this approach in three historical policy clusters. The first cluster covers the federal government's response to the tuberculosis problem among Indigenous peoples in the post-WWII period until the end of the 1960s. During this period, universal access to national hospital services was introduced and, at the end of the period universal health care was introduced. The second cluster looks at the federal government's response to the management of Indigenous tuberculosis throughout the 1970s and 1980s leading to the resurgence of elevated rates of tuberculosis in these communities in the 1990s, at a time when in 1982, Indigenous rights were recognized in the Canadian constitution and the federal government was pursuing self-government negotiations with Indigenous leaders. The third cluster examines the federal government's approach to the continuing elevated rates of tuberculosis in the 21<sup>st</sup> century amid the calls for a change in the nature of the Indigenous-government relationship arising from the national consultation process for the Kelowna Accord in 2005.

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<sup>20</sup> Ibid, Appendix C.

<sup>21</sup> Josée Lavoie, and Evelyn L. Forget. "Legislating identity: The legacy of the Indian Act in eroding access to care", *The Canadian Journal of Native Studies* 31, no. 1 (2011): 128.

## II - FOUNDATIONS OF THE RESEARCH

Beyond the direct implications for a case study on tuberculosis, this research extends Foucault's concept of state power and subjectivity to the reality of Indigenous health policies in Canada today. The concept of citizenship as an instrument of state control and power provides the analytical tool to add to existing theories about inequalities. This approach moves beyond the observation that inequalities exist, to exploring the conditions that led to their creation.

This research concludes that the federal government's policy interventions in tuberculosis over the past seven decades have maintained the colonial ideology of what constitutes citizenship in Canadian mainstream society, and the place of Indigenous peoples in that mainstream society. Marshall's model of social citizenship, characterized by the principles of equal and universal access to social rights for all citizens that developed in mid-20<sup>th</sup> century Britain, influenced the development of post-war social policies in Canada.<sup>22</sup> Yet, during this time, the federal government perpetuated unequal health and social conditions through policies that purposefully excluded Indigenous peoples from the full benefits of citizenship that were available and accessible to other Canadians. Federal policies were implemented in a manner that ignored the rights that Indigenous peoples had acquired as original inhabitants of this land and as signatories to colonial treaties with the British Crown. The federal government's interpretation of the place that Indigenous peoples should occupy in Canadian society was, and continues to be, based on political discourses developed from colonial ideologies of the perceived inferiority of Indigenous cultures. Federal health policies have been used as political instruments to progressively isolate, segregate and marginalize Indigenous peoples in order to facilitate the federal government's goal to assimilate them into mainstream settler society. The federal government's Draft Indian Policy that was tabled in the House of Commons as a government

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<sup>22</sup> Thomas H. Marshall and Thomas B. Bottomore. *Citizenship and social class*. Vol. 2. London: Pluto Press, 1992: p.6

White Paper in 1969 was the next step and the culmination of this assimilationist goal. It presented the dismantling of the reserve system and the delegation of the responsibility for Indigenous peoples to the provinces as the solution to addressing the inadequate economic and social conditions on-reserve.

The Government could press on with the policy of fostering further education; could go ahead with physical improvement programs now operating in reserve communities; could press forward in the directions of recent years, and eventually many of the problems would be solved. But progress would be too slow. The change in Canadian society in recent years has been too great and continues too rapidly for this to be the answer. Something more is needed. We can no longer perpetuate the separation of Canadians. Now is the time to change.<sup>23</sup>

While the federal government's policy statement acknowledges that education and physical improvements on-reserve are needed to solve the problems, it presents a sense of urgency to promoting a solution that is focused more on removing the jurisdictional separation between Indigenous peoples and other Canadians than it is with moving forward with improvements in their economic and social conditions. In his discussions about the 1951 amendments to the *Indian Act*, Tobias agrees that this sense of haste in finding solutions to addressing socio-economic problems on-reserve had more to do with accelerating the pace of assimilation than it did with bringing in long-term improvements.

Assimilation was still viewed by the government as the inevitable outcome and "the enactment of compulsory enfranchisement and the breaking down of the barriers of the reserve boundaries both literally by lease and sale and figuratively by making provincial laws apply there

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<sup>23</sup> Canada, "Statement of the Government of Canada on Indian Policy 1969", *Aboriginal policy studies*, Vol.1, no.1, 2011;197.

were all to promote more rapid assimilation”.<sup>24</sup> Using a citizenship lens, political ideology was more about making Indigenous peoples similar to other Canadians than it was about recognizing their rights and privileges as an Indigenous population within Canadian society. The case study on tuberculosis in this research concludes that this colonial priority to assimilate Indigenous peoples within mainstream society remains the determining factor in Indigenous health policy today.

It is within this colonial framework that the federal government’s response to the elevated rates of tuberculosis in Indigenous communities was, and continues to be, grounded in a self-serving interpretation of the division of powers between the provincial and federal governments that was set out in the 1867 *British North America Act (BNA Act)* and re-affirmed in the 1982 *Constitution Act*.<sup>25</sup> It is the federal government’s interpretation of the scope of their responsibility under these powers that lies at the heart of Indigenous health policy in Canada.

‘State power’ and ‘subjectivity’ are terms that appear in Foucauldian analyses of state control that explore the art of government. These terms are utilized in this research to characterize the unique circumstances of the Canadian federated state, and its European colonial origins. Foucault’s work on the elements of state power and control is extensive, and his analysis of the ‘art of government’ provides constructive insight into the nature of the government actions.<sup>26</sup> He studied the splintering of feudalism and the transformations in governance that led to the creation of administrative and colonial states in 16<sup>th</sup> century Europe,<sup>27</sup> a timeframe that overlapped with the establishment of European colonial governments in North America. Foucault observed how states shifted to a

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<sup>24</sup> John L. Tobias, “Protection, civilization, assimilation: An outline history of Canada's Indian policy”, *Sweet Promises – A reader on Indian-White Relation in Canada*, Ed, J.R. Miller (Toronto: University of Toronto Press, 1976): 138.

<sup>25</sup> Justice Laws Website, *Constitution Acts 1867-1982* (Government of Canada): <http://www.justice.gc.ca/eng/rp-pr/csj-sjc/constitution/lawreg-loireg/p1t11.html>

<sup>26</sup> Michel Foucault, “Governmentality”, *The Foucault Effect*, Eds Graham Burchell, Colin Gordon & Peter Miller (Chicago: The University of Chicago Press, 1999), 87-104.

<sup>27</sup> *Ibid*, 87-88.

narrower governance focus on managing the affairs of individuals and the inter-related economic well-being of groups of families:

The art of government... is essentially concerned with answering the question of how to introduce economy – that is to say, the correct manner of managing individuals, goods and wealth within the family (which a good father is expected to do in relation to his wife, children and servants) and of making the family fortunes prosper – how to introduce this meticulous attention of the father towards his family into the state.<sup>28</sup>

These 16<sup>th</sup> century fundamental paternalistic principles of economic well-being of the family had an influence on government ideology to determine what is best for the Indigenous peoples in Canada well into the 21<sup>st</sup> century.

#### **IV - CURRENT DEBATES**

##### *Tuberculosis and Indigenous Health*

There are two sources that have been instrumental in guiding this research project. The first book, Daschuk's *Clearing the plains: disease, politics of starvation, and the loss of Aboriginal life* is key to understanding the role that the federal government played in creating the conditions that facilitated the spread of tuberculosis among Indigenous peoples in the prairies in the 19<sup>th</sup> century. His analysis of the motivations and political incentives behind the government's 19<sup>th</sup> century Indigenous policies provides a foundation on which can be assessed future policies. He does not hesitate to draw direct linkages between government policies and the poor health conditions that have resulted from the implementation of these policies. Specifically, his analysis concludes that "Years of hunger and despair that coincided with extermination of the bison and

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<sup>28</sup> Ibid, 92.

relocation of groups to reserves, exacerbated by inadequate food aid from the dominion government, created ecological conditions in which the disease exploded.”<sup>29</sup>

Although Daschuk writes about the federal government’s policies in the prairies in the 19<sup>th</sup> century, his research is of significant national importance. These policies were developed to answer the government’s urgent need to acquire large tracts of land to meet the demands of the growing population of European immigrants that were settling in the prairie provinces, and to fulfill Prime Minister Mcdonald’s commitment to build a national railroad that linked British Columbia to the rest of the provinces.<sup>30</sup> The 1857 *Act for the Gradual Civilization of the Indian Tribes in the Canadas* played an instrumental role in establishing the political narrative that was used to establish power and control over the First Nations in the prairies provinces to meet the goals of land acquisition. It was followed by the 1867 *British North America Act* and 1876 *Indian Act*, that in turn extended the same government-Indigenous relationship to all First Nations across Canada. From a health policy perspective, McCallum, further argues that, on matters of health, the way that federal government chose to deal with Indigenous health issues to facilitate the westward expansion wrote the history of federal health policies : “the making of the Canadian West, which is ... the subject of the vast majority of Indigenous health history.”<sup>31</sup> This is reflected in the fact that much of the research into Indigenous health is based in western locations during the 19<sup>th</sup> century.<sup>32</sup> Of specific relevance to this case study on tuberculosis is that the 19<sup>th</sup> century political

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<sup>29</sup> James Daschuk, *Clearing The Plains: Disease, Politics of Starvation, and the Loss of Aboriginal Life* (Regina, University of Regina Press, 2013): 100.

<sup>30</sup> Ibid.

<sup>31</sup> Mary Jane Logan McCallum, "Starvation, Experimentation, Segregation, and Trauma: Words for Reading Indigenous Health History." *Canadian Historical Review* 98, no. 1 (2017): 101-102.

<sup>32</sup> Laurie Meijer Drees, "Training Aboriginal Nurses: The Indian Health Services in Northwestern Canada, 1939–1975; Paul Hackett, "From past to present: understanding First Nations health patterns in a historical context." *Canadian Journal of Public Health*. Vol. 96, Supplement 1, January-February 2005; Michel Hogue "Disputing the Medicine Line: The Plains Crees and the Canadian-American Border, 1876-1885." *Montana: The Magazine of Western History* (2002): 2-17; Mary-Ellen Kelm, *Colonizing bodies: Aboriginal health and healing in British Columbia, 1900-50*. (Vancouver: University of British Columbia Press, 1999); Mary Ellen Kelm, "Diagnosing the

ideologies of cultural inferiority of the Indigenous peoples continued to influence Indigenous health policies that were developed throughout the 20<sup>th</sup> century and into the 21<sup>st</sup> century.

The second book, Waldram, Herring & Young's *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives*, has proven instrumental in guiding the research in this case study.<sup>33</sup> The book is a comprehensive anthology of Indigenous health in Canada from the pre-contact period to the delivery of medical care in the 20<sup>th</sup> century. It provides an extensive review of government actions as Indigenous health is positioned at the centre of a multi-disciplinary analysis that includes a review of the anthropological, historical, cultural, social and economic conditions that continue to shape the lives of Indigenous peoples in Canada. The authors provide a contextual analysis of the diseases, the government programs that were implemented to manage them, and the capacity of the health system to deliver the care that was required. They argue that addressing the health needs of Indigenous peoples requires fundamental improvements in their socioeconomic status, an approach that demands government actions that lie beyond the health care system, including "providing a framework within the Canadian political system for the inherent right of self-determination."<sup>34</sup>

On the topic of tuberculosis, there is a wealth of literature that is rooted in the many historical accounts of the disease and epidemiological studies that track historical morbidity statistics and the evolution of treatment methods from sanatoria to the introduction of home-based chemotherapeutic

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discursive Indian: medicine, gender, and the 'dying race'", in *Ethnohistory* 52, no. 2. (2005); Maureen K. Lux, *Medicine that walks: Disease, medicine and Canadian Plains Native people, 1880-1940* (Toronto: University of Toronto Press, 2001); James R. Miller, *Skyscrapers hide the heavens: A history of Indian-white relations in Canada* (Toronto: University of Toronto Press, 2000): 262; John Milloy, *A National Crime: The Canadian Government and the Residential School System, 1879-1986* (Winnipeg: University of Manitoba Press, 1999); Hugh Shewell, *Enough to Keep Them Alive: Indian Welfare in Canada, 1873-1965* (Toronto: University of Toronto Press, 2004).

<sup>33</sup> James B. Waldram et al, *Aboriginal Health in Canada: Historical, Cultural, And Epidemiological Perspectives Second Edition*, (Toronto: University of Toronto Press, 2006).

<sup>34</sup> *Ibid*, 35.

and antibiotic chemo-antibiotic treatments.<sup>35</sup> While there is a large body of literature on the subject of health inequalities in Indigenous communities, there is a gap in the study of citizenship as an influence in the development of Indigenous health policies.

## V - METHODS

The anthropology of public policy (APP) is used to study the policy tools that the federal government employs to address health disparities in Indigenous communities. Since the federal government has the authority and the power within its governance structures to interpret the scope of its responsibility for Indigenous peoples, it uses this power to shape social change. On matters of health, the exercise of the federal government's power is evident in the policy tools that restrict access to health services and under which conditions it chooses to extend services as a last resort. The outcome is an ad-hoc patchwork policy approach to providing health services that relies on the discretionary authority of officials and leads to an inconsistent delivery of health services to Indigenous peoples across Canada.

APP provides a methodological framework to study the federal government's policy tools. It allows for the study of power and social change within the larger governmental processes where, as Shore states, domains of meaning and cultural worlds are created.<sup>36</sup> In this research, these cultural

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<sup>35</sup> Paul Farmer, *Infections and Inequalities: the modern plagues*. (London: University of California Press;1999); M. Gandy, M. (2003), "Life without germs: contested episodes in the history of tuberculosis", in *The return of the white plague: global poverty and the "new" tuberculosis*. (London: Verso, 2003); Stefan Grybowski, "Tuberculosis 2: history of the disease in Canada", in *Canadian Medical Association Journal*. 160 (7), 1999; Cassandra Kulmann and Chantelle A. Richmond, "Addressing the persistence of tuberculosis among the Canadian Inuit population: the need for a social determinants of health framework", in *The International Indigenous Policy Journal*, 2(1) 2011; Pamela Orr, "Adherence to tuberculosis care in Canadian Aboriginal populations: Part 1- definition, measurement, responsibility, barriers", in *International Journal of Circumpolar Health*, 70:2 2011; J. Rylance et al, "Priorities for tuberculosis research: a systematic review." *The Lancet, Infectious Disease*. 10:886-92 (2010); Frank J. Tester et al, "Structural violence and the 1962-1963 tuberculosis epidemic in Eskimo Point, NWT." *Études/Inuit/Studies* (2012): 165-185; George Wherrett, *The miracle of the empty bed*. (Toronto. University of Toronto Press, 1977).

<sup>36</sup> Cris Shore et al, *Policy Worlds: Anthropology and Analysis of Contemporary Power*, (New York, Bergahn Books, 2011): 1.

worlds are populated by government agents and they are the venues where ideology and domains of meaning are created and reflected in the work of policy decision-makers. It is not the Indigenous peoples who are the subject of this research, but the government itself: who were the major players involved in decision-making; their position of authority in the decision-making process; and their ideological values and beliefs about the role of Indigenous peoples in Canadian society. This thesis draws upon the works of Shewell, Weaver and Culhane Speck who conducted in-depth analyses of federal Indigenous policies in the 20<sup>th</sup> century.<sup>37</sup> In what could be interpreted as an APP approach, Shewell pulls back the curtain on the discretionary powers of the bureaucrats at Indian Affairs responsible for the management of social welfare programs until the 1960s. Weaver captures the backroom discussions and negotiations of the politicians and decision-makers involved in shaping the 1969 Draft Indian Policy White Paper. Culhane Speck documents the political ideology that influenced the Health Transfer Policy in the 1980s. This thesis will add to this body of work with an analysis of the federal government's response to tuberculosis in the post-War II era.

There is a field of study in the political sciences that is dedicated to policy analysis, and it is important at this point to clarify the difference between policy analysis and the anthropology of public policy approach. Wedel et al theorize that in political science, the dominant form of policy analysis uses a rational theory framework that evaluates, among other things, the efficiency of decision-making, the effectiveness of outputs and other indices that are commonly associated with evaluation frameworks. They point out that there are two general types of such policy analysis studies

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<sup>37</sup> Hugh Shewell, *Enough to Keep Them Alive": Indian Welfare in Canada, 1873-1965* (Toronto: University of Toronto Press, 2004); Sally M. Weaver, *Making Canadian Indian policy: the hidden agenda 1968-70*. Vol. 9. (Toronto: University of Toronto Press, 1981); Dara Culhane Speck, "The Indian Health Transfer Policy: A step in the right direction, or revenge of the hidden agenda", in *Native Studies Review* 5, no. 1 (1989): 187-213.

in public policy decision-making: the first conducts an in-depth assessment of a specific policy; and the second analyzes the effectiveness and efficiency of the process itself.<sup>38</sup>

The anthropology of public policy, on the other hand is rooted in critical theory, allowing for self-reflection and for the explicit introduction of factors that look at differential power and control.<sup>39</sup> This approach supports the findings put forward in this thesis that the federal government's policies represent much more than the words published in government documents and in the bureaucratic processes and authorities whose mandate it is to operationalize these policies. Using the anthropology of public policy, this thesis takes a two-fold approach by analyzing the values and beliefs that shape the policies, and by investigating the delegated power processes that are instituted to implement these policies within Canadian society.<sup>40</sup> It brings research beyond the scope of policy analysis and involves research into those individuals in whom discretionary power is delegated on behalf of the state.

### *Documentation*

In selecting the materials for analysis, sources were sought that have historical significance in Canadian history, that reflect major policy initiatives involving Indigenous peoples, and that add to the analysis of government intentions on health, social and citizenship issues. These documents include primary and secondary sources. Primary sources include: historical government documents and legislation such as the *British North America Act* (1867), the *Indian Act* (1876), the *Constitution Act* (1982) and the *Canada Health Act* (1984); records of Hansard and minutes of Parliamentary

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<sup>38</sup> Leslie A. Pal, *Beyond policy analysis: public issue management in turbulent times* (Toronto: Nelson Education, 2010); Deborah Stone, *Policy paradox: the art of political decision making* (New York: W. W. Norton, 1997).

<sup>39</sup> Janine R. Wedel et al, "Toward an anthropology of public policy", in *The ANNALS of the American Academy of Political and Social Science* 600, no. 1 (2005): 30-51.

<sup>40</sup> Wedel & al, "Toward an anthropology of public policy".

committee meetings; official government reports tabled in Parliament such as the Marsh Report (1943), the Hawthorn Report (1966) and the Draft Indian Policy White Paper (1969); as well as government publications such as annual reports of federal departments and reports of government committees such as the Parliamentary Standing Committee on Health. These historical documents and government reports are readily available through on-line archives of the federal government and Indigenous organizations. In addition, Library and Archives Canada has records of correspondence, briefing notes and subject reports from the departments of National Health and Welfare, Health Canada, and Indian and Northern Affairs Canada. Secondary sources include: academic articles that provide research into the events, discussions, and debates surrounding major government policy announcements; and background papers and position papers prepared by Indigenous organizations on issues of relevance to this thesis.

The use of annual reports as the archival documents of choice for this research project is based on two factors. The first factor is that this project tracked policy approaches over a period of seventy years. Policies are defined as “a course of action or inaction chosen by public authorities to address a given problem or set of problems”<sup>41</sup>. The notion of action and inaction implies that policy is a process, not just a one-time statement or document. Departmental annual reports are valuable archival documents that are released under the signature of the Minister as an account of the department’s commitment to the public, and as such, reflect government policy. Through annual program and expenditure reporting, they also offer an effective way to track policy actions. Policy inactions became apparent in the review of omissions and absences over the years.

The second factor was the limited access to federal Indigenous health policy documents. Searches of Library and Archives RG 29 records at the time of preparing this research provided files

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<sup>41</sup> Pal, *Beyond policy analysis: public issue management in turbulent times*, 2.

from 1940 to 1985 including files from the Medical Services Branch Central Registry. These documents had limited availability because the cataloguing of transferred files from the closure of Health Canada's departmental library was not complete. In addition, access to policy documents dated from 1985 were still restricted as confidential.

Annual reports, on the other hand, are public documents and available more widely, including in university libraries. The annual reports for National Health and Welfare from 1945-1946 and for Health Canada until 1991-1992 are also available online at the University of Saskatchewan Indigenous Studies Portal Research Tool [iportal](#). There is a gap in annual reports in the period from 1992-1993 when the federal government discontinued departmental annual reports until 1995-1996 when they were replaced with annual Departmental Performance Reports as part of the Main Estimates process. The First Departmental Performance Report for Health Canada was published in 1997 to cover the 1996-1997 fiscal year.

Unlike the department of Indigenous and Northern Affairs Canada which maintains a departmental library and provides access to Indigenous policy documents and reports such as the 1969 Draft Indian Policy on their website, Health Canada has no departmental library, and on matters of Indigenous health policy, its website does not provide access to archived public policy documents such as the original 1979 *Indian Health Policy* or the 1989 *Health Transfer Policy*. This discrepancy created a significant barrier to accessing relevant Indigenous health policy documents. As a result, secondary sources in academic literature served as a source of information for this research project.

The *Indian Act* was a fundamental document to explore who is an 'Indian' in federal policy and the enfranchisement process as part of the discussion of social rights and the inclusions and exclusions to health care services. Three Supreme Court Decisions were also relevant, including the 1939 Decision that Inuit were to be defined as 'Indians' for the purposes of the application of rights

under Section 91(24) of the *Constitution Act*, a definition that continues to be reflected in the current federal position on Indigenous health. Two other Supreme Court Decisions in the 1945-2015 timeframe were reviewed. Although the 1990 Sparrow Decision was not about health, it offered a reference for interpreting the scope of federal obligations to Indigenous peoples, and the April 2016 Decision that Métis and non-status Indians can also be defined as ‘Indians’ under Section 91(24) of the *Constitution Act* served to challenge the federal government’s position on Indigenous health care.

### *Indigenous identity*

The term “Indigenous” is used to collectively identify the three peoples referred to in the *Constitution Act*, and is used interchangeably with the term “Aboriginal” where appropriate. The term “Indian” is used to historically identify the group as defined in the *Indian Act* and in the *Constitution Act*. The term “First Nations” is used as the preferred designation that this group uses to identify themselves. The way that Indigenous peoples have been identified over the 20<sup>th</sup> and 21<sup>st</sup> centuries for policy purposes has undergone significant shifts. The federal government’s use of the terms ‘Aboriginal’, ‘Status Indians’, ‘Non-Status Indians’ and ‘First Nations’ has served to include and exclude specific Indigenous peoples from accessing certain health programs and services.

### *Challenges and limitations*

These fluctuations in nomenclature present challenges when tracking the federal government’s narrative over a period of seven decades. This research project uses the federal government’s perspectives on First Nations as the main narrative for the changing nature of the political ideology over the period under review. First Nations are the largest group, representing the main focus of the government’s attention, and the federal government’s reliance on the terminology

in Section 91(24), which identifies ‘Indians’ as their area of responsibility, skews national Indigenous policy primarily to the needs of First Nations, although at times the more comprehensive term ‘Aboriginal’ is used without specific reference to the scope of application.

This case study on tuberculosis presents yet another challenge, as it is influenced from two perspectives. From a policy perspective, services for Inuit are framed primarily as an extension to the overall federal approach, influenced by the 1939 Supreme Court of Canada decision that Inuit (Eskimo as they were called at the time) were to be defined as ‘Indians’ for the purposes of the application of rights under Section 91(24) of the *Constitution Act*.<sup>42</sup> With the creation of Nunavut in 1999, the federal government’s narrative changed to identifying government response for Inuit services as being the responsibility of the new territorial government.

From an epidemiological perspective, the federal government’s reports include information on all Indigenous peoples. They note that First Nations and Inuit communities are most affected with elevated rates of the disease as they share similar environmental and social conditions and because data from current research and government studies are readily available for both these groups. Reports by the Canadian Lung Association and the Public Health Agency of Canada confirm the overall tuberculosis rates among all Indigenous peoples. The rates among the Métis generally mirror the overall Canadian average. Although their rates are reported, the federal government’s tuberculosis policies and programs exclude Métis, as they are considered to be under provincial authority rather than federal. This position could change at some point in the future as a result of the April 2016 decision of the Supreme Court of Canada that Métis and non-status Indians can also be defined as

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<sup>42</sup> Supreme Court of Canada (SCC) Decision (1939) SCR 104 available at the SCC website: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/8531/index.do>

‘Indians’ under Section 91(24) of the *Constitution Act*.<sup>43</sup> Federal government policy does not yet reflect this latest decision, and therefore Métis-specific policies lie beyond the scope of this thesis.

Where it is necessary to present the views of Indigenous peoples, this research project remains respectful of their words and cautious about the use of western discourse that presents Indigenous peoples as “Other” in the analysis of power relationships <sup>44</sup>

## VI- DISSERTATION OUTLINE

**Chapter 2** explores Foucault’s notion of power and subjectivity within the framework of citizenship and the academic debate about Marshall’s model of social citizenship within the context of Foucauldian relations of power. Anthropology of public policy is discussed as a method to review government documents to determine the political motives and narratives behind the federal government’s position on Indigenous health care delivery in general, and on the provisions of tuberculosis programs targeted to Indigenous peoples.

**Chapter 3** explores the rise of the post-World War II Welfare State in Canada and the political discourse of economic opportunity and social equality including shifting public attitudes about the need to improve living conditions on reserve. A national universal health care system for all Canadians was the cornerstone of federal/provincial agreements. While tuberculosis rates in Canada were continuing to decline, this chapter looks at the government’s approach to the higher incidence of the disease that persisted in Indigenous communities throughout this time.

**Chapter 4** reviews the notion of rights-based Indigenous citizenship in Section 35 of the 1982 *Constitution Act* and the ideological narrative about the place of Indigenous health within the

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<sup>43</sup> Supreme Court of Canada (SCC) Decision 2016 SCC 12 available at the SCC website: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/15858/index.do>

<sup>44</sup> Linda Tuhiwai-Smith, *Decolonizing methodologies. Research and Indigenous Peoples* (London: Zed Books, 1999).

Canadian health care system that shaped the 1989 Health Transfer Policy. The government remained complacent in its response to tuberculosis until a resurgence of the disease in the early 1990s resulted in increased rates in First Nations and Inuit communities and the federal government was pressed to deal with the growing inequalities in the prevalence of the disease between Indigenous communities and non-Indigenous communities.

**Chapter 5** reviews the promise for an increased Indigenous voice in policy decision-making at the start of the new century against the backdrop of a shifting political environment in federal politics. The government's renewed efforts to address the persistent inequalities in the prevalence of tuberculosis in First Nations and Inuit communities fall short of eliminating the disease.

**Chapter 6** examines the consequences of the federal government's interpretation of who qualifies as an 'Indian' for health policy purposes, and concludes that this interpretation lies at the core of a political environment that remains unsuccessful in addressing the root causes of diseases like tuberculosis in Indigenous communities. Recommendations for federal action to remove barriers that are based on colonial categorizations of Indigenous identity are explored.

## CHAPTER 2

### CONCEPTUAL FRAMEWORK: STATE POWER AND CITIZENSHIP

Since the sixteenth century, a new political form of power has been continuously developing. This new political structure, as everyone knows, is the state. But most of the time, the state is envisioned as a kind of political power which ignores individuals, looking only at the interests of the totality, or, I should say, of a class or a group among the citizens. That's quite true. But I'd like to underline the fact that the state's power (and that's one of the reasons for its strength) is both an individualizing and a totalizing form of power.<sup>45</sup>

The Renaissance period in Europe that bridged the Middle Ages to modern history from the 14<sup>th</sup> to the 17<sup>th</sup> centuries is an important era in the development of Foucault's theories. It marked the rise of territorial monarchies and humanist movements that led to a new relationship between the state and the individual. Treatises on what Foucault calls the "art of government" began to appear. Political reflection touched on human activity covering all strata of society from "the smallest stirrings of the soul to the largest military maneuvers of the army. Each activity in its own specific way demanded reflection on how it could best be accomplished."<sup>46</sup> Rabinow maintains that Foucault's use of the word "best" in this context meant "most economical" and that governments became concerned with "the correct manner of managing individuals, goods and wealth within the family, how to introduce this meticulous attention of the father towards his family, into the management of the state."<sup>47</sup>

In Canada, it is the special nature of the nation-to-nation relationship between Indigenous peoples and the federal government that frames the discussion in this research project. It is a

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<sup>45</sup> Michel Foucault as cited in Hubert L. Dreyfus and Paul Rabinow. *Michel Foucault: Beyond structuralism and hermeneutics* (Chicago, University of Chicago Press, 2014): 213.

<sup>46</sup> Paul Rabinow, ed., *The Foucault Reader* (New York, Pantheon Books, 1984): 15

<sup>47</sup> Ibid.

relationship that pre-dates colonial governments and the state institutions that are in place today. When European powers established colonial governments in Canada, they reflected European values in state institutions. There were, however, peoples who already inhabited these lands with their own systems of governance, and colonial governments created different instruments of state control over both European settler communities and Indigenous communities. Arguably, today's federal structure of government in Canada is vastly different from France's republican model where Foucault's theories of state power are set. Nonetheless, they provide a valuable tool for analysis of state power since Canadian state institutions were based on European models.

The federal government's special relationship with the Indigenous peoples in Canada is often characterized in terms of citizenship. The inclusion and exclusion of Indigenous peoples as citizens of Canada has provided the federal government with a key mechanism for control. In colonial days, Indigenous peoples had to abandon their Indigenous status and treaty rights in order to become a Canadian citizen with the promise of better living conditions. The mid 20<sup>th</sup> century development of welfare states introduced the concept of government-provided social and health care services. Marshall's inclusion of social services as a distinct bundle of social rights in a model of citizenship that already recognized civil and political rights provides a valuable framework for the analysis of Indigenous health policies in Canada. It is through the inclusive-exclusive nature of citizenship rights, that is, which Indigenous individuals are entitled to receive which social services, that the separate instruments of state power over Indigenous peoples are distinguished.

Although there are many examples of racialization practices by the federal government, especially in categorizing Indigenous peoples as a sickly and inferior race, the notion of race and racialization theories are not emphasized in this research project because the nature of the relationship of Indigenous peoples with the federal government goes beyond racial distinction. It who

they are as separate peoples within Canadian society, and the nature of the unique relationship that is identified and protected in the Canadian constitution, that provides the backdrop for this research project. It is the perspective offered by Foucauldian theories of state power, and by Marshall's citizenship theories, which together provide the perspective from which to conduct this research.

This chapter examines Foucault's theory of state power and subjects as well as Marshall's notion of citizenship rights. In addition, the anthropology of public policy provides a framework to discuss the interpretation of federal policy instruments that perpetuate health, social and economic conditions in Indigenous communities.

## I. STATE POWER TO CREATE SUBJECTS

### *Citizens vs subjects*

Foucault introduces the principles of subjectification in the states' use of power over its citizens. Cruikshank argues that Foucault uses the word 'subject' to articulate a form of power that both 'subjugates' and 'makes subject to'<sup>48</sup> It is Tocqueville's depiction of the difference between citizens and subjects that has served as a benchmark to define democratic citizenship that is rooted in notions of power over individuals. Cruikshank describes how the citizen has the autonomy and the power to act, whereas the subject does not<sup>49</sup>

What is most important, undergirding the contest about what citizenship means, is that the self-evidence of critical categories such as citizen/subject makes it unnecessary to inquire into *how* power works to make subjects out of citizens and citizens out of subjects. If we fail to scrutinize the ways that citizens are made, we may completely overlook the constitutive discourses of citizenship that are characteristic of liberal democracies<sup>50</sup>.

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<sup>48</sup> Barbara Cruikshank, *The will to empower: Democratic citizens and other subjects*. (Ithaca: Cornell University Press, 1999): 21.

<sup>49</sup>Ibid, 23.

<sup>50</sup> Ibid, 24.

Foucault identifies three organizational technologies to describe the ways that a state defines and characterizes individuals as subjects: dividing practices; scientific classification; and subjectification. The first, dividing practices, involves the process of separating and excluding individuals, usually in a physical sense, but always in a social one. The selection of Indigenous peoples from the general Canadian population, for the purposes of excluding them from access to health services, contributed to their social and political marginalization. The second, scientific classification, arises from the aggregation of intimate data about separate individuals to create scientific knowledge about a group. In Canada, the federal government relied on scientific enquiry to justify policies that sustained the narrative that Indigenous peoples were a dying race and to assess their capabilities to adapt and assimilate as productive citizens into settler society.

According to Rabinow, it is Foucault's third mode, subjectification, that represents his most original contribution to this field of study. It concerns the "way a human being turns him-or herself into a subject."<sup>51</sup> This self-formation involves an external authority figure, usually the state or an agent of the state, that intervenes in an individual's conduct and social activities. On matters of Indigenous health throughout the 20<sup>th</sup> century, it was the proliferation of social science research by non-Indigenous scientists, rather than the Indigenous peoples themselves, upon which the federal government relied to define Indigenous peoples and the state of their health. As such, the scientific community became the external authority figures on Indigenous matters, and the combined efforts of dividing practices, scientific classification and subjectification were the tools used for the government's goals of assimilation and integration into settler society.

Indigenous peoples were considered a dying race that was culturally and genetically inferior to the European settlers, and they were deemed to be incapable of surviving the scourge of diseases

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<sup>51</sup> Rabinow, *The Foucault Reader*, 11.

that was spreading among the population.<sup>52</sup> These categorizations not only continue to influence the development of Indigenous health policies into the 21<sup>st</sup> century, they also impact the way that Indigenous peoples can access health care services. Even in its modern day application, the categorization of ‘Indian’ that was introduced in the *Indian Act* serves as the prime organizational technology with which the federal controls the health of individual Indigenous peoples and supports the federal government’s assimilationist goals.

*Scientific methods and the creation of Indigenous peoples as subjects*

Foucault argues that it is knowledge that informs the study of the power of government responses in modern times. Statistics in turn create the knowledge about individuals and societies that allows the state to use that knowledge to act as “an agent of the transformation of human life.”<sup>53</sup> The value of this knowledge is that it provides the state with information that can serve to interfere into the personal lives of its citizens for the purposes of facilitating the state’s governance over societies. The introduction of this new political form of power during the Renaissance coincides with European powers’ colonial administrations, including in North America, where they established similar institutions and forms of state power.<sup>54</sup> Within this context of increased state knowledge about individuals, state intervention extends to the human body as an object to be manipulated and controlled by using a set of systems and processes - what Foucault calls “technologies”- to link statistical knowledge and state power.

Foucault further argues that the aim of governing individuals is that it allows the shaping of a

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<sup>52</sup> These themes are discussed in: Tobias, “Protection, civilization, assimilation: An outline history of Canada’s Indian policy.”; Kelm, “Diagnosing the discursive Indian: medicine, gender, and the ‘dying race’.”

<sup>53</sup> Michel Foucault, *The History of Sexuality*, Vol. I (1976; New York: Pantheon, 1978), p. 143.

<sup>54</sup> For more historical information on the colonial voyages of European states, see Alan Taylor, *American Colonies: The Settling of North America -The Penguin History of the United States, Volume*. (Penguin Random House, 2002).

"docile body that may be subjected, used, transformed and improved."<sup>55</sup> One of the ways that bodies can be shaped is through the use of discipline. He explains how discipline arises from organizational technologies that organize individuals within a given space. Using the prison system, he demonstrates that this can be accomplished through processes such as the rigid standardization of scheduled actions over time, and through the strict control of the space that individuals are allowed to occupy.<sup>56</sup>

In Canada, Kelm expands Foucault's concepts of power and argues that these organizational technologies were used by the federal government to disrupt Indigenous cultural systems that existed at the time of contact in order to create what she refers to as "weakened bodies."<sup>57</sup> The relocation of Indigenous peoples to isolated reserves provided the federal government the power to organize these individuals within a space that was selected to suit the goals of the state, and whose boundaries were regulated by the state. These spaces profoundly impacted the living conditions of Indigenous peoples by assigning them to non-productive land, restricting their access to traditional hunting and fishing grounds, and encouraging the consumption of non-Indigenous foods.

Kelm attributes a direct link between the weakening of Indigenous bodies to the state's motivation to lessen Indigenous resistance to the process of colonization. "Take away a people's access to adequate quantities of nutritious food, and soon you have a population of weakened bodies who must struggle just to survive, who cannot band together to make change, to fight back".<sup>58</sup> Daschuk's analysis of Prime Minister John A. Mcdonald's government's starvation policies in the late 19<sup>th</sup> century reveals how he purposely withheld food and restricted access to financial resources to force Indigenous peoples to accept the relocation to isolated reserves in order to survive. They

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<sup>55</sup> Michel Foucault, *Discipline and Punish* (New York, Second Vintage Books Edition, 1995): 198.

<sup>56</sup> Ibid.

<sup>57</sup> Mary-Ellen Kelm as cited in: Lisa Helps, *Body, Power, Desire: Mapping Canadian Body History*, *Journal of Canadian Studies/Revue d'études canadiennes*, Volume 41, Number 41, Winter 2007: 139.

<sup>58</sup> Ibid

were promised that relocation would give them access to the necessities of life.<sup>59</sup>

The 19<sup>th</sup> century witnessed an increase in the use of statistical measures and scientific knowledge to inform government policy actions. Rather than using moral measures of right and wrong, scientific advances in medicine, psychiatry, and social sciences led to what Foucault calls ‘normalization’ of what was to be considered normal in a given population. Individual citizens became ‘subjects’ for scientific purposes as data were gathered about every aspect of their behavior through the state’s use of statistics and surveillance data. Aggregated data about a population was then used by the state to characterize population groups and to calculate gaps between individuals in any given population.<sup>60</sup> Rabinow concludes that the use of this data gives the state the power to not only to define and characterize individuals, but to produce “an increasingly totalizing web of control” over these individuals.<sup>61</sup>

#### *Identification of ‘Indians’ under the Indian Act*

The federal government continues to define its relationship with Indigenous peoples by exercising state powers that date back to colonial regimes. In mid 19<sup>th</sup> century, the British Colonial Office shifted its priorities from securing territorial acquisitions to managing the affairs of the individuals who occupied these lands. As Titley explains, political priorities then shifted to what they identified as an ‘Indian problem’, that is, what to do with the Indigenous peoples who lived in Canada.<sup>62</sup> The 1876 *Indian Act* allowed the colonial government to identify and categorize a separate class of individuals called ‘Indians’ that they deemed would require civilization and assimilation

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<sup>59</sup> James W. Daschuk, *Clearing the plains: Disease, politics of starvation, and the loss of Aboriginal life*. (Regina, University of Regina Press, 2013): 100.

<sup>60</sup> Foucault, *Discipline and Punish*, 190.

<sup>61</sup> Rabinow, *The Foucault Reader*, 22.

<sup>62</sup> Brian E. Titley, *A narrow vision: Duncan Campbell Scott and the administration of Indian affairs in Canada* (Vancouver, University of British Columbia Press, 1986): 4.

before they could assume citizenship. Throughout the history of Canada, the federal government used different policy instruments to establish control and surveillance over Indigenous peoples. The 1876 *Indian Act* gives the federal government the power to determine who is an ‘Indian’, and the status that these individuals hold as citizens in Canadian society.

### *Who is an ‘Indian’*

The Marshallian concept of social citizenship provides an interesting framework with which to review the *Indian Act* and Section 91(24) of the *BNAA*. These two documents remain the foundation on which the federal government relies to define the rights to which Indigenous peoples are entitled. Weaver contends that in addition to bestowing the federal government with the power to decide who is an ‘Indian’ for purposes of eligibility to access federal programs, services and benefits, the *Indian Act* also serves as the only legislative record of government policy on Indigenous rights<sup>63</sup>

The federal government created a register to keep track of the individuals that meet the criteria outlined in the *Indian Act*.<sup>64</sup> The responsibility to maintain the Indian Register rests with Indigenous and Northern Affairs Canada and is the official record identifying all Registered Indians according to the terms of the *Indian Act*. In policy documents, registered Indians are sometimes also referred to as status Indians. Foucault would argue that the Indian Register, and the position of the Registrar that oversees the process, serve as a political technology to enforce state control over a specific population group.<sup>65</sup> The classification of ‘Indians’ as a specific group worthy of government scrutiny is an example of the objectification of a group of selected

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<sup>63</sup> Weaver, *Making Indian Policy in Canada: The Hidden Agenda 1968-1970*.

<sup>64</sup> *The Indian Register*. Indigenous and Northern Affairs Canada website: <https://www.aadnc-aandc.gc.ca/eng/1100100032475/1100100032476>.

<sup>65</sup> Foucault, *Discipline and Punish*, 209-210.

individuals drawn from a more homogenous population and given an identity through these dividing practices.<sup>66</sup>

The Indian Register also serves to exclude others that do not meet the terms of the *Indian Act* thereby segregating the ‘Indian’ designation of Section 91(24) into two sub-groups: status and non-status Indians. These exclusions are based on social grounds, as was the case of before 1985 when Indian women ‘lost’ their status when they married a non-Indian man. These designations are administrative and arbitrary, but their impact in policy is significant. On matters of health policies, the federal government has maintained that their responsibility applies only to Status Indians who live on reserve. This means that any individual who is not a Status Indian, or who is a Status Indian who lives off-reserve, is deemed to be outside their area of jurisdiction and is therefore the responsibility of the provinces as ‘Subjects of Exclusive Provincial Legislation’ in accordance with Section 92 of the *BNAA*. This supports a de facto form of assimilation of Indigenous people to mainstream society.<sup>67</sup>

The Section 91(24) government-created definition of who qualifies as an ‘Indian’ for the purposes of federal authority has been challenged. In 1939, the government of Québec argued that they had no jurisdiction over Inuit who lived in their province, a challenge that was brought to the Supreme Court of Canada (SCC). The SCC issued a decision that Eskimo (as Inuit were known at the time) were to be defined as ‘Indians’ for the purposes of the application of rights under Section 91(24) of the *Constitution Act*.<sup>68</sup> Following the Supreme Court decision, the government has funded Inuit health programs across Canada. The recognition of Inuit in the

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<sup>66</sup> Michel Foucault, "The subject and power", in *Critical inquiry* 8, no. 4 (1982): 777-795.

<sup>67</sup> Waldram, *Aboriginal health in Canada: historical, cultural, and epidemiological perspectives*.

<sup>68</sup> Supreme Court of Canada (SCC) Decision (1939) SCR 104 available at the SCC website: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/8531/index.do>

current name of the Health Canada branch that is responsible for Indigenous health, the First Nations and Inuit Health Branch, attests to the federal commitment to that decision.

Bill C-31, an amendment to the Indian Act, was enacted in 1985 to address gender discrimination. Indian women who had lost their status due to marriage would regain their status, as well as other Indians (men and women) who had been forcibly enfranchised due to previous discriminatory practices were also able to regain their status. More recently, in April 2016, the Métis and non-status Indians won a court case that they are also to be considered as ‘Indians’ as defined under Section 91(24) of the *Constitution Act*.<sup>69</sup> There has not yet been federal policy action on this decision.

With respect to the federal government’s position on Indigenous health, the Supreme Court decisions on the Inuit and the Métis, in addition to Bill C-31 reinstatements could be interpreted that all Indigenous peoples in Canada should be included in the definition of who is an ‘Indian’ under the terms of the *Constitution Act*. Yet, the federal government’s tuberculosis policy continues to pursue a segregated approach by selectively targeting its programs and resources to First Nations peoples who live on-reserve, but only in very specific First Nations communities located in specific areas across the country<sup>70</sup>

### *Assimilation through citizenship*

Foucault argues that elements of meaning in information that is transmitted by the state can have as their objective, or as their consequence, certain results in defining the scope of the state’s power.<sup>71</sup> Arguably, the effects of government actions therefore go beyond the written and spoken

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<sup>69</sup> Supreme Court of Canada (SCC) Decision 2016 SCC 12 available from the SCC website: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/15858/index.do>

<sup>70</sup> Health Canada, *Health Canada’s Strategy Against Tuberculosis for First Nations On-Reserve*.

<sup>71</sup> Foucault, "The Subject and Power", 782.

word. Assimilation was clearly identified as the goal of early colonial policies, and although the narrative of Indigenous policy may have shifted over the 20<sup>th</sup> century, the overall assimilationist goals of the federal government are still evident beyond the written word.

Titley maintains that mid-19<sup>th</sup> century was an important turning point in Indigenous-government relationships. The goal of the government's Indigenous policies shifted from managing the lands, to managing the affairs of the Indigenous peoples who occupied these lands. To this end, in 1857, the British government introduced the *Act for the Gradual Civilization of the Indian Tribes in the Canadas*<sup>72</sup> which offered parcels of land and monetary inducements to Indigenous individuals who were deemed to be literate and debt-free on the condition that they abandoned their traditional lifestyle and adopted a "civilized" life as a "citizen".<sup>73</sup> Being 'civilized' meant that they accepted their assimilation into European society and culture. This legislation set the framework for the assimilation policies that followed.

The British Colonial Office identified an 'Indian problem' as they struggled on the question of what to do with the Indigenous peoples in Canada.<sup>74</sup> British officials recognized the 'perilous situation' of overcrowded and poorly ventilated houses that bred a host of diseases, including tuberculosis, but failed to recognize that it was their own strategy to rush the assimilation and to populate western lands with European settlers, while trying to incur the least expense possible, that was responsible for creating the conditions.<sup>75</sup> Titley explains that the hoped-for result was that Indigenous peoples would be "self-supporting individuals who were indistinguishable from their fellow citizens."<sup>76</sup>

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<sup>72</sup> A copy is available at: <http://www.thecanadianencyclopedia.ca/en/article/gradual-civilization-act/>

<sup>73</sup> Titley, *A narrow vision: Duncan Campbell Scott and the administration of Indian affairs in Canada*, 3.

<sup>74</sup> *Ibid*, 4.

<sup>75</sup> Lux, *Medicine that walks: Disease, Medicine and Canadian Plains Native people, 1880-1940*, 4.

<sup>76</sup> Titley, *A narrow vision: Duncan Campbell Scott and the administration of Indian affairs in Canada*, 3.

When the 1867 *BNAA* completed the transfer of full responsibility for the management of Indigenous peoples to the new Dominion Government, it also symbolically severed the direct ties between Indigenous peoples and the British government. The British government's relationship with Indigenous peoples predates the colonial governments' that had been established to govern the colonial provinces of Upper and Lower Canada. King George III signed the Royal Proclamation on October 7, 1763 to integrate the newly acquired French territories into the British Empire. With the end to the French-British hostilities now extending to North America, the document heralded a new era in approach for the settlement of lands. More importantly, the Royal Proclamation was a defining document in establishing the relationship between Aboriginal and non-Aboriginal populations.

The Royal Proclamation created a new administrative structure that included the definition of the lands west of the established colonies as "Indian Territories" and the edict that all these lands were lands under the sovereignty and protection of the Crown for the use of Indigenous peoples.

And We do further declare it to be Our Royal Will and Pleasure, for the present as aforesaid, to reserve under Our Sovereignty, Protection, and Dominion, for the Use of the said Indians, all the Lands and Territories not included ... within the Limits of the Territory granted to the Hudson's Bay Company, as also all the Lands and Territories lying to the Westward of the Sources of the Rivers which fall into the Sea from the West and North West, as aforesaid; and We do hereby strictly forbid, on Pain of Our Displeasure, all Our loving Subjects from making any Purchases or Settlements whatever, or taking Possession of any of the Lands above reserved, without Our especial Leave and Licence for that Purpose first obtained.<sup>77</sup>

The Royal Proclamation established the premise that all land transactions were to be conducted between the Crown and "assemblies of Indians", not directly with settlers, and could only be acquired by either a treaty or by purchase by the Crown. As such, it is the Indigenous perspective that

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<sup>77</sup> Available at: <https://www.aadnc-aandc.gc.ca/eng/1370355181092/1370355203645#a6>

... the Proclamation portrays Aboriginal nations as autonomous political units living under the Crown's protection and on lands that are already part of the Crown's dominions. Aboriginal nations hold inherent authority over their internal affairs and the power to deal with the Crown by way of treaty and agreement. In a word, it portrays the links between Aboriginal peoples and the Crown as broadly 'confederal'.<sup>78</sup>

On Indigenous matters, the Dominion Government stepped into the shoes of the British Colonial Office. With a stroke of the legislative pen, Indigenous peoples in Canada were now to be governed by the same settler population against whom the Royal Proclamation had deemed it necessary to offer them protection one hundred years earlier. The legacy of that relationship was the fact that the responsibility for Indigenous peoples would not be delegated to the provinces, but would remain with the Dominion Government under Section 91(24) of the *BNAA* that gave the Parliament of Canada the legislative authority over “Indians and lands reserved for the Indians”.<sup>79</sup> It is the only population group mentioned in the *BNAA*.

The first major change in Indigenous policy came nine years later when the Dominion Government enacted the *Indian Act* in 1876 that consolidated the existing provisions in the *Gradual Civilization Act* (1857), the *Indian Lands Act* (1860), and the *Gradual Enfranchisement Act* (1869). It is the language that was employed in these legislative documents, and that was replicated in the *Indian Act*, that is of consequence in this research project, as it reflects settler values and beliefs about Indigenous peoples. This legislation may now seem archaic, but the need to ‘civilize’ and ‘enfranchise’ Indigenous peoples as described in these documents was instrumental in creating the assimilation ‘domains of meaning and the cultural worlds’<sup>80</sup> that shaped health and social policies, as well as the management of the tuberculosis inequalities into the 21<sup>st</sup> century. More importantly, these pieces of legislation continue to provide the foundations

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<sup>78</sup> Canada. Royal Commission on Aboriginal Peoples, *Volume 1 - Looking Forward Looking Back, Part One - The Relationship in Historical Perspective* (Ottawa: Supply and Services Canada, 1996)

<sup>79</sup> Available at: : <http://laws-lois.justice.gc.ca/eng/const/page-4.html>

<sup>80</sup> Shore et al, *Policy worlds: Anthropology and the analysis of contemporary power*: 1.

upon which the federal government determines policy priorities and allocates resources to implement health programs.

## II. CITIZENSHIP AS A POLICY INSTRUMENT

Before examining the classification and designation of Indigenous peoples in Canada, it is important to review the concepts behind citizenship.

### *Background*

Citizenship is a concept that dates back to ancient Greece but has evolved over the centuries. Isin and Turner identified four meanings of what the term ‘citizenship’ has come to mean in the 21<sup>st</sup> century.<sup>81</sup> The first and most familiar meaning is that a citizen has political and civil rights to vote in national elections, to hold elected office, to have the right to a fair trial, and to serve on juries. The second meaning is understood as possessing ‘nationality’ under a specific state where some basic rights are protected, regardless if those rights include rights of political participation such as voting. The third meaning is general in nature and refers to citizens as those people who decide to join and belong to a community such as a neighbourhood, an institution, or any broad political community. Finally, the fourth meaning is value-driven and refers to certain standards of proper conduct, as in the case of ‘citizenship’ awards for community service. For the purposes of this research project, citizenship is discussed within the context of the first two meanings, that is, a person with civil and political rights, and a person who possesses nationality within a nation-state.

By the mid-20<sup>th</sup> century, citizenship in western countries had evolved to represent certain rights and obligations allocated to individuals. In addition to civil rights (free speech and movement,

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<sup>81</sup> Engin F. Isin and Bryan S. Turner, eds. *Handbook of citizenship studies*. (London, Sage, 2002): 105.

the rule of law) and political rights (voting, seeking electoral office), the notion of social rights (education, welfare, and health care) was introduced. It did not necessarily follow, however, that these rights were applied universally to all citizens, an observation that was put forward by Marshall in 1949 when he offered a new model for citizenship in a modern state.<sup>82</sup> He noted that citizenship in Britain at that time was composed of bundles of rights that had evolved historically, beginning with the growth of civil rights during the 18<sup>th</sup> century and followed by political rights in the 19<sup>th</sup> century. He argued that it was fitting that in the 20<sup>th</sup> century social rights be introduced as a third bundle of rights that comprised citizenship.<sup>83</sup>

It was Marshall's understanding of the universal nature of state-run social programs in the emerging welfare state in Britain after World War II that influenced this new interpretation. The spectrum of social rights that Marshall introduced was less defined than the existing list of civil and political rights, and was intended to cover "the whole range from the right to a modicum of economic welfare and security, to the right to share to the full in the social heritage and to live the life of a civilized being, according to the standards prevailing in the society".<sup>84</sup> He argued that political and civil rights did not go far enough in guaranteeing what an ideal society should look like, and that social rights were a means to addressing the economic inequalities that he had observed among the different social classes in Britain.

...there is a kind of basic humanity associated with the concept of full membership of a community – or, as I should say, of citizenship – which is not consistent with the inequalities which distinguish the various economic levels in the society. In other words, the inequality of the social class system may be acceptable provided the equality of citizenship is recognized.<sup>85</sup>

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<sup>82</sup> Thomas H. Marshall, *Citizenship and Social Class and other essays*, (London, Cambridge University Press, 1950).

<sup>83</sup> Marshall, *Citizenship and Social Class and other essays*, ix.

<sup>84</sup> *Ibid*, 8

<sup>85</sup> *Ibid*, 6.

It was the inherent injustices of inequalities between classes against the perceived equality of citizenship that inspired Marshall to identify social rights as an integral citizenship right. His concern was that inequalities had become so firmly accepted that citizenship had itself become “the architect of legitimate social inequality”<sup>86</sup> Citizenship should represent the status that is bestowed on those who are full members of a society, and that those who possess this status should be considered equal with respect to the rights and duties that flow from that status. Since he found no universal principle that defines what those rights and duties should be, he argued that citizenship should be an ‘ideal’, one whose ultimate goal is equality: “societies in which citizenship is a developing institution should create an image of an ideal citizenship against which achievement can be measured and towards which aspiration can be directed.”

### *Citizenship rights and the Constitution*

One place where a citizen could expect to see their citizenship rights entrenched would be in the country’s constitution. Marshall’s arguments for an ‘ideal citizenship’ did not materialize for Indigenous peoples with the government’s inclusion of a new definition of Aboriginal peoples and the recognition of Aboriginal rights in Section 35 of the 1982 *Constitution Act*.<sup>87</sup> The revision of the document should have offered the opportunity for a renewed concept of citizenship for Indigenous peoples. The designation of Aboriginal peoples as a population category in Canada was new, and appeared to be inclusive of Indians, Inuit and Métis individuals in Canada. Yet, this definition offered no clarity of the government’s responsibility towards, or the extension of rights and benefits to, the individuals in this new category. Future policies involving the delivery of health services and benefits specifically excluded certain Indian and Inuit individuals depending on whether they were status or

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<sup>86</sup> Ibid, 7.

<sup>87</sup> Available at: <http://laws-lois.justice.gc.ca/eng/Const>

non-status and depending on their place of residence. Additionally, although they are identified as an Aboriginal people in Section 35, the federal government never recognized a responsibility to provide health services to Métis. Even recognition as citizens within the Canadian Constitution offered no guarantee to equal access to the rights and benefits that accrue from citizenship.

With respect to the principle of equality, there continues to be a disconnect between the identification of an Indigenous population in Canada and the continued inequalities that persist among the Indigenous groups for the purposes of health policy. The federal government's position on its responsibility for the health of Indigenous people did not change as a result of the introduction of Section 35. The federal government continues to choose to define its role based on two principles. The first principle is the federal government's very limited interpretation of who is an 'Indian' under a separate section of the 1982 *Constitution Act*, section 91(24), the wording of which dates back to the 1867 British North America Act (BNA). Under that section, federal responsibility for 'Indians and lands reserved for the Indians' is assigned as a federal responsibility.<sup>88</sup> The wording for this section was not amended when the *Constitution Act* was revised in 1982. The second principle is the government's interpretation that health is a provincial responsibility under section 91 (7) of the *Constitution Act* which assigns provincial responsibility for "The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals."<sup>89</sup>

The federal government's interpretation appears consistently throughout the National Health and Welfare and Health Canada annual reports where Indigenous peoples are expected to access health services from provincial agencies. The legal arguments concerning the impact of Section 35 on Section 91(24) are outside the scope of this research project. However, it is worthwhile to note that

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<sup>88</sup> Available at: <http://laws-lois.justice.gc.ca/eng/Const/page-4.html>

<sup>89</sup> Ibid.

the 1990 Supreme Court Sparrow decision addressed the impact of Section 35 (1) on the meaning of the exclusive federal legislative authority over “Indians, and Lands reserved for the Indians” in section 91(24).

It is clear, then, that s. 35(1) of the *Constitution Act 1982* represents the culmination of a long and difficult struggle in both the political forum and the courts for the constitutional recognition of aboriginal rights. The strong representations of native associations and other groups concerned with the welfare of Canada's aboriginal peoples made the adoption of s. 35 (1) possible and it is important to note that the provision applies to the Indians, the Inuit and the Métis. Section 35 (1), at the least, provides a solid constitutional base upon which subsequent negotiations can take place. *It also affords aboriginal peoples constitutional protection against provincial legislative power.*<sup>90</sup> (*italics added for emphasis*)

Although the subject of the Sparrow case was about fishing rights, the Supreme Court's interpretation appears to indicate that the federal role to protect Indigenous peoples extends to all three groups and to protect against provincial power. The review of federal health policies in the chapters that follow offers different policy circumstances when it comes to the provision of health services, as it is the federal government that is persuading Indigenous peoples to access provincial services, representing a deliberate policy action on the part of the federal government, as opposed to the actions of an individual First Nation person. The motives behind the federal government's actions remain clear - the transfer of responsibility for Indigenous health to the provinces, and the withdrawal of federal involvement in the provision of Indigenous health services.<sup>91</sup> Inequalities in health confirm there is in fact a “disconnect” between policy and reality:

Considering that Aboriginal Peoples experience an overall inferior health status when compared to the non-Aboriginal population, it is not surprising that various recent studies on Aboriginal health and health care have found a “disconnect” between Aboriginal Peoples and Canadian governments that accounts for this poor health status.<sup>92</sup>

Following the recognition of Aboriginal rights in Section 35 of the 1982 *Constitution Act*,

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<sup>90</sup> <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/609/index.do>

<sup>91</sup> Ibid, 28

<sup>92</sup> University of Saskatchewan et al. *First Nations, Métis and Inuit Health Care: the Crown's Fiduciary Obligation*. National Aboriginal Health Organization, 2004: 31

there are indications that the “disconnect” in health policy became part of the federal government’s political narrative on Indigenous policy. A commitment to hold federal-provincial constitutional conferences with Indigenous peoples on matters of concern to them is an obligation that derives from Section 35 (1) of the 1982 *Constitution Act*.<sup>93</sup> The first Federal-Provincial Conference of First Ministers on Aboriginal Constitutional Matters took place in March 1984. The agenda for that meeting included: the entrenchment of Aboriginal rights in the Constitution; native self-government, sexual equality, title and treaty rights, land and resources for communities.<sup>94</sup> Although health was not a separate topic on the agenda, Prime Minister Trudeau expressed concern “that the life expectancy of Aboriginal Peoples was ten years less than the population as a whole; suicides, particularly in the 15-24 age group, were more than six times the national rate and one in three families lived in overcrowded conditions”<sup>95</sup> He further noted the perceived injustices that these inequalities represent.

These statistics illustrate that aboriginal peoples have long been victims of severe injustices that are not tolerable in Canadian society... But perhaps the greatest injustice is the hard fact that their condition has been almost totally ignored by the mainstream society, including its governments.<sup>96</sup>

A similar tone of concern was expressed by Prime Minister Mulroney at the next Federal-Provincial Conference of First Ministers on Aboriginal Constitutional Matters in April 1985. The agenda for that meeting was again the entrenchment of the principle of native self-government in the Canadian constitution.<sup>97</sup> This time, although social determinants were not an agenda item for

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<sup>93</sup> Justice Canada website: <http://laws-lois.justice.gc.ca/eng/const/page-16.html#docCont>

<sup>94</sup> Library of Parliament, *Constitutional Conferences*. Available at the Parliament of Canada website:

<http://www.lop.parl.gc.ca/parlinfo/compilations/Constitution/ConstitutionalConferences.aspx>

<sup>95</sup> University of Saskatchewan et al., *First Nations, Métis and Inuit Health Care: The Crown's Fiduciary Obligation*. National Aboriginal Health Organization, 2004: 31.

<sup>96</sup> Statement by Prime Minister Trudeau at the March 1984 Federal-Provincial Conference of First Ministers on Aboriginal Constitutional Matters. As cited in: University of Saskatchewan et al, *First Nations, Métis and Inuit Health Care: The Crown's Fiduciary Obligation*. National Aboriginal Health Organization, 2004: 31.

<sup>97</sup> Library of Parliament. *Constitutional Conferences*:

<http://www.lop.parl.gc.ca/parlinfo/compilations/Constitution/ConstitutionalConferences.aspx>.

discussion within constitutional terms, the Prime Minister nonetheless addressed links between socio-economic inequalities and Indigenous rights:

Improvements to the economic and social circumstances of aboriginal peoples must be pursued at the same time as changes to our constitution are sought to define the rights of aboriginal peoples. Action is required on both fronts and these two sets of endeavours, while separate, are mutually supportive ...<sup>98</sup>

These statements from two different prime ministers representing two different political parties, reveal differing perceptions as to the root causes of health inequalities. Prime Minister Trudeau focused on the social and political injustices that led to health and social inequalities, while Prime Minister Mulroney raised the importance of addressing the socio-economic conditions. The disconnect between policy and reality as is evidenced in unequal health status, and the interpretations of its causes, can also be expressed within the context of citizenship rights and the place of Indigenous peoples in Canadian society. The constitutionality of the federal government's position on Indigenous health is challenged:

Such a characterization is a discriminatory reading of Canada's commitments to provide the highest attainable standard of physical and mental health to *all* residents of Canada and to facilitate reasonable access to health services without financial or other barriers based on need... One only has to look at the unequal health status to witness how government discretion has been exercised... Given the equality provisions of the *Charter of Rights and Freedoms*, one must surely expect that Aboriginal Peoples are entitled to the same standards of health as Canadians generally.<sup>99</sup>

This introduces an important perspective on the Marshallian concept of equality of social rights. It goes beyond the notion of equal rights as meaning equality in accessing health services (which is about process), to the notion of equal rights meaning entitlement to the same health standards (which is about outcomes). Based on that principle, the disparities in health status

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<sup>98</sup> Statement by Prime Minister Mulroney at the April 1985 Federal-Provincial Conference of First Ministers on Aboriginal Constitutional Matters. As cited in: University of Saskatchewan et al, *First Nations, Métis and Inuit Health Care: The Crown's Fiduciary Obligation*. National Aboriginal Health Organization, 2004: 32.

<sup>99</sup> University of Saskatchewan et al, *First Nations, Métis and Inuit Health Care: The Crown's Fiduciary Obligation*. National Aboriginal Health Organization, 2004: 35.

between Indigenous and non-Indigenous peoples is an indication that Indigenous peoples are not being treated as equals to other citizens in Canada. Ironically, while the federal government's 1979 Indian Health Policy recognizes and affirms the government's unique constitutional obligations to Indigenous Peoples, it fails to implement these obligations for health care by virtue of the principles entrenched in the 1974 Health Policy that limited its responsibility to being the 'payer of last resort', ensuring only "the availability of services by providing it directly where normal services [were] not available and giving financial assistance to indigent Indians to pay for necessary services."<sup>100</sup> Health Canada's 2012 *Strategy Against Tuberculosis for First Nations On-reserve*,<sup>101</sup> with its ad-hoc patchwork policy approach to select groups of First Nations individuals who live in specific First Nations communities in geographically dispersed locations across the country based on the availability of provincial tuberculosis services,<sup>102</sup> is an indication that the federal government is still maintaining a payer of last resort approach. Other Indigenous peoples are on their own and expected to obtain services from provincial agencies.

### *Critiques of social citizenship*

Marshall's arguments about the need to identify social rights as deriving from citizenship sparked academic debates that continue into the 21<sup>st</sup> century. His essay was released in 1950, at a time when there was a renewed sense of optimism as soldiers returned home at the end of World War II (WWII), and when countries like Britain and Canada were adjusting to peacetime prosperity. For that reason, Marshall's critics argue that his concept of social citizenship is a dated notion that has not stood the test of time. Brodie explains that one of the reasons that social rights as defined by Marshall have not prevailed as an integral part of citizenship is because they are more ambiguous than the

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<sup>100</sup> Ibid, 32-33.

<sup>101</sup> Health Canada. *Health Canada's Strategy Against Tuberculosis for First Nations On-reserve*.

<sup>102</sup> Ibid.

legally embedded civil and political rights. As a result, “neo-liberal rationalities of government at the end of the twentieth century systematically attempted to dismantle social programs, erode other forms of collective provision, and dismiss citizen claims-making...”.<sup>103</sup>

By introducing the concept that social rights were an integral element of citizenship, Marshall sought to justify social rights as universal, and therefore an element of equal rights for all citizens. King and Waldron question the normative claims of Marshall’s ideal model.<sup>104</sup> Marshall’s assessment of citizenship looks at equality and universality as ideals in a model society by addressing the patterns of social inequality that are inherent in the capitalist system. He also suggested that citizenship implies that there should be no stigma attached to the use of public services, and no public attitudes condemning dependency.<sup>105</sup> Prime Minister Pierre Trudeau’s reference to the Canadian ‘ideal’ in his address on the occasion of the signing of the new *Constitution Act* on April 17, 1982<sup>106</sup> suggested a Marshallian notion of ideal citizenship that “societies in which citizenship is a developing institution should create an image of an ideal citizenship against which achievement can be measured and towards which aspiration can be directed.”<sup>107</sup>

Lister, on the other hand, argues that there is an exclusionary feature to Marshall’s concept of universality, that his notion of social rights is based on the false universalism of mid-20<sup>th</sup> century social values upon which rest the traditional concept of citizenship as being male, white and heterosexual. She argues that social rights should encompass the concepts of universal differentialism and inclusivity that would lead to a reformulation of the traditional concept inherent in Marshall’s

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<sup>103</sup>Janine Brodie, "The social in social citizenship." *Recasting the social in citizenship* (Toronto, University of Toronto press, 2008): 22-23.

<sup>104</sup> King and Waldron, *Citizenship, Social Citizenship and the Defence of Welfare Provision*, 422.

<sup>105</sup> King and Waldron, *Citizenship, Social Citizenship and the Defence of Welfare Provision*, 422 (Note 26).

<sup>106</sup> Prime Minister Pierre Trudeau’s remarks at the Proclamation Ceremony April 17, 1982:

<http://www.collectionscanada.ca/primeministers/h4-4024-e.html>

<sup>107</sup> Marshall, *Citizenship and social class*, 28

theory.<sup>108</sup> This reformulation would ensure an individual who comes from one or more of the many different groups in society that are often marginalized or excluded (including women, children, individuals from different races, individuals experiencing poverty, individuals experiencing disabilities) is included as a citizen on an equal basis.<sup>109</sup>

Implicit in Marshall's definition of social citizenship is the assumption that social rights should be available to all those who possess citizenship status. This implies that there is an empirical connection between social rights and effective participation by everyone as citizens, and that social equality leads to better citizenship. King and Waldron argue that there are limitations that make social rights vulnerable to the political changes that transform the commitment for state involvement in social programs.<sup>110</sup> This was the case in the 1980s and the 1990s when austerity measures resulted in drastic cuts to social program expenditures. Brodie explains that under a political ideology of fiscal austerity, the modern ideal of citizenship where social benefits are available to all those who possess citizenship status, as Marshall would maintain, was systematically dismantled with the erosion of some social programs and other forms of collective provision of social rights.<sup>111</sup> This thesis maintains that austerity measures on health and social programs, and the resulting impact on social rights, are part of the root causes of the continuing disparities in Indigenous communities.

### **III - ANTHROPOLOGY OF PUBLIC POLICY**

Policies are defined as “a course of action or inaction chosen by public authorities to address a given problem or set of problems.”<sup>112</sup> That definition raises two elements that are significant for this

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<sup>108</sup> Ruth Lister, *Citizenship: feminist perspectives* (New York, New York University Press, 2003): 49.

<sup>109</sup> Ruth Lister, “Inclusive citizenship: realizing the potential”, *Citizenship Studies*, Vol II, Issue I, February 2007

<sup>110</sup> King and Waldron, *Citizenship, Social Citizenship and the Defence of Welfare Provision*, 422.

<sup>111</sup> Brodie, “The social in social citizenship”, 23.

<sup>112</sup> Pal, *Beyond policy analysis: public issue management in turbulent times*, 2.

research project. First, the notion of action and inaction implies that a decision is made to proceed in a specific direction and that decision is shared by public announcement. In the case of Indigenous health policies, policy decisions are shared in public statements by the Minister responsible for that portfolio, or can be communicated through departmental channels to service providers and their clients. These are usually evident in the case of announcements of new funding or new program initiatives. Inaction decisions are a little more complex. In the case of tuberculosis programs and resources, inaction became evident in the reduction of reporting on a problem. If there are no reports of the problem, there is an assumption that the problem no longer exists.

Second, the reference to a course of action and inaction implies that policy is a process, not just a one-time statement or document. It can be assumed therefore that, if the purpose of policy is to address a problem, then policy must run through a progression of actions, or inactions, until the problem is resolved. Such an approach would require that time becomes a factor and that the process is adjusted over time to reflect progress, successes, challenges and barrier. In the case of tuberculosis, both these elements frame the government response to addressing the elevated rates of the disease in Indigenous communities.

Finding evidence of inaction can be a more challenging task than tracking political statements. One approach is to track how government reports on its activities in addressing the problem. This research project relies in large part on departmental annual reports to track the way that policy actions are reported. Annual reports serve as a valuable source as they are released under the signature of the Minister as an account of the department's commitment to the public, and as such, reflect government policy. They are also an effective way to track policy actions over time, and inactions become apparent by omissions and absences.

The review of the language that is used to describe policy directions is an important component in the anthropology of public policy framework as it allows for the study of shifts in power relations and in the way that the political and cultural influences are reflected in the work of the policy decision-makers.<sup>113</sup> It allows for the study of the ideology and values in the language used to describe government policies that reveal much more about the motives and intentions behind government policy actions than about the problem that the policy is supposed to address.

In the case of Indigenous tuberculosis, a review of departmental annual reports reveals that the federal government has not been able to achieve its policy goal of eliminating the disease. It has also not been able to address the disparities in the rates of tuberculosis between the Indigenous and non- Indigenous populations in Canada. What has become apparent, however, is that the motive is less about dealing with the disease, than it is about shifting the responsibility to another level of government. Over time, the language that is used to describe Indigenous peoples as nomads, primitive and complacent about their own health was more revealing about the policy decision-makers' values than it was about report about policy progress. From a citizenship perspective, the language used in these reports further reflects the citizenship values and the place in Canadian society that the federal government attributed to Indigenous peoples, that they were culturally inferior to other Canadian citizens.

#### **IV - CONCLUSION**

Health inequalities in Indigenous communities have existed for over a century, and they endure because Indigenous peoples are treated differently by the federal government. There are two

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<sup>113</sup> Shore et al, *Policy Worlds: Anthropology and Analysis of Contemporary Power*, 1.

principles that explain these differences. The first is the state's use of power to create subjects, and the second is the use of citizenship as a policy instrument.

### *State Power*

Foucault's theories of state power offer a framework within which to study how citizens are made into subjects. Cruikshank describes how the citizen has the autonomy and the power to act, and the subject does not. This distinction has served as a benchmark to define democratic citizenship, and is rooted in notions of state power over individuals.<sup>114</sup>

In Canada, the colonial governments recognized that Indigenous peoples were different from the growing population of European settlers. Framed within British values, the question remained as to what to do with them. They were regarded as primitive, lacking culture and needing to be civilized to join the rest of society, that is, to obtain citizenship into the Canadian state.

Foucault's three organizational technologies of dividing practices, which include scientific classification; and subjectification, provide a description of how a state defines individuals or populations as subjects. Throughout the history of Canada, the federal government used these organizational technologies to establish control and surveillance over Indigenous peoples. First, the establishment of the reserve system for the purposes of separating them from the settler population and excluding them from access to social and economic rights and benefits, contributed to their social and political marginalization. Second, scientific research data and knowledge were used to justify federal policies that sustained the narrative they were 'sick Indians' and a 'dying race' and advanced the assimilation goal. Third, it was the non-Indigenous scientific community that became the external authority figure on Indigenous matters, rather than the Indigenous peoples themselves.

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<sup>114</sup> Barbara Cruikshank, *The will to empower: Democratic citizens and other subjects*. Ithaca, NY, Cornell University Press, 1999: 21.

The status of citizenship, and the allocation of the rights and benefits that flow from that status, is the policy instrument that allows the federal government to encourage Indigenous peoples to assimilate into mainstream society. The *Indian Act*, creates a separate class of citizens called ‘Indians’, and the government exercises the power to determine who is an ‘Indian’ and the status that these individuals hold within Canadian society. The creation of reserves wherein Indians were relocated, isolated and marginalized from the rest of the Canadian population initiated a governance and citizenship regime that vested all powers in the federal government. The *Indian Act* defines a reserve as a “tract of land, the legal title to which is vested in Her Majesty, that has been set apart by Her Majesty for the use and benefit of a band”.<sup>115</sup> The federal government continues to control Indigenous peoples because they have the unrestricted discretionary power to implement policies on reserves that impact on their health and well-being.<sup>116</sup> This is evident in the 2012 *Health Canada’s Strategy Against Tuberculosis for First Nations On-reserve* where it purposefully picks and chooses which communities they deem should receive the services based on their own criteria of need.<sup>117</sup> There is, in fact, no equality.

#### *Citizenship as a policy instrument*

Isin’s notion of citizenship, that a citizen is a person who holds political and civil rights within a state, is used to exercise these powers.<sup>118</sup> What the federal government did not consider was the disincentive that existed for Indigenous peoples, that is, the loss of Indigenous rights and identity. Historically, this loss was through the enfranchisement process in the *Indian Act*. More recently, on

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<sup>115</sup> “*The Indian Act*”, Justice Laws Website: <http://laws-lois.justice.gc.ca/eng/acts/I-5/section-2-20141216.html>

<sup>116</sup> James R. Miller, *Skyscrapers hide the heavens: A history of Indian-white relations in Canada* (Toronto, University of Toronto Press, 2000): 262.

<sup>117</sup> Health Canada, *Health Canada’s Strategy Against Tuberculosis for First Nations On-reserve*.

<sup>118</sup> Isin and Turner, *Citizenship studies: An introduction*, 105.

matters of health, it is the loss of access to federal programs when they leave the reserve. Marshall's theory provides a framework to review citizenship from the perspective of rights.

Rather than creating equality among the Canadian population, the evolution of Marshall's notion of citizenship as bundles of rights as it applies to Indigenous populations in Canada ironically points to the existence of inequalities. Until the amendments to the *Indian Act* in 1951, Indians did not have the right to independent legal counsel or to take the government to court to pursue treaty and land claims. When James Gladstone became Canada's first Status Indian to be appointed as senator in 1958, he still did not have the right to vote. Until 1960, if First Nations persons decided to enfranchise, they lost their Indian Status.<sup>119</sup> Except for Family Allowance payments that were extended to Status Indians in 1946, Indigenous peoples did not have access to the same health and social benefits and programs as other Canadians because the federal government did not always offer the same level of services as was available to provincial residents.

Why is social citizenship important? Because Marshall had it right. He came at it from the normative perspective of the ideal citizenship, and under that scenario, political and civil rights under citizenship do not necessarily mean that there is equality among citizens. That is why he introduced social rights as a means to addressing these inequalities in order that individual citizens do not face barriers in accessing their civil and political rights. In Canada, this notion is corroborated in the fact that 'citizenship', as it was presented in 1960 as the political right to vote and hold political office, did nothing to address the health and social inequalities in Indigenous communities.

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<sup>119</sup> Len Marchand was the first Status Indian elected to the House of Commons in the 1968 election.

When it comes to the rights-based approach to citizenship, Indigenous peoples in Canada face a unique challenge. The principles of citizenship are based on colonial values, and behind every policy incentive to become a ‘citizen’, the federal government’s motive was clearly to eradicate the Indigenous race from Canadian society and not necessarily protect their rights. The Indian residential Schools system had the same goal and was targeted at children. Therefore, it was likely that they were a ‘dying race’ not only because they were dying from illness, but also because the federal government was taking deliberate steps to make them disappear, as a group, from the political landscape. The motive - because they were considered inferior and needed to be ‘civilized’.

The historical notion of citizenship in Canada was deeply rooted in the premise that Indigenous peoples were summarily excluded, and needed to earn the right to citizenship. Their presence in Canada was directed by the *Indian Act*, a separate piece of legislation that identified and categorized them as a separate race under the control of the federal government. They were not considered citizens unless they became civilized, submitted to the enfranchisement process and relinquished their Indigenous rights. They were excluded from the 1947 *Citizenship Act*, and were required to apply for citizenship and to undergo ‘Canadianization’ training along with other immigrants.

From a social policy perspective, the theory was that once Indigenous peoples became Canadian citizens, their conditions would automatically improve and become equal to all other citizens.<sup>120</sup> The logic in that approach is that, in the absence of federal commitment to improve the conditions on reserves, the only way that equality could be achieved is if they joined the rest of the population. The fact that health, social and economic disparities continue to persist in

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<sup>120</sup> Marshall, *Citizenship and Social Class and other essays*, 7.

Indigenous communities is evidence that citizenship on its own accord is not a guarantee of equality among citizens.

Marshall's notion of including social rights on the same level as civil and political rights was a progressive evolution in modern day citizenship, but it has not lived up to expectations in Canada. Health and social programs remain policy initiatives that citizens access as benefits, not as a matter of rights. The Indigenous claim that health is a treaty right, because it was mentioned in Treaty Six<sup>121</sup> has not shifted the federal position. Ironically, although the federal government does not recognize social rights as citizenship rights, this research project shows that it nonetheless used rights to health services as incentives for Indigenous peoples to become Canadians, or at the very least, integrate into the provincial system.

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<sup>121</sup> Indigenous Affairs and Northern Development website: <http://www.aadnc-aandc.gc.ca/eng/1100100028710/1100100028783>

## **CHAPTER 3**

### ***CHANGING NARRATIVE: TUBERCULOSIS IN THE POST-WAR ERA (1945-1969)***

#### **I - INTRODUCTION**

The end of World War II (WWII) in 1945, following six years of hostilities, brought a renewed sense of optimism and ushered in an era of significant changes in Canadian society. Seeking a national Canadian identity that was separate from its membership in the British Commonwealth became part of the social discourse, and the first *Citizenship Act* in 1947 established a separate Canadian citizenship. Prior to 1947, Canadian citizens were both British subjects and citizens. Although they were still considered British subjects after the 1947 legislation, Canadians were no longer British citizens. Canada continued the process of asserting its unique individuality. As a symbol of a Canadian identity, in 1965, the federal government adopted the red maple leaf as the Canadian flag, replacing the British red ensign that had served as the Canadian flag.

The post-war period also supported the rapid development of social programs associated with the development of a welfare state. The federal government entered into a series of extensive discussions with the provinces to establish national health and social care systems across Canada ostensibly to serve all Canadians. The result was the approval of the *Canada Assistance Plan (1966)* and the *Medical Care Act (1968)* in the House of Commons that established universal health and social benefits for all Canadians.

Public attitudes about Indigenous peoples were also starting to change during this period. Indigenous individuals had enlisted in the armed forces and had fought alongside other

Canadians in battle during WWII (1939-1945) and the Korean War (1950-1953), yet Canadians soon realized that these individuals were not treated equally on their return. There was less public tolerance for the pre-war attitudes that had prevailed about the inferiority of Indigenous peoples.<sup>122</sup> As a result, the government adopted a shift in the established political narrative of assimilation that had dominated since the mid-19<sup>th</sup> century. There was growing recognition of the living conditions on-reserve and a new narrative of integration of Indigenous peoples into Canadian society started to emerge. In acknowledgement of the role of the federal government, the Special Joint Committee of the Senate and the House of Commons on the *Indian Act*, 1946-1948,<sup>123</sup> was established to look into the crisis in the administration of Indigenous peoples.

That process, however, was flawed. Leslie contends that the “government policy-makers were bankrupt of ideas and bereft of inspiration. Paternalism dominated government thinking and practices. The official policy of Indian assimilation was aimed at destroying all vestiges of ‘Indianness’.”<sup>124</sup> Although flawed, the process did provide one important innovation, as Indigenous leaders were invited to join the meetings. The fundamental message that they brought to the politicians and federal officials at these meetings was that “Common to all tribal groups was the desire to retain their distinctive traditions, culture and languages; treaty rights and benefits; and other inherent rights accruing to them as Aboriginal peoples.”<sup>125</sup>

The federal government used the Special Joint Committee to pursue its own post-war policy agenda which was about the government administration of the *Indian Act*, and not necessarily about the problems that were experienced on-reserve. Indigenous peoples, their

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<sup>122</sup> Leslie, "The policy agenda of native peoples from World War II to the 1969 White Paper", 15-29.

<sup>123</sup> Minutes of Proceedings and Evidence. Special Joint Committee of the Senate and House of Commons on the *Indian Act*, 1946-1948. As cited in Leslie "The policy agenda of native peoples from World War II to the 1969 White Paper", 16.

<sup>124</sup> *Ibid.*

<sup>125</sup> *Ibid.*

supporters, and interest groups were held on the periphery of political power in a role of ‘policy takers’, not policy makers.<sup>126</sup> Indigenous representatives took advantage of the process to put forward their notion of ‘Indians’ as ‘citizens plus’, a concept that acknowledged that Indigenous peoples not only held rights as Canadian citizens, but that they also held rights as the original inhabitants of this land.<sup>127</sup> Although this notion was largely discounted by policy makers in the 1940s and 1950s, it was a concept that nonetheless caught the attention of scholars, and was raised again as an option two decades later in Hawthorn’s *Survey of the Contemporary Indians of Canada: Economic, Political and Educational Needs and Policies* in 1966,<sup>128</sup> and became the rallying theme of Indigenous rejections of government policy in the 1970s.

The state of health of Canadians was important in the post-war period, and the federal government created the new department of National Health and Welfare (NHW) in 1945 as a symbol of that national priority. What remained, however, was the growing disparity in the health status between Indigenous and non-Indigenous Canadians. Of specific interest was tuberculosis. Whereas the overall national tuberculosis rates in Canada were declining as a result of public health improvements and the discovery of effective antibiotic treatments, there was only modest improvement in the mortality rates and the incidence rates of the disease in Indigenous communities.

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<sup>126</sup> Ibid

<sup>127</sup> John F. Leslie, "Assimilation, Integration or Termination: The Development of Canadian Indian Policy 1943-1963" (PhD diss., Carleton University, 1999): iv.

<sup>128</sup> Harry B. Hawthorn, ed. *A survey of the contemporary Indians of Canada: A report on economic, political, educational needs and policies*. (Ottawa: DIAND, Indian Affairs Branch, 1966).

## II – TUBERCULOSIS

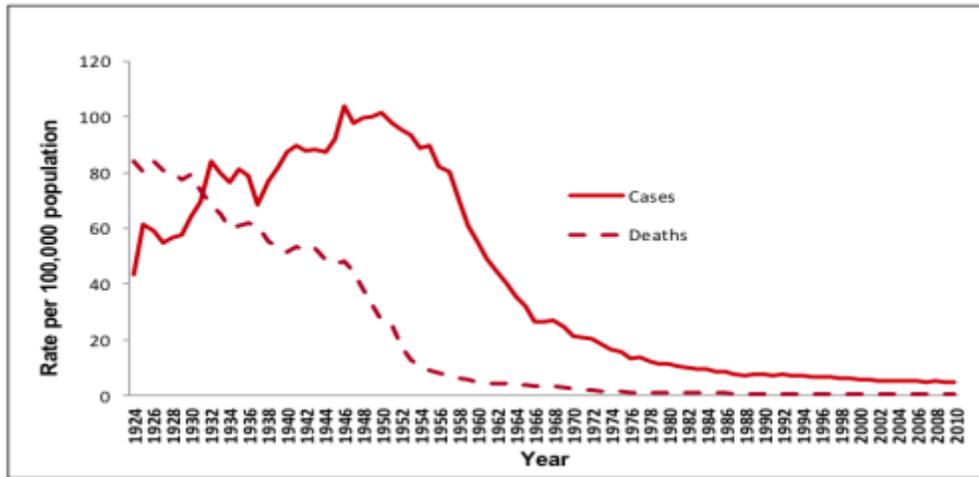


Figure 1: Reported tuberculosis incidence and mortality rates in Canada, 1924-2010

Tuberculosis is a highly infectious disease that is spread from person to person, primarily through the air by coughing, sneezing or talking. It was a major cause of morbidity and mortality in Canada during the first half of the 20<sup>th</sup> century.<sup>129</sup> Figure 1 illustrates how the rates of tuberculosis cases increased until the 1940s, at which time the rates levelled off, and then entered a period of steep decline in the 1950s.<sup>130</sup> This decline is attributed to a combination of improvements in health and social conditions that were introduced at that time, including the establishment of community-based public health programs, improvements in housing and living conditions, the introduction of sanatoria across the country, and the introduction of streptomycin in 1944 as an effective antibiotic treatment against the tuberculosis bacillus.<sup>131</sup>

<sup>129</sup> Chief Public Health Officer of Canada, *The Chief Public Health Officer's Report on the State of Public Health in Canada, 2013 Infectious Disease—The Never-ending Threat*, (Ottawa, Minister of Health, 2014): 1.

<sup>130</sup> Canada. Public Health Agency of Canada, et al, *Canadian tuberculosis standards, 7th Edition*. (Ottawa. Minister of Health, 2014): 8.

<sup>131</sup> For more discussion on this topic see: Matthew Gandy and Alimuddin Zumla, eds. *The return of the white plague: global poverty and the "new" tuberculosis* (London, Verso, 2003); Waldram et al, *Aboriginal health in Canada: historical, cultural, and epidemiological perspectives*, 75; and Wherrett, *The miracle of the empty beds: A history of tuberculosis in Canada*, 17.

There is ongoing debate as to whether tuberculosis was present in North America before European contact, or whether the disease accompanied European settlers. In his 2010 Annual Report, the Chief Public Health Officer (CPHO) of Canada echoed the commonly held view that tuberculosis infection did not exist in Indigenous communities, and that they had been free of disease before contact with Europeans.<sup>132</sup> Maher and Daschuk argue that a form of tuberculosis was endemic before contact through bovine and was transmitted to humans through the consumption of bison, but that Indigenous peoples had contained and managed the disease themselves.<sup>133</sup> Waldram et al further clarify that the form of tuberculosis that became epidemic in North America coincided with the arrival of the Europeans, and that it is with that form of tuberculosis that Indigenous peoples became infected, along with the settlers.<sup>134</sup>

For the purposes of this research, public attitudes about the existence and the spread of tuberculosis on Canadian soil are an important policy factor. Historically, in colonial western Canada, health had been a personal matter. Indigenous peoples practiced their traditional medicine, and settlers relied on churches and doctors in their communities.<sup>135</sup> Infectious diseases like smallpox, tuberculosis and influenza changed the way that diseases were perceived, as they had the effect of going beyond the borders of a community. Indigenous peoples saw tuberculosis as the result of the arrival of settlers, and therefore, it was a ‘white’ disease thus they needed outside resources to deal with the problem. Settlers saw First Nations reserves as breeding

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<sup>132</sup> David Butler-Jones, *The Chief Public Health Officer's Report on the State of Public Health in Canada: 2010*. Public Health Agency of Canada, 2010.

<sup>133</sup> Stephen J. Maher, "Tuberculosis among the American Indians." *American Review of Tuberculosis and Pulmonary Diseases* 19 (1929): 407-11; and Daschuk, *Clearing the plains: Disease, politics of starvation, and the loss of Aboriginal life*, 100.

<sup>134</sup> Waldram et al, *Aboriginal health in Canada: historical, cultural, and epidemiological perspectives*.

<sup>135</sup> The development of community-based health care in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries is explored in further detail in: Waldram et al, *Aboriginal health in Canada: historical, cultural, and epidemiological perspectives*, Chapter 7.; and Maureen Lux, "Care for the 'Racially Careless': Indian Hospitals in the Canadian West, 1920-1950.", 407-434.

grounds for diseases and the need for government intervention to protect their communities from Indigenous peoples.

### III - EARLY 20<sup>TH</sup> CENTURY

In order to better understand the government's response to tuberculosis in the post WWII era, it is important to review tuberculosis treatment in the early 20<sup>th</sup> century. There were two major medical approaches that had the greatest impact in shaping government response to tuberculosis in Canada: the first was the establishment of sanatorium treatment to cure the patients; and the second was the introduction of the Bacille Calmette-Guérin (BCG) vaccine as a preventative approach to the disease.<sup>136</sup>

#### *Sanatorium treatment – the cure*

Throughout the first half of the 20th century, treatment relied on rest, fresh air and segregation. The first private sanatorium, the Muskoka Cottage Sanatorium, opened in 1897, and in 1902 the Muskoka Free Hospital for Consumption opened, which was believed to be the first free sanatorium for the treatment of TB in the world.<sup>137</sup> Long explains that the Canadian sanatorium movement spawned a spirit of medical and public health cooperation that is unsurpassed in modern times as “families, communities, lay organizations, government, and the medical and nursing professions were marshalled to the tasks of creating a uniquely salutary environment for the patient and preventing transmission.”<sup>138</sup>

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<sup>136</sup> Richard Long, "The Canadian Lung Association/Canadian Thoracic Society and tuberculosis prevention and control." *Canadian Respiratory Journal: Journal of the Canadian Thoracic Society* 14, no. 7 (2007): 427.

<sup>137</sup> Stefan Grzybowski and Edward A. Allen. "Tuberculosis: 2. History of the disease in Canada." *CMAJ: Canadian Medical Association Journal* 160, no. 7 (1999): 1026.

<sup>138</sup> Long, "The Canadian Lung Association/Canadian Thoracic Society and tuberculosis prevention and control.":428.

For the tubercular patient, sanatorium treatment meant financial stress and separation from family that lasted from months to years.<sup>139</sup> Saskatchewan was the first to introduce a fully tax-supported plan for tuberculosis treatment in 1929, with other provinces following their lead throughout the 1930s.<sup>140</sup> Government intervention to cover the costs of patient treatment in sanatoria led to the introduction of two major pieces of legislation in Saskatchewan; the 1947 *Hospital Insurance Act* that guaranteed hospital care without a fee, followed by the *Saskatchewan Medical Care Insurance Act* in 1962 which guaranteed access to the services of a physician.<sup>141</sup> Saskatchewan's initiatives paved the way for the 1957 *Hospital and Diagnostic Services Act* that established federal cost-shared funding for provincial health insurance plans, and in 1966 by the *Medical Care Act* that extended federal cost-sharing to cover physician services outside the hospital setting.

The number of sanatoria across Canada grew exponentially: there were 61 sanatoria with 9,000 beds in 1938, and by 1953, the number had grown to 101 sanatoria and tuberculosis units in general hospitals for a total of 19,000 beds. Grzybowski and Allen argue that because "of the misguided parsimony of the government with respect to the suffering of aboriginal people, aboriginal patients were rarely offered sanatorium treatment in the 1930s. However, after protests and investigation, care for aboriginal people improved and by the end of 1953, 2,627 aboriginal people and 348 Inuit were in sanatoria."<sup>142</sup>

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<sup>139</sup> Wherrett, *The miracle of the empty beds: A history of tuberculosis in Canada*, 39-40; Stefan Grzybowski and Edward A. Allen. "Tuberculosis: 2. History of the disease in Canada." *CMAJ: Canadian Medical Association Journal* 160, no. 7 (1999): 1025-1028.

<sup>140</sup> Wherrett, *The miracle of the empty beds: A history of tuberculosis in Canada*, 44-45.

<sup>141</sup> Long, "The Canadian Lung Association/Canadian Thoracic Society and tuberculosis prevention and control.":428.

<sup>142</sup> Stefan Grzybowski and Edward A. Allen. "Tuberculosis: 2. History of the disease in Canada." *CMAJ: Canadian Medical Association Journal* 160, no. 7 (1999): 1026.

The federal government's response in managing Indigenous patients created undue community loss. Not only were Indigenous patients removed from their communities and relocated in sanatoria long distances from home, there was no communication with families about the patients' medical progress. Many patients did not return home, nor were the bodies of the deceased returned to their families. Butler-Jones, the Chief Public Health Officer of Canada recognized the long term effects of the government's actions as an example of continued disparities. "The legacy of these practices has adversely influenced communities and affected the social acceptance of prevention and treatment."<sup>143</sup>

Ultimately, the success of drug therapy meant that by the 1960s, sanatoria were essentially obsolete, and there remained only a few beds devoted to patients requiring hospital care or isolation.

### *Scientific Inquiry*

Throughout the early 20<sup>th</sup> century, the federal government's views on the health of Indigenous peoples were influenced by scientific health studies. In her study of early 20<sup>th</sup> century medical journals, Kelm identifies the beginning of a discourse of pathology in which the Indian problem was medicalized. "In order for there to be any writing at all on aboriginal health, there had to first be an epistemological space created for that writing—a kind of examining room in which aboriginal bodies could be figuratively inspected, diagnosed, and treated."<sup>144</sup> The pre-1940 discourse that Indigenous peoples were a 'dying race' and the increasing Indigenous population in the subsequent decades prompted fears of tuberculosis transmission to non-

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<sup>143</sup> Chief Public Officer of Canada, *The Chief Public Health Officer's Report on the State of Public Health in Canada, 2013: Infectious Disease—The Never-ending Threat*, 5.

<sup>144</sup> Kelm, *Diagnosing the discursive Indian: medicine, gender, and the 'dying race'*, 373.

Indigenous communities. It also provided the foundation on which scientific inquiry into aboriginal health could proceed and, arguably, shaped the federal government's policy approach throughout the rest of the 20<sup>th</sup> century, that its role was to provide health services based on humanitarian grounds.

Kelm described how public health officials discovered that Indigenous populations that were confined to reserves, subject to government surveillance, and infected with various epidemic diseases “provided an intriguing experimental case” and thus created Indigenous health as a new research category.<sup>145</sup> The goal, however, was scientific curiosity, not health improvement. For example, a tuberculosis survey team between 1926 and 1928 recorded that rates of infection were significantly higher in Indigenous communities than those in adjacent settler populations in British Columbia and Saskatchewan. The survey came to an abrupt halt, however, when the team realized that the government was not going to pay to treat all the sufferers that they identified. They concluded that there was no advantage in telling Indigenous leaders that individuals in their community “will die in a year without immediate care, without the care which will be provided two years from now... Much better to let them die in peace meantime until the whole system is ready to operate.”<sup>146</sup> This type of research knowledge reinforces Foucault's principle of creating subjects for state control through scientific inquiry. Government-sanctioned scientific studies were used to add to the body of scientific literature that pathologized Indigenous health and provided the federal government with data on which to rationalize their response to Indigenous health.<sup>147</sup>

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<sup>145</sup> Kelm, *Diagnosing the discursive Indian: medicine, gender, and the 'dying race'*, 373.

<sup>146</sup> *Ibid*: p. 373

<sup>147</sup> For more in-depth discussion of the government's state-sanctioned scientific studies in Indigenous health: Kelm, *Diagnosing the discursive Indian: medicine, gender, and the 'dying race'*, 371-406; Waldram et al, *Aboriginal health in Canada: historical, cultural, and epidemiological perspectives*, Chapter 7; Ian Mosby "Administering colonial

### *The BCG vaccine - Prevention*

Whereas the goal of sanatorium treatment was to cure the disease, the goal of the Bacillus Calmette-Guerin (BCG) vaccine was to prevent the disease. According to the World Health Organization (WHO) the BCG vaccine which was developed in 1921 remains the only available vaccine against tuberculosis. It is, however, only partially effective. WHO claims that although it provides some protection against severe forms of pediatric tuberculosis, it is not completely protective against disease in infants, and it is unreliable against adult pulmonary tuberculosis.<sup>148</sup>

A study of the BCG vaccine trial in Saskatchewan First Nations infants that was undertaken in the 1930s and 1940s by Dr. R. G. Ferguson, is an important milestone in Indigenous health from both medical and social perspectives. Ferguson's study was the first randomized trial of this nature in Canada, and its findings that the BCG vaccine offered an 80% protective factor to reduce death among newborns were groundbreaking. His study not only influenced federal policy to promote the administration of the vaccine to children across Canada for decades, its results are still subject to debate in the 21<sup>st</sup> century.<sup>149</sup> Two articles in 2004 use the Ferguson study as base data to discuss the effectiveness of the BCG vaccine in providing protection against tuberculosis. Dawar et al contend that "The earliest trial of BCG vaccine in

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science: Nutrition research and human biomedical experimentation in Aboriginal communities and residential schools, 1942–1952." *Histoire sociale/Social history* 46, no. 1 (2013): 145-172.

<sup>148</sup>World Health Organization, Immunization, Vaccines and Biologicals, n.d., <http://www.who.int/immunization/research/development/tuberculosis/en/>

<sup>149</sup> For epidemiological discussions on the Ferguson study's finding of the 80% protective factor of the BCG vaccine in First Nations newborns: T. K. Young, "BCG vaccination among Canadian Indians and Inuit: the epidemiological bases for policy decision." *Canadian journal of public health= Revue canadienne de santé publique* 76, no. 2 (1985): 124; John W. Davies, "BCG vaccination—Its place in Canada." *Canadian Journal of Public Health/Revue Canadienne de Santé Publique* (1965): 244-252; Grzybowski, Stefan, and Edward A. Allen. "Tuberculosis: 2. History of the disease in Canada." *CMAJ: Canadian Medical Association Journal* 160, no. 7 (1999): 1025; Richard Long, "The Canadian Lung Association/Canadian Thoracic Society and tuberculosis prevention and control." *Canadian Respiratory Journal: Journal of the Canadian Thoracic Society* 14, no. 7 (2007): 427.

Saskatchewan in the 1930s and 40s showed the vaccine reduced the risk of TB death in infants by 80%. Two case studies with control studies conducted in Manitoba and Alberta in the late 70s and early 80s also demonstrated a 50-60% protection from TB disease in the vaccinated groups.<sup>150</sup> Although Long agrees that these early studies demonstrated that the BCG vaccination provided a protective effect, he argues against its effectiveness as a public health measure. In his 2004 study he states that the BCG “does not prevent ‘infection’ and there is no good evidence that it protects against disease for more than 10 years after vaccination. Accordingly, neonatal vaccination has little or no impact on the occurrence of tuberculosis in adults, who represent the largest pool of potential source cases”.<sup>151</sup>

While the medical and epidemiological analyses focus on the scientific methods and the outcomes of the BCG vaccine study that was conducted in Fort Qu’Appelle-File Hills, in the 1930s and 1940s, from a social perspective, the decision to proceed with the study reveals interesting insights into the federal government’s response to tuberculosis in Indigenous communities. Lux’s analysis of the study, *Perfect subjects: race, tuberculosis, and the Qu’Appelle BCG Vaccine Trial*<sup>152</sup> captures the conflation of medical science and government Indigenous policy along two political narratives: budgetary constraints; and, the perceived inferiority of Indigenous communities.

In the 1920s, the Canadian Tuberculosis Association (CTA) expressed an interest in testing the efficacy of the BCG vaccine as a viable and cost-effective treatment option to address the

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<sup>150</sup> M. M. Dawar et al, "A fresh look at an old vaccine: Does BCG have a role in 21st Century Canada?." *International journal of circumpolar health* 63, no. sup2 (2004): 230-236.

<sup>151</sup> Richard Long et al, "Pediatric tuberculosis in Alberta First Nations (1991-2000): outbreaks and the protective effect of Bacille Calmette-Guérin (BCG) vaccine." *Canadian Journal of Public Health/Revue Canadienne de Santé Publique* (2004): 249-255.

<sup>152</sup> Maureen K. Lux, "Perfect subjects: race, tuberculosis, and the Qu'Appelle BCG Vaccine Trial." *Canadian Bulletin of Medical History/Bulletin canadien d'histoire de la médecine* 15, no. 1 (1998): 277-295.

tuberculosis problem in Indigenous communities.<sup>153</sup> However, research into the BCG at that time was controversial. The results of trials in France and in Montreal were challenged under accusations that subjects were selectively chosen to skew the results in favor of the vaccinated group, and in a German scientific clinical BCG experiment, 71 infants died when they received a BCG vaccine that had been contaminated with tuberculosis bacilli.<sup>154</sup> Governments in the US and in Britain had rejected the use of the BCG vaccine.<sup>155</sup> However, Dr. Ferguson, who was the medical superintendent of the Fort Qu'Appelle Sanatorium, expressed an interest in the vaccine because he wanted to prove that BCG could provide resistance to tuberculosis even among the "less evolved races."<sup>156</sup>

In 1933, Dr. Ferguson received approval to proceed with a BCG clinical trial in the Indigenous community of Fort Qu'Appelle–File Hills in Saskatchewan. The decision to proceed provides important insight into the federal government's medical and social stereotypes. Lux describes how an Indigenous community was selected as the site for the trial since "It has long been known that Indians are far more susceptible to tuberculosis than are the White races of mankind" who had developed "a resistance to the disease greater than that of the Indian."<sup>157</sup> The federal government also considered the vaccine to be "a far less expensive method of controlling tuberculosis than the alternatives of case-finding, lengthy sanatorium treatment, and improved living conditions."<sup>158</sup> Arguably, the federal government's motivation appeared to be based on two principles: that Indigenous peoples provided the ideal laboratory to test the vaccine; and that it could serve as a less expensive treatment method than treatment protocols. It was state power that

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<sup>153</sup> Lux, "Perfect subjects: race, tuberculosis, and the Qu'Appelle BCG Vaccine Trial", 281.

<sup>154</sup> *Ibid*, 288.

<sup>155</sup> *Ibid*, 281.

<sup>156</sup> *Ibid*, 277.

<sup>157</sup> *Ibid*, 282.

<sup>158</sup> *Ibid*, 282.

sanctioned this unethical research in Indigenous communities, conducted without their consent or explanation of potential health risks, that would probably not have been conducted in other communities in Canada at the time. These studies were legitimized through racist assumptions and served to further racialize the Indigenous populations. The underlying assumption was that Indigenous people were completely expendable.

Lux critiques the political motives behind both the conduct of the study, and the interpretation of the results. She observes that although the vaccine trial received some attention from historians, “the focus has been on either the vaccine or the doctors who administered it, never the people who became the subjects of study. How did an isolated, poverty-stricken agency in an equally isolated province come to be the site for a major medical experiment? Who were the subjects and how did they benefit?”<sup>159</sup> The racist implications of the trial go beyond the tuberculosis benefits that it could bring to Indigenous communities, it was also meant to benefit non-Indigenous peoples through the wider-spread usage of the BCG vaccine. That is, Indigenous infants in the Fort-Qu’Appelle- File Hills community were in fact used as laboratory test subjects (without parents being informed of the risks or consenting to the procedure) to determine whether the BCG vaccine was safe before it was introduced as an effective tuberculosis treatment intervention to the rest of the population.

Lux’s analysis also exposes important links between disease and poverty. “While BCG afforded some protection against tuberculosis, nearly one-fifth of the children in the trial died from diseases of poverty, gastroenteritis and pneumonia, as a result of the lethal living conditions on the reserves.”<sup>160</sup> Therefore, even though the study showed that the BCG vaccination protected newborns against tuberculosis, its limited scope neglected to explore other health problems on

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<sup>159</sup> Ibid, 277-278

<sup>160</sup> Ibid, 277

reserves that also contributed to infant mortality, against which infants were not provided protection.

From a political perspective, it was still the threat of Indigenous people spreading tuberculosis, and not the rampant conditions of poverty in Indigenous communities, that captured public attention. There were continued pressures on the federal government to do something about the "scattered islands of infection throughout Canada... a menace to the surrounding population."<sup>161</sup>

#### IV - THE POST-WAR ERA

When the first *Citizenship Act* was implemented in January 1947, people living in Canada could be legally recognized as Canadian citizens rather than British citizens. The *Citizenship Act* was inspired by a sense of 'Canadianness' that flourished in the period between the two World Wars when Canada began to maintain a presence on the international stage that was separate from membership in the British Empire.<sup>162</sup> The rates of tuberculosis in Indigenous communities also declined over this period, however, not at the same rate as in the rest of the population<sup>163</sup> It would appear that Indigenous communities did not fully benefit from the same improvements as in non-Indigenous communities.

The link between disease and mortality among people living in conditions of poverty is well recognized in public health research. In the *Origins of Human Disease*, McKeown

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<sup>161</sup> Ibid, 290.

<sup>162</sup> Janine Brodie, "Citizenship and solidarity: Reflections on the Canadian way." *Citizenship Studies* 6, no. 4 (2002): 377-394.

<sup>163</sup> Public Health Agency of Canada (PHAC) et al, *Canadian tuberculosis standards, 7th Edition* (Ottawa, Minister of Health, 2014); D. Waldram, et al, *Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives*. (Toronto. University of Toronto Press, 1997); George Wherrett, *The miracle of the empty bed*. (Toronto. University of Toronto Press, 1977).

maintained that at a population health level, infectious diseases generally decline with economic growth. Although the links between poverty and disease are well-known, McKeown argues that they are also misunderstood, “For although it has long been evident that people who are sick are often poor, it has not always been evident that many of them are sick because they are poor.”<sup>164</sup> The conditions of poverty that existed on reserve caught the attention of politicians, and the post-war years held the promise of optimism as policy reforms to address Indigenous health appeared to be off to a good start.

By the time the Minister of National Health and Welfare (NHW), the Honourable Brooke Claxton, testified at the *Special Joint Committee on the Indian Act* in 1946 that the conditions on reserve and in the North were ‘abysmal’,<sup>165</sup> social policy actions had already been initiated. In 1945, Indian families had started to receive Family Allowances, and the Indian Health Services Division was transferred from the Department of Mines and Resources to the newly-formed NHW. In his testimony, the Minister further confirmed that he was hopeful about new treatment procedures for tuberculosis, and “that Indian and Eskimo healthcare was a moral responsibility of the federal government and a vital component for fostering Native social and economic development.”<sup>166</sup> The Minister’s use of the term ‘moral responsibility’, rather than a legal or constitutional responsibility, confirmed the government’s position that it had no legal obligation for Indigenous health.

### *Government Response - Decline in tuberculosis deaths*

A review of the NHW Annual Reports from 1945 to 1970 highlights two general themes

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<sup>164</sup> Thomas McKeown, 1988. *The Origins of Human Disease*, (Oxford, Blackwell Publishing, 1988).

<sup>165</sup> Leslie, "Assimilation, Integration or Termination: The Development of Canadian Indian Policy 1943-1963", 123.

<sup>166</sup> Ibid.

with respect to policy on Indigenous people and tuberculosis: the declining rates of tuberculosis deaths; and the federal government's obligation to provide health services.

The 1945-46 NHW Annual Report was the first for the new department. The inaugural report stated that 125,686 Indians as defined in the *Indian Act* and 7,700 Eskimo 'Indians' as recognized in the 1939 Supreme Court Decision, came within the responsibility of the Indian Health Services Division (IHS), with an estimated yearly increase of 1,500.<sup>167</sup> IHS reported on a list of program activities, including the seventeen departmental hospitals. A total of 900 tubercular patients were in sanatoria and hospitals, and IHS conducted yearly tuberculosis surveys of children and staff in Indian residential schools as well as in communities when beds in sanatoria were available. IHS concluded that tuberculosis constituted "one of the major Indian health problems" and that "the utmost attention, consistent with available staff and existing facilities, was given to ensuring adequate measures for the prevention and control of tuberculosis amongst Indians."<sup>168</sup>

IHS described tuberculosis as a "scourge" and the "leading cause of death."<sup>169</sup> While it reported a steady decline in the actual number of tuberculosis deaths on a yearly basis, the government used available statistics to indicate that tuberculosis death rates were over ten times higher than in the non-Indigenous population.<sup>170</sup>

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<sup>167</sup> Medical Services Branch. *Annual Report 1945-1946*. Ottawa. 1946: p. 25.

<sup>168</sup> *Ibid*, 25-28.

<sup>169</sup> Medical Services Branch, *Annual Report 1947-1948*. Ottawa, 49-50.

<sup>170</sup> Medical Services Branch, *Annual Report 1955-1956*. Ottawa, 99.

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	.....

ANNUAL REPORT

\* For the first time includes those of Indian status only.  
† Includes Newfoundland.  
‡ Provisional.

IHS's program focus at that time was on reducing tuberculosis mortality. Access to data about the number of Indigenous patients was not consistent and comparisons with the non-Indigenous population was not readily available. NHW attributed the reduction in the number of deaths to medical and public health advancements through tuberculosis surveys in Indian residential schools and communities; medical treatments such as chest surgery and chemotherapy in sanatoria and hospitals; and, the administration of the BCG vaccines in infants on-reserve and in Inuit communities.<sup>171</sup>

Annual reports also included program data that showed increased staff activity. Staff interactions with Indigenous populations, specifically in isolated and remote communities, were described in value-laden language that hinted at a sense of cultural detachment, as if they were not connecting with fellow Canadians, but with a population whose health knowledge and competence they considered to be inferior to socially accepted values. Indigenous peoples were portrayed as 'nomads' and this appeared to present unique challenges to their work.

On occasion, it was necessary to pursue not only the program but its beneficiaries, since the degree of *self-discipline demanded by modern medical care is unfamiliar to the nomad*. In the pursuit, medical officers and nurses of the Service had occasion to use every modern means of transport and some which are strange to the more settled areas. In many far-off places in Canada, the dog-drawn sleigh and komatik, freight canoes and freight cabooses, saddle and carry-all, are still the only vehicles available or practical,

<sup>171</sup> For more detailed information on NHW's programs and staff activities: Medical Services Branch. *Annual Report 1955-1956*, 84-90.

even in this Atomic age.<sup>172</sup> (*italics added for emphasis* ).

This description of the program extends beyond the transportation challenges that staff must face. Rather than taking the opportunity to learn from a different way of life that is uniquely different from the one with which they are familiar in urban and settler communities, staff instead seemed to blame the Indigenous peoples themselves for not meeting ‘modern’ standards.

Even in mid-20<sup>th</sup> century, colonial practices were integral to the management of federal programs. Examples of assimilationist goals were evident in IHS annual reports in two additional ways. First, the IHS population count included the number of Indians who were projected to enfranchise or otherwise assimilate, and would therefore no longer be their responsibility. As Indian Health work expanded, so did the population to be served. In spite of regular losses to the general population, either by imperceptible assimilation or by enfranchisement of some 500 persons per year, the native population was increasing.<sup>173</sup>

At the latest census in 1954 the Indian population was shown to be 151,500 as compared with 136,500 in 1949... 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.<sup>174</sup>

It was the racist discourse that Indigenous peoples were inferior peoples and the federal policies that led to isolation on reserves, and the lack of resources and services on a par with other Canadians that legitimized the types of scientific inquiry that perpetuated information about the health of Indigenous peoples. Second, by characterizing some First Nations as ‘nomads’, IHS took advantage of federal obligations, such as treaty payment gatherings in order

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<sup>172</sup> Medical Services Branch. *Annual Report 1949-1950*. Ottawa. 1950: 80.

<sup>173</sup> *Ibid.*

<sup>174</sup> Medical Services Branch, *Annual Report 1955-1956*, 84-85.

to advance their vaccination and tuberculosis control programs.

The tuberculosis case finding program of Indian Health Services has been progressively intensified during recent years. While the scattered population presents peculiar problems, advantage has been taken of special assemblies when the nomadic people come together at Christmas and Easter, the termination of the hunting season, and treaty payment time.<sup>175</sup>

While the approach described above advanced IHS's public health goals, there is no indication as to whether First Nations were consulted and or whether the vaccination blitzes were an imposed intrusion by federal officials into community cultural gatherings. Although it could be assumed that treaty gatherings had a sanctioned federal presence to which they could have joined in their capacity as government officials, it is not clear whether a federal presence was also planned at the Easter, Christmas and end of hunting season gatherings, which appear to be social and community-based.

#### *Government Response - The federal obligation*

It wasn't until the 1947-1948 NHW Report, that the federal government chose to describe its *raison d'être*.

A health service for native Indian and Eskimo was developed as a voluntarily assumed moral obligation on the part of the government, to provide assistance to a more primitive people and to protect the new inhabitants from epidemics which might explode in a population not previously exposed to the diseases of Europe.<sup>176</sup>

This statement confirmed the four ideological principles that framed the government's involvement in Indigenous health care: there was no treaty or legal obligation to health care; health services were provided on a humanitarian basis; Indigenous people were 'primitive' and

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<sup>175</sup> Medical Services Branch. *Annual Report 1950-1951*. Ottawa. 1951: 64.

<sup>176</sup> Medical Services Branch, *Annual Report 1945-194*, 40.

therefore inferior to European settlers; and, the government needed to protect non-Indigenous communities from them.

The report also recognized that it was to assume an expanding role for Indigenous health care that would serve to promote the assimilation of Indigenous peoples.

Commencing, as it did, in response to an obvious public health need, the native health service has been required to assume an increasingly larger responsibility in providing protective and active treatment. Certain Indian communities contribute extensively from their funds, but the majority contribute nothing. The economic status of the more remote peoples will always be on a lower level, but, in the more populated areas, the Indian can assume, gradually, more and more of the responsibility of his neighbours. This economic evolution must be slow, because the native is psychologically distinctly a different race to the more western cultures of the new population of Canada. Provision for tomorrow is not, and likely never will be, a trait of the unadulterated Indian or Eskimo, but assimilation should be attended by education in economic independence, including provision against ill-health, to the degree current in their areas.<sup>177</sup>

The federal government's goal for the IHS shifted to economic assimilation with the expectation that Indigenous communities would assume financial responsibility for their own health care services. However, the federal government recognized that there were two categories of Indigenous peoples: those who live in remote areas and whose economic status would remain at a 'lower level'; and those closer to urban areas who could integrate with their 'neighbours'. Since there was no expectation that Indigenous prosperity could be achieved on reserve, Indigenous peoples were depicted as needing assimilation in order to survive in Canadian society, including access to health care services. The emphasis on 'western cultures' inherently sanctioned the superiority of European culture.

The ideology that Indigenous peoples were not yet ready to be accepted into 'western cultures' is reflected in the omission of Indigenous peoples in the first *Citizenship Act* in 1947. As Bohaker and Iacovetta explain, it is based on this premise that post-war citizenship policies

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<sup>177</sup> Medical Services Branch, *Annual Report 1947-1948*, 41.

required Indigenous peoples to be trained through the same Canadianization programs that were required for immigrants from countries other than western Europe. The assumption was that they did not meet the citizenship standard of western culture to be accepted as Canadian citizens.<sup>178</sup> Citizenship classification assigned to Indigenous peoples played a crucial role in that assumption, as the federal government's expectations were based on their successful migration to the provincial health systems. This central theme of a diminishing federal responsibility for Indigenous health care in conjunction with increasing integration into provincial responsibility formed the ideological framework for Indigenous health care policy well into the 1960s.<sup>179</sup>

The 1950s brought the federal government a sense of confidence that they had fulfilled their humanitarian responsibility in Indigenous health. Tuberculosis deaths were decreasing and they intimated that it was time for them to withdraw from providing Indigenous health care services and to leave the field to other providers.

Although the incidence of tuberculosis among Indians and Eskimos is high in comparison with the rest of the population in Canada, it is similar to that in comparable groups of other countries. Over the past few years the tuberculosis death-rate among Indians and Eskimos has been reduced at a rate parallel to or better than that in the remainder of the population. In 1949 the rate was 399.6 per 100,000 but in 1950 it was sharply reduced to 298.8.<sup>180</sup>

The government erroneously concluded that tuberculosis among Indigenous peoples was no longer a problem. This conclusion was based on the assumption that the decline in Indigenous tuberculosis had been keeping pace with the decline in the overall population. Yet, while it acknowledged that the incidence of Indigenous tuberculosis, although in decline, remained

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<sup>178</sup> Bohaker, Heidi, and Franca Iacovetta. "Making Aboriginal People 'Immigrants Too': A Comparison of Citizenship Programs for Newcomers and Indigenous Peoples in Postwar Canada, 1940s-1960s." *Canadian Historical Review* 90, no. 3 (2009): 427-462.

<sup>179</sup> For an in-depth discussion of the government's transition to integration policy see: Leslie, John F. "Assimilation, Integration or Termination: The Development of Canadian Indian Policy 1943-1963" (PhD diss., Carleton University, 1999): Chapter 5 pp. 244-303

<sup>180</sup> Medical Services Branch, *Annual Report 1951-1952*, 51-52.

higher than in the general population, there is no indication that it intended to address this inequality. Further, the comparison of the high rate of Indigenous tuberculosis being comparable to “groups in other countries’ is perplexing as there is no indication as to which countries are being referred. The report presents as a given fact that: the incidence of Indigenous tuberculosis remained higher than in the non-Indigenous population in Canada, but that was acceptable because their rates were comparable to rates in other unnamed countries. This approach was race-based and must be seen as unacceptable.

Racial nuances also became evident in the federal government’s changing tone about the complexity of its mandate. The federal government made its intentions categorically clear that it no longer had an obligation to provide the health services that it previously delivered on humanitarian grounds, that there was no intention to continue to provide these services to Indigenous peoples in the long term, and that it was time for this responsibility to be assumed by other parties. It was equally clear that the way to achieve this was by assimilation.

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.<sup>181</sup>

The federal government’s message is persistent and consistent with the broader Indigenous policy goal of assimilation. Through enfranchisement, Indigenous peoples can expect to ‘reach full social, economic and educational equality with their white neighbours’, and there is

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<sup>181</sup> Medical Services Branch. *Annual Report 1954-1955*. Ottawa. 1955: 84.

no doubt that health care is part of that objective. The use of the term ‘white neighbours’ suggests that ‘white’ culture is the ‘gold standard’. The report recognizes that this is a work in progress, and that in the interim, IHS functions primarily as a public health service, with eligibility stipulations:

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.*<sup>182</sup> (*italics added for emphasis*)

The federal government’s position on these three conditions that determine eligibility to receive health services from the federal government (Status Indian, on-reserve, and indigent) represent the principles that guided Indigenous health policies until the federal government approved the Indian Health Policy in 1979.

#### *Government Response - The 1960s*

The NHW Annual Reports in the early 1960s maintained the narrative that the health of Indigenous peoples could only be improved if they renounced their ways of life. Their living conditions were described as “rather primitive” in underdeveloped areas remote from normal medical services. It was also the government’s assessment that Indigenous peoples lacked “both the knowledge and the means to arrange for such services themselves.”<sup>183</sup> The federal government’s commitment was based on a moral obligation to assist Indigenous peoples to meet their medical needs, albeit with some restrictions:

In 1960 there were about 185,000 registered Indians... There are many other thousands of persons of Indian extraction but unless recorded on a band register they are presumed to

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<sup>182</sup> Ibid.

<sup>183</sup> Medical Services Branch. *Annual Report 1960-1961*. Ottawa. 1961: 19

be eligible for care in the same fashion as other citizens. There are about 12,000 Eskimos. They are the particular concern of Northern Affairs Branch of the Department of Northern Affairs and National Resources except on the Labrador Coast where the provincial government assumes all obligations *although with the assistance of this directorate for medical treatment*. In addition to the 1,800 Indians in the Yukon Territory there were about 12,000 other residents. In the Northwest Territories there were 8,500 Eskimos, 5,000 Indians and 9,500 others.<sup>184</sup> (*italics added for emphasis*)

In the above paragraph, NHW accepts responsibility for individuals based on whether they are identified as registered Indians in accordance with the *Indian Act*. Those that are not, are considered as provincial and territorial residents. The itemization of the numbers of individuals serves to contain the scope of federal responsibility to 233,000 individuals, representing 1.3% of the total Canadian population of 18 million at that time.<sup>185</sup> In the North, federal responsibility is presented as a temporary one: “because the sparsely populated northern territories have not developed their own health agencies, the directorate serves in lieu of a health department for the Yukon Territory and the Northwest Territories.”<sup>186</sup>

Although the incidence of Indigenous tuberculosis is still many times greater than the general population, the report makes no linkages between tuberculosis and the ‘primitive’ conditions that they identified. The focus is instead shifted onto the individuals themselves. “Finding illness among non-demonstrative people has been a first priority of the directorate and this has been maintained and extended.”<sup>187</sup> By 1965, departmental officials celebrated the fact that “deaths from tuberculosis which used to be very consistently ten times the national rate, fell to five times.”<sup>188</sup> This was not the case in the North, however, where the death rate among Inuit was twice the national rate, and where “During the previous three years there has been an

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<sup>184</sup> Ibid.

<sup>185</sup> Data from the 1961 Census available at: <http://www.statcan.gc.ca/pub/11-516-x/pdf/5500092-eng.pdf>

<sup>186</sup> Medical Services Branch, *Annual Report 1960-1961*. Ottawa. 1961: 19.

<sup>187</sup> Ibid, 20.

<sup>188</sup> Medical Services Branch, *Annual Report 1964-1965*. Ottawa. 1965: 87.

increase in tuberculosis which tended to appear in the form of explosive outbreaks of epidemic proportions.”<sup>189</sup> Notwithstanding the northern epidemics, the report presented a positive interpretation of the success of its anti-tuberculosis vaccination and detection programs.

In an important change from the narrative that dominated previous reports, socio-economic conditions, and even the health care system itself, were presented as the main challenges for improved Indigenous health.

Indians usually tend to require longer hospitalization than other patients, partly because they frequently come to treatment in the more advanced stages of disease or suffer more severely because of other factors such as faulty nutrition, deficient hygiene or severer environmental stresses, but also because their home conditions and the distances they have to travel make it advisable to keep them hospitalized until more completely recovered than is always necessary for other types of patients.<sup>190</sup>

In addition to social conditions, there was also a shift to the broader jurisdictional issues as a determinant of health. The needs of ‘Indians’ and ‘Eskimos’ were presented in two separate sections, highlighting different policy directions. With respect to First Nations south of the 60<sup>th</sup> parallel, the focus of the NHW’s work was on integrating them into the provincial systems, confirming that assimilation, not the health needs of First Nations, remained the underlying departmental goal. “Considerable educational effort is required to raise Indian standards of living and get them to make prompt and proper use of the services available to them...”<sup>191</sup> In contrast, the departmental focus for Inuit health was on improving social programs. “Special educational efforts, sociological and economic as well as health, are being made to improve the lot of Eskimos and this is beginning to improve the health picture. Continuing improvements in housing are also having some effect though much remains to be

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<sup>189</sup> *Ibid*, 93.

<sup>190</sup> *Ibid*, 87.

<sup>191</sup> *Ibid*, 88.

done in all these areas.”<sup>192</sup> In light of the tuberculosis outbreaks that had occurred in Inuit communities, the federal government’s commitment to addressing housing problems was promising.

There was a growing divide that became evident in the way that First Nations and Inuit health policy were reported that coincided with a major organizational change within NHW. In January 1962, the Indian and Northern Health Services Directorate was transferred from the departmental Health Branch, to the newly formed Medical Services Branch (MSB). The responsibility of the formerly separately administered divisions for Civil Aviation Medicine Division, Civil Service Health Division, Indian Health, Northern Health, Quarantine, Immigration Medical and Sick Mariners Services were grouped together under the new MSB, with the common denominator being that they were all divisions within NHW with staff who were directly involved in working at field level.<sup>193</sup>

In the 1964-1965 Annual Report, using the geographical North-South divide of the 60<sup>th</sup> parallel, MSB sought to clarify the federal government’s different positions on the delivery of health services to First Nations and Inuit. It acknowledged that in the South, Indian health is a responsibility of provincial governments and MSB is required only to augment and supplement provincial services in some special program areas. In the North, however, MSB identified that it functioned in the role of a territorial department of health until such time as the respective territorial governments can organize and finance their own departments. MSB also confirmed that in the North, it was responsible for all health services, including hospital insurance, for the total population without regard to ethnic group.<sup>194</sup>

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<sup>192</sup> Ibid.

<sup>193</sup> Medical Services Branch. *Annual Report 1962-1963*. Ottawa. 1963: 79.

<sup>194</sup> Medical Services Branch, *Annual Report 1964-1965*, 88.

When the 1969-1970 NHW Annual Report was released in 1970, it was to a significantly transformed political Indigenous policy environment after the federal government's 1969 Draft Indian Policy (White Paper). Yet the federal government chose to challenge First Nations claims of a treaty right to health.

Despite popular misconception of the situation and vigorous assertions to the contrary, neither the federal nor any other government has any formal obligation to provide Indians or anyone else with free medical services. All governments, however, have a moral obligation to care for those within their jurisdiction who cannot care for themselves.<sup>195</sup>

Following so closely on the release of the government position in the White Paper, the federal government continued to perpetuate the fundamental assimilation assumptions that had been criticized by Indigenous leaders.<sup>196</sup> The reference to the government's moral obligation to those 'within their jurisdiction' was a politically loaded statement that reinforced the federal position that, on matters of health, First Nations fit in naturally with the rest of population under provincial jurisdiction.

Medical problems among Indians do not differ significantly from medical problems elsewhere save that infectious diseases associated with defective domestic hygiene and inferior nutrition tend to be rather more prevalent... Indians in the Atlantic provinces and Quebec reflect almost the same health picture presented by all residents of the province. Indians in other provinces present some interesting differences from both their provincial neighbours and Indians in the eastern provinces.<sup>197</sup>

With respect to tuberculosis, after decades of being the top national Indigenous health concern, it was no longer considered a priority and was surpassed by "Accidents, pneumonia and diseases of early infancy"<sup>198</sup> as chief causes of death. Tuberculosis is mentioned only as a vague

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<sup>195</sup> Medical Services Branch. *Annual Report 1969-1970*. Ottawa. 1970: 105.

<sup>196</sup> Alberta, Indian Chiefs of. "Citizens Plus." *Brief Presented to Federal Government* (1970). Available at: <https://ejournals.library.ualberta.ca/index.php/aps/article/view/11690/8926>

<sup>197</sup> Medical Services Branch, *Annual Report 1969-1970*, 105.

<sup>198</sup> *Ibid*, 106.

cautionary note that “though under control again, still remains a source of worry.”<sup>199</sup> Although this is a prophetic statement in light of the persistence of the disease into the 21<sup>st</sup> century, the report offers no explanation nor any indication of what measures were being taken to address the problem.

## V- CONCLUSION

Throughout the post-war era, the federal government maintained the position that it has no “formal obligation to supply health care to Indians” and that resources were set aside by Parliament for “humanitarian reasons to assist indigent Indians and Eskimos.”<sup>200</sup> The language of indigence is particularly troubling as it implies a requirement that appears contrary to the 1957 *Hospital Insurance and Diagnostic Services Act* that guaranteed hospital care and the 1968 *Medical Care Act* that had guaranteed universal access to health care with no financial barriers. The only way for First Nations to remove this barrier was to assimilate.

With respect to tuberculosis, the federal government may have had cause to feel cautiously optimistic as there had been a dramatic drop in the rates of tuberculosis during the post-war era. However, inequalities persisted in the prevalence of tuberculosis in Indigenous communities. For the period from 1966 to 1970, although they numbered just over 1 percent of the total population,<sup>201</sup> the combined Indian and Eskimo population represented between 13 to 16 percent of all new cases and between 14 and 20 percent of all re-activated cases of tuberculosis.<sup>202</sup> It is

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<sup>199</sup> Medical Services Branch. *Annual Report 1969-1970*, 106.

<sup>200</sup> Medical Services Branch. *Annual Report 1967-1968*. Ottawa. 1968: p. 102.

<sup>201</sup> Dominion Bureau of Statistics. *Tuberculosis Statistics, vol. I: Tuberculosis Morbidity and Mortality, 1965*. Statistics Canada Catalogue no. 83-206. Annual. 1966: p. 32

<sup>202</sup> Detailed information on the rates of tuberculosis for the years from 1965 to 1970 is available in the individual yearly reports in: Canada. Dominion Bureau of Statistics. *Tuberculosis Statistics, vol. I: Tuberculosis Morbidity and Mortality*. Statistics Canada Catalogue no. 83-206.

this level of inequality between Indigenous communities and the general population that was not fully discussed in the NHW annual reports throughout the 1960s. There appeared to be an air of complacency, as the overall rates continued to drop dramatically.

Hospitals were a factor in the battle against tuberculosis in the post-war period. Lux argues that the government's hospital policy also reflected an unprecedented public interest in Indigenous people's place in Canadian society. "As Minister Claxton assured Canadians recently troubled by the "Indian problem", the creation of Indian hospitals was motivated not by quaintly vague treaty promises, but by "the highest humanitarian ideals.""<sup>203</sup> In addition, the move of the federal government's responsibility from the Indian Affairs Branch to NHW signaled the federal government's assimilation goals as it demonstrated the government's intentions to include Indigenous people in "the calculations of national health, if only to keep them sufficiently isolated."<sup>204</sup>

The Charles Camsell Hospital, opened in 1946 in Edmonton, was to be the federal government's showcase of the expanding Indian Health Services. Although it appeared to be an acknowledgement of the government's responsibility for Indigenous health care, Lux explains that this was not the case in the long term. The opening of new hospitals gave the option to other community hospitals to refuse Indigenous patients. As more Indian hospitals opened in the late 1940s, a two-tier system for hospitalization developed in Canada, where the federally-run hospitals were resourced with a smaller budget and funded on a much lower cost per patient rate than provincial hospitals. For example, in 1949, the Director of the Indian Health Services

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<sup>203</sup> Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s*, 47.

<sup>204</sup> *Ibid.*

estimated that the cost was between \$8 and \$10 per day to treat patients in provincial hospitals and between \$3.99 and \$4.66 per day per patient at the four largest Indian hospitals.<sup>205</sup>

The discrepancy in the funding allocated to Indian hospitals affected Indigenous tuberculosis policies from two perspectives. The first is the entrenchment of inequalities in the level, and quality, of health care for Indigenous patients. Excluded from access to better funded provincial health care institutions, their only access was to separate, lesser quality health care services than other Canadians. Second, there was a budgetary incentive for Indian hospitals to keep at full occupancy in order to reduce the per patient rate. Lux documents the measures that physicians and hospital administrators undertook to keep Indigenous patients in hospital longer, including performing lung resection surgery at a time when chemotherapy treatment made surgery of this nature unnecessary. It was a treatment which was rarely practiced in provincial hospitals.<sup>206</sup>

The inequalities in treatment and health care bring into question the concepts of universality and equality in citizenship and highlight Lister's criticism of the false universalism of the traditional notion of citizenship as being male, white and heterosexual.<sup>207</sup> The universal citizenship ideology that influenced health policies in the post-war era served to explicitly exclude Indigenous peoples who chose to protect their cultural identities and as a result were deemed to not meet the Euro-centric definition of a Canadian citizen.

The role of health care system in this process centred not only on the fact that it was universal, meaning equal access for all citizens, but that this universality could only be achieved through provincial governments. This approach is juxtaposed against the stated

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<sup>205</sup> Maureen Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s*, 47-68.

<sup>206</sup> For an in-depth discussion of the costs and occupancy for Indian hospitals: Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s*, 47-68.

<sup>207</sup> Ruth Lister, *European Journal of Social Theory* July 1998 vol. 1 no. 1 71-90

responsibility of the federal government for “Indians and lands reserved for Indians” in Section 91(24) of the *BNAA*. In a speech delivered in Vancouver on August 8, 1969, Prime Minister Pierre Trudeau suggested that being equal under Canadian citizenship means being the same as everyone else, and categorically rejects the notion that First Nations have special status, explaining that they are not ‘a race apart in Canada’. Further, by contextualizing Indigenous peoples as being at “the crossroads”, the speech pretends to offer Indigenous peoples a choice in shaping their future. However, the speech demonstrates the extent to which the government intends to pursue extinguishing treaty rights in the name of equality.<sup>208</sup>

As was the case with the enfranchisement provisions in the *Indian Act*, the Prime Minister’s speech leaves no doubt that the Indian Policy proposed in the White Paper means that Indigenous peoples would lose their rights. The choices, from the government’s perspective were clear:

It must be a very agonizing choice to the Indian peoples themselves because, on the one hand, they realize that if they come into the society as total citizens, they will be equal under the law, but they risk losing certain of their traditions, certain aspect of a culture and perhaps even certain of their basic rights, and this is a very difficult choice for them to make...<sup>209</sup>

Considering that in the past Indigenous peoples chose to protect their rights over the right to vote, it is not clear why the federal government would assume that the same conditions would suddenly become more palatable when framed as equal citizenship.

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<sup>208</sup> University of Saskatchewan Archives, Our Legacy. *Prime Minister Trudeau: Remarks on Indian Aboriginal and Treaty Rights*, part of a speech given August 8, 1969 in Vancouver, British Columbia.

<http://digital.scaa.sk.ca/ourlegacy/solr?query=ID%3A24992&start=0&rows=10&mode=view&pos=0&page=1>

<sup>209</sup> University of Saskatchewan Archives, Our Legacy. *Prime Minister Trudeau: Remarks on Indian Aboriginal and Treaty Rights*, part of a speech given August 8, 1969 in Vancouver, British Columbia.

<http://digital.scaa.sk.ca/ourlegacy/solr?query=ID%3A24992&start=0&rows=10&mode=view&pos=0&page=1>

## CHAPTER 4

### SHIFTING PARADIGM: TUBERCULOSIS IN THE SELF-GOVERNMENT ERA (1970-1999)

We suggest that the period of displacement and assimilation, the third stage, was concluded by the federal government's 1969 white paper. The reaction it provoked and the influence of certain court decisions shortly thereafter clearly marked the beginning of the negotiation and renewal phase.<sup>210</sup>

#### I - INTRODUCTION

The thirty year period that followed the 1969 White Paper is crucial to understanding how the transformation in the government-Indigenous relationship shaped the federal government's response to the higher rates of tuberculosis in Indigenous communities. At the start of the 1970s the health and social infrastructure of Canada's welfare state was being put in place with the implementation of national programs such as the *Canada Assistance Plan* (1966), which established a national framework to support provincial social assistance and services; and the *Medical Care Act* (1968)<sup>211</sup>, which supported the development of provincial support for personal medical care. Indigenous protests to the 1969 White Paper launched a renewed sense of dialogue that had been initiated during the 1946-1947 Special Joint Committee of the Senate and the House of Commons on the *Indian Act*, between the federal government and Indigenous leaders on matters such as land claims negotiations, self-determination and a new Indigenous-government relationship. Constitutional discussions dominated the national political agenda in the 1980s and 1990s, and the recognition of Aboriginal Rights in Section 35 of the 1982 *Constitution Act* was the

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<sup>210</sup> Canada. Royal Commission on Aboriginal Peoples. Report of the Royal Commission on Aboriginal Peoples. Vol. 1: Looking Forward Looking Back: PART ONE Relationship in Historical Perspective. Ottawa: 1996: p. 44

<sup>211</sup> The *Medical Care Act* was introduced in 1966 and passed in 1967, but implementation was delayed until 1968 to allow individual provinces the time to implement the legislation, which is why the latter date is used.

focal point of discussion about the place of Indigenous peoples in Canadian society. There was, however, no shift in the federal position on Indigenous health. The federal government continued to claim that it had no legal or treaty obligation to provide health services to Indigenous peoples as it pursued its goal to transfer the responsibility for Indigenous health to provincial health care systems.

Although the White Paper contained no specific reference to health services, its goals were to remove the “legislative and constitutional bases of discrimination” inherent in the *Indian Act*, and to erase the existence of separate services for Indigenous peoples. These goals were to be achieved through the provincial takeover of services that the federal government provided to Indigenous peoples. Since health care was deemed a provincial responsibility, it was understood that the implementation of the White Paper would have included a complete federal withdrawal from involvement in Indigenous health care services.<sup>212</sup> While the White Paper was announced with much fanfare in 1969, the federal government’s retraction of the policy was much more subdued. Weaver describes how the tone of the federal government’s parliamentary speeches changed in the months following the release of the White Paper and hinted at the need for increased cooperation with Indigenous organizations on matters of policy. It was the March 1971 remarks by the Minister of Indian Affairs and Northern Development (DIAND) that formalized the retraction of the White Paper:

The Government put forward its proposals for a future Indian Policy a year and a half ago. These stimulated and focused a debate and have served a necessary purpose. They are no longer a factor in the debate. *The Government does not intend to force progress along the directions set out in the policy proposals of June 1969.* The future direction will be that which emerges in meetings between Government and Indian representatives and people.<sup>213</sup> (*Italics added for emphasis*)

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<sup>212</sup> T. Kue Young, 1984. Indian health services in Canada: a sociohistorical perspective. *Social Science & Medicine*, 18(3): 262

<sup>213</sup> As cited in Weaver, Sally M. *Making Canadian Indian policy: the hidden agenda 1968-70*. Vol. 9. University of Toronto Press, 1981:186-187

Indigenous health policy remained at the periphery of the meetings to which the Minister refers in his speech, and, as the Commission on the Future of Health Care in Canada confirmed in their Final Report (Romanow Report) in 2002, the federal position of ‘payer of last resort’ continued to be reflected in Indigenous health policies.

According to the federal government... there is no constitutional obligation or treaty that requires the Canadian government to offer health programs or services to Aboriginal peoples. As a result, the federal government limits its responsibility to being the “payer of last resort.” A 1974 ministerial policy statement describes federal responsibility for Aboriginal health issues as voluntary, aimed at ensuring “the availability of services by providing it directly where normal services [were] not available and giving financial assistance to indigent Indians to pay for necessary services when the assistance [was] not otherwise provided” (Canada. Health and Welfare 1974). This continues to be the position of the federal government.<sup>214</sup>

Three major health policies shaped the federal response to dealing with tuberculosis in Indigenous communities during this period. As a result of Indigenous protests to reverse federal health policies that treated Indigenous peoples as indigent patients, the 1979 Indian Health Policy presented a revised community-based approach to Indigenous health. The 1989 Health Transfer Policy represented the government’s intention to transfer the responsibility for federally-funded community-based health services to First Nations control. Finally, the 1992 National Tuberculosis Elimination Strategy was the first federal policy to specifically target the higher rates of tuberculosis among the Indigenous population. These three policies continue to play a significant role in Indigenous policy to this day. Both the 1979 Indian Health Policy and the 1989 Health Transfer Policy are still the current policy of Health Canada. The 1992 National Tuberculosis Elimination Strategy was in force for 20 years until it was replaced by the 2012 Health Canada’s Strategy Against Tuberculosis for First Nations On-Reserve.

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<sup>214</sup> Roy Romanow, *Building on Values: Report of the Commission on the Future of Health Care in Canada* (Ottawa, Commission on the Future of Health Care in Canada, 2002): 212.

Throughout the 1970s the rates of Indigenous tuberculosis were dropping but they remained higher and showed no indication of approaching the rates in the non-Indigenous population. Except for a passing reference in 1975 that simply noted that the rates for new and reactivated tuberculosis showed no significant change from the previous year,<sup>215</sup> tuberculosis no longer appeared to be a program priority. It was not until 1976 that Medical Services Branch (MSB) reported that it was confident that the drop in Indigenous tuberculosis cases was the result of their program efforts:

Until 1952, tuberculosis was the leading cause of death among the Indian and Inuit people. The decline since that time is due to a number of factors including hospital treatment of all active cases, the introduction of chemotherapy, and an active program of preventive measures.<sup>216</sup>

By 1978, MSB was rationalizing that the problem behind an increase in the rates of tuberculosis reactivation rested with the patients themselves.

Although the number of new cases of tuberculosis declined from 330 to 294, the number of reactivations increased from 58 to 76, reversing the trend established in the previous year. *The problem of persuading inactive tuberculosis patients to take their preventive drugs conscientiously demands constant supervision by members of the local health team.*<sup>217</sup> (italics added for emphasis)

Yet, MSB's medical approach to Indigenous health did not factor in its own observation that "environmental deficiencies such as sub-standard housing, polluted water and inadequate waste disposal, coupled with a harsh climate, provide unique challenges to the medical and paramedical personnel employed in Indian and Northern Health Services."<sup>218</sup> Instead, two health principles framed the government response to Indigenous tuberculosis. The first was the federal government's use of indigence as one of the criteria to determine eligibility for health services,

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<sup>215</sup> Medical Services Branch. *Annual Report 1974-1975*. Ottawa. 1975: 12.

<sup>216</sup> Medical Services Branch. *Annual Report 1975-1976*. Ottawa. 1976: 13.

<sup>217</sup> Medical Services Branch. *Annual Report 1977-1978*. Ottawa. 1978: 13.

<sup>218</sup> Medical Services Branch, *Annual Report 1975-1976*, 12.

and the second was the federal government's complacency in the face of the persistent inequalities in the prevalence of tuberculosis in Indigenous communities.

## II - THE 1970S – THE POST-1969 WHITE PAPER ERA

MSB's Indigenous health policies confirmed the federal position that they were under no legal obligation to provide Indigenous health care services and benefits whereas Indigenous peoples maintained that health care was a right. Although health was not specifically stated in the 1969 White Paper, the Indian Chiefs of Alberta made special mention of it in their 1970 response, *Citizen Plus* (referred to as the Red Paper). They noted that citizenship included the "right to receive, without payment, all health care services without exception".<sup>219</sup> To support their position, they used the notion of 'Citizens Plus' that had been advanced in the federally commissioned Hawthorn Report:

Indians should be regarded as 'Citizens Plus'. In addition to the rights and duties of citizenship, Indians possess certain additional rights as charter members of the Canadian community.<sup>220</sup>

Young explains that during the 1970s, provincial Indian associations were deeply concerned that the unilateral transfer of the federal government's responsibility for Indigenous health to the provinces could signal broader political implications in the fight for Indigenous rights.

In the face of *de facto* provincial involvement in health services for many of the more southerly situated and urbanized bands, the federal government was held responsible for the provision of a full range of benefits over and beyond those covered under universal medical care insurance. Ultimately the Indians demanded control of their own health services through the establishment of health boards and committees.<sup>221</sup>

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<sup>219</sup> Alberta, Indian Chiefs of. "Citizens Plus." *Brief Presented to Federal Government* (1970). Available at: <https://ejournals.library.ualberta.ca/index.php/aps/article/view/11690/8926>

<sup>220</sup> Harry B. Hawthorn, *A survey of the contemporary Indians of Canada: A report on economic, political, educational needs and policies – Part 1*. (Ottawa, Indian and Northern Affairs Canada, 1966): 20.

<sup>221</sup> Young, "Indian health services in Canada: a sociohistorical perspective". *Social Science & Medicine*: 262.

Young further argues that the Indigenous call for more control over their health care remained unheeded and Indigenous health policies did not keep in step with the political narrative of Indigenous policies.<sup>222</sup> In the 1971 retraction of the White Paper, the DIAND Minister had stated that “The Government does not intend to force progress along the directions set out in the policy proposals of June 1969”,<sup>223</sup> directions that had included that “All Indians should have access to all programs and services of all levels of government equally with other Canadians.”<sup>224</sup> Since health was one of the services that the federal government provided to Indigenous communities, the Minister’s statement should have signified that the transfer of Indigenous health services to the provinces would not be pursued but that was not the case. The government limited its post White Paper discussions to policy matters under the responsibility of the DIAND Minister. Since Indigenous health was a part of NHW, the DIAND Minister’s commitments did not extend to health services.

This decision to proceed with the transfer of health to provincial responsibility was evident in 1974 when the NHW Minister tabled the *Policy of the Federal Government concerning Indian Health Services* (1974 Health Policy) at a federal-provincial health ministers’ conference. The 1974 Health Policy required Indigenous peoples to seek services from provincial agencies and that the federal government would step in only if services were not available and they were requested to do so on the basis of need for indigent patients.<sup>225</sup> Ignoring the Indigenous protests that led the federal government to retract its policy proposals in the 1969 White Paper, MSB announced its decision to formally proceed to the transfer Indigenous health to provincial control

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<sup>222</sup> Young, “Indian health services in Canada: a sociohistorical perspective”. *Social Science & Medicine*: 262.

<sup>223</sup> As cited in Weaver, *Making Canadian Indian policy: the hidden agenda 1968-70*, 186-187.

<sup>224</sup> Canada. *Statement of the Government of Canada on Indian Policy*. Ottawa. 1969. Available at: <http://www.aadnc-aandc.gc.ca/eng/1100100010189/1100100010191>

<sup>225</sup> Young, “Indian health services in Canada: a sociohistorical perspective”, 262.

in its 1975-1976 Annual Report. Using the 1974 Health Policy as its mandate, the only commitment that MSB made toward establishing a new relationship with Indigenous peoples in the post 1969 White Paper era, was to consult with Indigenous peoples as they proceeded with this transfer.

The question of takeover of Indian health services by the provinces has also been raised at federal-provincial meetings of Health Ministers. Consultation with the Indian and Inuit people affected by the transfer is a mandatory step in any negotiations relating to responsibility for the provision of health care services to these special groups.<sup>226</sup>

MSB soon expressed serious concerns about rising expenditures by patients that they did not consider to be indigent, and who they perceived were creating widespread abuse in requests for assistance for health services that were not covered by provincial health care insurance such as drugs, glasses, dental care and medical transportation.<sup>227</sup> Yet, in 1970, MSB had clearly identified that the coverage of these services was part of their mandate.

In areas to which provincial health services do not extend and where conventional sources of health care are not available, the branch supplies services which conform as closely as possible to the conventional system. Dental care is provided by staff dentists or by dentists in private practice on a fee-for-service basis; patients requiring specialised care are transported to the nearest specialty centre; arrangements are made with optometrists and ophthalmologists for eye care; and assistance is provided, where necessary, to Indians who require medication and prosthetic devices.<sup>228</sup>

Departmental efforts continued to be focused on the needs of indigent individuals, confirming that they were “charged with arranging for medical care and public health services for indigent or impoverished groups of the indigenous races.”<sup>229</sup> Culhane Speck maintains that it was MSB’s intentions behind the use of the term “needs” that was problematic because it was based on the financial needs and employment status of individual applicants rather than the treatment of

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<sup>226</sup> Medical Services Branch, *Annual Report 1975-1976*. Ottawa, 13.

<sup>227</sup> Young, “Indian health services in Canada: a sociohistorical perspective”, 262.

<sup>228</sup> Medical Services Branch, *Annual Report 1970-1971*, 55.

<sup>229</sup> Medical Services Branch, *Annual Report 1968-1969*, 102.

health problems.<sup>230</sup> In order to address the financial pressures, MSB issued a more restrictive Policy Directive in 1978 implementing tighter controls on providing the health services, such as prescriptions, eye care and dental care that were not covered by provincial insurance plans but had identified as part of their mandate in 1970. First Nations immediately and publicly objected to the imposed restrictions claiming that the federal government had violated their citizenship rights.<sup>231</sup> What the federal government was arguing was a government benefit, Indigenous leaders claimed as a right.

By the spring of 1979, the NHW Minister bowed to Indigenous pressure and agreed to suspend the 1978 Policy Guidelines for six months. The guidelines were replaced in September 1979 by the *Statement on Indian Health Policy* (1979 Indian Health Policy) that cancelled the indigence requirement for eligibility and implemented medical criteria that were to be based on professional medical and dental judgement.<sup>232</sup> The 1979 Indian Health Policy remains Health Canada's current policy, and it is based on three pillars: community development, the traditional relationship of the Indian people to the Federal Government, and the interrelated Canadian health system.<sup>233</sup> Even after Indigenous peoples, as a collective group, were recognized under Section 35 of the 1982 *Constitution Act*, being classified as being either Indian, Inuit or Métis, was not a guarantee of having access to federal health programs. Since the federal government did not recognize health care as a right, government policy remained the same: health care programs

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<sup>230</sup> Culhane Speck "The Indian Health Transfer Policy: A step in the right direction, or revenge of the hidden agenda", 195.

<sup>231</sup> Young, "Indian health services in Canada: a sociohistorical perspective", 262.

<sup>232</sup> Ibid.

<sup>233</sup> Available at Health Canada website:

<https://www.canada.ca/en/health-canada/corporate/about-health-canada/branches-agencies/first-nations-inuit-health-branch/indian-health-policy-1979.html>

would continue to be designed in such a way as to restrict eligibility, limit access and constrain the financial obligations of government.

### **III - THE 1980s – TUBERCULOSIS, THE QUIET YEARS**

In the 1980s political priorities were dominated by constitutional issues arising from the signing of the *Constitution Act* in 1982. The recognition of Aboriginal rights in Section 35 of the *Constitution Act* offered a new narrative for the discussions of Indigenous health policies. With respect to tuberculosis, while the rates were still 10 times higher than in the non-Indigenous population, the 1980-1981 MSB Annual Report minimized the impact of the disease to sporadic outbreaks and emphasized health education “to stimulate continued awareness of the dangers of tuberculosis.”<sup>234</sup> Tuberculosis was not mentioned in annual reports until 1986-1987 where it was highlighted as one of many other health priorities.<sup>235</sup> A similar message was repeated in the 1987-1988 annual report, giving the impression that MSB no longer considered tuberculosis to be a problem. “Mortality and morbidity patterns remained essentially unchanged during the year, with sporadic incidents of tuberculosis reported.” The priority in Indigenous health had shifted to what they termed ‘lifestyle-related diseases’, particularly in the areas of cardiovascular disease, accidents and violence.<sup>236</sup> A review of MSB’s annual reports indicates that there was little reporting on the disease during this time, confirming WHO’s observation that the low national rates of tuberculosis in western countries had led governments to become complacent about tuberculosis programs.<sup>237</sup>

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<sup>234</sup> Medical Services Branch. *Annual Report 1980-1981*. Ottawa. 1979: 12.

<sup>235</sup> Medical Services Branch. *Annual Report 1986-1987*. Ottawa. 1987: 18.

<sup>236</sup> Medical Services Branch. *Annual Report 1987-1988*. Ottawa. 1988: 20.

<sup>237</sup> World Health Organization, “Chapter 6, Tuberculosis Complacency”, *Bugs, Drugs and Smoke: Stories from Public Health*. (Geneva, World Health Organization, 2011): 108.

Although tuberculosis was not a government priority during this time, the recognition of Aboriginal rights in Section 35 of the *Constitution Act* inspired significant shifts in Indigenous policy, which in turn influenced the federal government's approach to Indigenous health issues.

35. (1) The existing aboriginal and treaty rights of the aboriginal peoples of Canada are hereby recognized and affirmed.  
(2) In this Act, "*aboriginal peoples of Canada*" includes the Indian, Inuit and Métis peoples of Canada.<sup>238</sup>

The 1982 *Constitution Act* replaced the 1867 *British North America Act (BNA)* which had, until that time, acted as Canada's constitution. In his remarks at the April 17, 1982 Proclamation Ceremony on Parliament Hill, Prime Minister Pierre Trudeau alluded to Canada's coming to terms with its political maturity:

Today, at long last, Canada is acquiring full and complete national sovereignty. The Constitution of Canada has come home... It is with happy hearts, and with gratitude for the patience displayed by Great Britain, that we are preparing to acquire today our complete national sovereignty. It is my deepest hope that Canada will match its new legal maturity with that degree of political maturity which will allow us all to make a total commitment to the Canadian ideal.<sup>239</sup>

With Canada's national sovereignty to amend its own constitution, the Prime Minister intimated that the colonial link with Britain was severed. The notion that the last of the British colonial influence was swept away with the removal of the word 'British' in the title of the constitution may be somewhat misleading. With the exception of the new amending formula and the newly incorporated Charter of Rights and Freedoms, the wording and provisions of the *BNA* remained at the core of the new Constitution. For Indigenous peoples, this meant that the provisions of Section 91(24) for 'Indians, and lands reserved for Indians' that had shaped their definition as peoples under federal responsibility did not change.

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<sup>238</sup> Justice Laws Website, *Constitution Act 1982*. <http://laws-lois.justice.gc.ca/eng/Const/page-15.html#docCont>

<sup>239</sup> Prime Minister Pierre Trudeau's remarks at the Proclamation Ceremony April 17, 1982: <http://www.collectionscanada.ca/primeministers/h4-4024-e.html>

The Prime Minister's reference to the 'Canadian ideal' suggests a Marshallian notion of ideal citizenship that "societies in which citizenship is a developing institution should create an image of an ideal citizenship against which achievement can be measured and towards which aspiration can be directed."<sup>240</sup> Although the term 'Canadian ideal' was not defined, it evokes memories of the White Paper that was presented as being based on principles of equality among all citizens that required Indigenous peoples to assimilate in order to become equal. The Prime Minister's remarks also suggest protection from 'tyranny of the majority' within the Charter of Rights and Freedoms where equality of all citizens is supported before the law:

I speak of a Canada where men and women of aboriginal ancestry, of French and British heritage, of the diverse cultures of the world, demonstrate the will to share this land in peace, in justice, and with mutual respect... For if individuals and minorities do not feel protected against *the possibility of the tyranny of the majority, if French-speaking Canadians or native peoples or new Canadians do not feel they will be treated with justice*, it is useless to ask them to open their hearts and minds to their fellow Canadians.<sup>241</sup>  
(Italics added for emphasis)

The concept of the 'tyranny of the majority' is not defined other than within of the context of being 'treated with justice'. If tyranny is defined as "oppressive power exerted by government",<sup>242</sup> then the Charter of Rights and Freedoms should provide Indigenous peoples with protection from government policy actions that are deemed as oppressive. These concepts, arising from the Prime Minister's constitutional commitment, provide a social context in which to assess the impact of federal policy actions on Indigenous people and on Indigenous health. Although there were no changes to the federal government's responsibility for 'Indians and lands reserved for Indians' under Section 91(24) of the *Constitution Act*, the new Section 35 had a major impact on Indigenous policy. A new collective population group, called Aboriginal

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<sup>240</sup> Marshall, *Citizenship and social class*, 28

<sup>241</sup> Prime Minister Pierre Trudeau's remarks at the Proclamation Ceremony April 17, 1982:  
<http://www.collectionscanada.ca/primeministers/h4-4024-e.html>

<sup>242</sup> From Merriam-Webster online at: [www.merriam-webster.com/dictionary/tyranny](http://www.merriam-webster.com/dictionary/tyranny)

peoples, was recognized and defined as being comprised of three groups: Indians, Inuit and Métis. Aboriginal rights were also recognized, although the section did not define what is comprised in these rights.

The process that led to the inclusion of Section 35 is as important as the final wording of that section. Throughout the many constitutional discussions between the different levels of government, none had drawn attention to Indigenous issues. It was not until the early 1980s, after political campaigns and demonstrations by Indigenous groups to have their rights enshrined and protected, that the patriation discussions started to include recognition of Indigenous peoples. Indigenous groups also highlight the fact that, while Section 35 *recognizes* Aboriginal rights, it did not *create* them. Aboriginal rights existed before Section 35.<sup>243</sup>

It is against a backdrop of ongoing constitutional discussions that the nature of the relationship between Indigenous peoples and the federal government took shape in the 1980s. Section 35.1 of the Charter requires the federal government to “invite representatives of the aboriginal peoples of Canada to participate in the discussions”<sup>244</sup> before any amendment is made to the British North America Act’s Section 91(24). This meant that proposals such as the 1969 White Paper could no longer proceed without formal Indigenous participation.

In 1982, a Special Committee of the House of Commons on Indian Self-Government was appointed to review the legal and institutional issues related to the status, development, and responsibilities of band governments on reserves.<sup>245</sup> The majority of the recommendations in their 1983 Final Report (Penner Report) proposed constitutional recognition of Indigenous self-government. Hurley and Wherrett argue that it was the Penner Report which provided the federal

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<sup>243</sup> Available from University of British Columbia Indigenous Foundations:

[http://indigenousfoundations.arts.ubc.ca/constitution\\_act\\_1982\\_section\\_35/](http://indigenousfoundations.arts.ubc.ca/constitution_act_1982_section_35/)

<sup>244</sup> Available at the Justice Canada website: <http://laws-lois.justice.gc.ca/eng/const/page-16.html>

<sup>245</sup> Mary C. Hurley and Jill Wherrett. *Aboriginal self-government* (Ottawa, Parliamentary Research Branch, 1999):3.

government with the basis for a significant departure in the way that it had been approaching Indigenous policies at that time. Specifically, in March 1985 the federal government adopted a ‘two-track’ approach to self-government: constitutional negotiations, as outlined in Section 35.1 of the Charter; and community-based program negotiations with First Nations. This means that non self-government policy decision-making processes, such as education, health and social services, were to be framed within a community-based policy approach that was referred to as ‘devolution.’<sup>246</sup> It is this federal devolution approach to Indigenous health programs, outside the context of self-government discussions that is crucial to understanding the next steps in the federal government’s response to health issues such as tuberculosis.

Rae defines devolution of program delivery to First Nations as “a downloading process in which a program’s operations are shifted to the local level, producing what can be called self-administration or perhaps self-management.”<sup>247</sup> She argues that self-administration is not genuine self-government and that governments were simply handing over “bits and pieces of the administrative apparatus” to Indigenous peoples while blocking them from assuming the broad powers of governance.<sup>248</sup> It is within this political and ideological narrative that the federal government pursued the devolution of Health Canada’s community-based health programs to First Nations with the implementation, in 1989, of the Health Transfer Policy.

Tuberculosis was not reported as a priority for MSB for the rest the 1980s. What did emerge as an area of interest in the 1986-1987 Annual Report was HIV/AIDS. MSB shifted to a health

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<sup>246</sup> Hurley, Mary C., and Jill Wherrett. *Aboriginal self-government*. Parliamentary Research Branch, 1999: 4.

<sup>247</sup> Rae, Judith. "Program Delivery Devolution: A Stepping Stone or Quagmire for First Nations?" (2009) 7." *Indigenous LJ 2*: p.7

<sup>248</sup> Canada. Royal Commission on Aboriginal Peoples, *People to People, Nation to Nation: Highlights from the Report of the Royal Commission on Aboriginal Peoples* (Ottawa: Supply and Services Canada, 1996) [RCAP, Highlights] at “Looking Forward, Looking Back”. As cited in Rae, Judith. "Program Delivery Devolution: A Stepping Stone or Quagmire for First Nations?"(2009) 7." *Indigenous LJ 2*: p.7.

education protocol for HIV/AIDS activities in First Nations and Inuit communities as part of the departmental Minister's Advisory Committee on AIDS <sup>249</sup> and to the development of a manual on AIDS, “for use by professional staff at the field level to meet the needs of the community for AIDS-related information and disease prevention.”<sup>250</sup> While it acknowledged that the rates of HIV/AIDS were rising, the focus of the department’s public health programming was on preventive measures where it was deemed that health education strategies about the risks of transmission would address the problem. Linkages between the incidence of tuberculosis and HIV/AIDS would soon become an issue of global health concern in the 1990s.

#### **IV- THE 1990s - TUBERCULOSIS ‘RETURNS’**

In 1993, WHO declared tuberculosis to be a global emergency with 3 million deaths and 7.3 million new cases annually, the majority of which were in South-East Asia, and in sub-Saharan Africa.<sup>251</sup> Although the symptoms had remained constant throughout the decades, there were two complicating factors that affected the spread and treatment of tuberculosis in the 1990s. People living with HIV are more likely than others to become ill with tuberculosis. This is because HIV weakens the immune system, which makes it harder for the body to fight tuberculosis germs. One-third of the incidence of tuberculosis in the 1993-1995 period was linked to HIV. This means that a person with latent tuberculosis who became infected with HIV was 30 times more likely to become ill with active tuberculosis.

As well, up to 50 million people may have been infected by strains of the tuberculosis bacillus that had become resistant to one or more drugs that had been used for treatment over the

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<sup>249</sup> National Health and Welfare, *Annual Report 1986-1987*, 18.

<sup>250</sup> Medical Services Branch, *Annual Report 1987-1988*, 20.

<sup>251</sup> World Health Organization. *The World Health Report 1998. Life in the 21<sup>st</sup> Century. A vision for all.* (Geneva. World Health Organization, 1998): 54.

decades.<sup>252</sup> In Canada, neither HIV-tuberculosis co-morbidity nor multi-drug resistant tuberculosis, were considered factors in the higher rates of tuberculosis in Indigenous communities.<sup>253</sup> By 1995, WHO offered a political opinion that shifted attention to a lack of commitment by governments as a contributing factor in the epidemic. “The world's biggest killer and the greatest cause of ill-health and suffering across the globe is ... extreme poverty.”<sup>254</sup> The WHO placed the responsibility squarely on the shoulders of governments for their complacency and inaction in dealing with the socio-economic factors contributing to the re-emergence of the disease.

In Canada, the new tuberculosis outbreak targeted Indigenous communities disproportionately, as the rates in the Canadian-born non-Indigenous population were not affected and continued their downward trend. Increased rates in the Indigenous population peaked to 50 per 100,000 population in the 1992-1994 period.<sup>255</sup>

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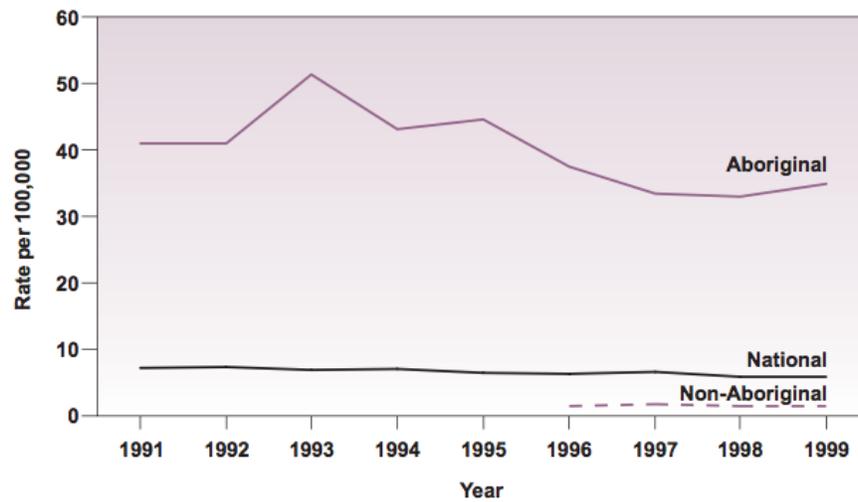
<sup>252</sup> Ibid

<sup>253</sup> For more information on HIV-tuberculosis co-morbidity and multi-drug resistance in Canada: Health Canada, Canadian Lung Association. *Canadian Tuberculosis Standards 5th Edition*. (Ottawa Minister of Public Works and Government Services Canada, 2000); and, Public Health Agency of Canada. *Tuberculosis: Drug resistance in Canada 2014*. (Ottawa. Minister of Public Works and Government Services, 2015).

<sup>254</sup> World Health Organization, *WHO World Health Report 1995* (Geneva, World Health Organization, 1995): 1. [http://www.who.int/whr/1995/media\\_centre/executive\\_summary1/en/index3.html](http://www.who.int/whr/1995/media_centre/executive_summary1/en/index3.html)

<sup>255</sup> Health Canada, *Tuberculosis in Canada 1999*. (Ottawa, Minister of Public Works and Government Services Canada, 2002): 4.

**Figure 2**  
**Age-standardized rate of TB incidence in Canada by origin, 1991-1999**



After years of reporting that tuberculosis in Indigenous communities consisted only of sporadic controllable minor incidents, MSB acknowledged in 1992 that tuberculosis “continued to cause concern”.<sup>256</sup> It also announced that it would take the necessary steps to eliminate the disease. “Standard preventive procedures were improved and meetings of key informants were held to establish a long-term strategy for eliminating TB in consultation with national expert (sic) and First Nation participants.”<sup>257</sup> This short statement in the MSB 1991-1992 Annual Report reflected a significant shift in government response for three reasons. First, it acknowledged that the federal government had not been successful in addressing the elevated rate of tuberculosis. Second, the stated goal shifted to eliminating the disease. Third, MSB committed to including First Nations in developing a strategy to eliminate tuberculosis.

As a result, the federal government collaborated with the Assembly of First Nations (AFN) to develop the *National Tuberculosis Elimination Strategy (1992 National Tuberculosis*

<sup>256</sup> National Health and Welfare. *Annual Report 1991-1992* :13.

<sup>257</sup> Ibid.

*Elimination Strategy*).<sup>258</sup> The use of the term ‘elimination’ is significant. The epidemiological definition of elimination is a reduction of disease incidence to 1 per million population.<sup>259</sup> The mandate of the 1992 *National Tuberculosis Elimination Strategy* was an ambitious one. The plan was to reduce the incidence of tuberculosis in Indigenous communities from 49 cases per 100,000 people in 1992 to less than 1 case per 100,000 people by the year 2010.<sup>260</sup> The federal government was likely influenced by the fact that the rates of tuberculosis in the Canadian-born non-Indigenous population were continuing their downward trend. They may, however, have underestimated the complexity of the challenges awaiting them.

The 1992 *National Tuberculosis Elimination Strategy* was also centered on the notion that “program planning, implementation and evaluation are based on community ownership and participation at all stages, and are strengthened and maintained by community and agency partnerships.”<sup>261</sup> Collaboration with local communities was a crucial element to ensure the success of Directly Observed Treatment Short-course (DOTS) for latent tuberculosis “which requires the patient to be seen by a second person during the course of his treatment to ensure that prescribed medication are taken as instructed in the presence of the second person”<sup>262</sup> One of the concerns with this form of treatment is the difficulty with poor adherence and taking the full course of medication regime over a protracted period of time.

Orsini describes three of the main challenges for the 1992 *National Tuberculosis Elimination Strategy*: control programs; case management; and, jurisdiction. First, tuberculosis control in Canada is governed by two treatment models: a centralized control program that

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<sup>258</sup> Health Canada. *National Tuberculosis Elimination Strategy*, 2.

<sup>259</sup> Michael Clark, *Tuberculosis in First Nations Communities 1999*. (Ottawa, Health Canada, 1999): 3.

<sup>260</sup> *Ibid*, 2.

<sup>261</sup> Health Canada. *National Tuberculosis Elimination Strategy*, 14.

<sup>262</sup> *Ibid*.

includes the provision of clinical services; and a program of centralized and decentralized public health elements that relies on community-based specialists and primary care physicians for the delivery of clinical services.<sup>263</sup> Since there is no national program and no program consistency across provinces, the default position is that tuberculosis programs are otherwise provincial.<sup>264</sup> Second, tuberculosis control involves a long case management period for the treatment of the disease. Public health staff must develop strong relationships with primary care and other physicians, as well as develop relationships with agencies or partners that can provide psychosocial services to help individuals address and overcome barriers to treatment compliance.<sup>265</sup> Third, jurisdictional ambiguities are a major impediment to the coordination and delivery of public health programs. In the case of Indigenous populations, a national tuberculosis strategy not only requires the federal government collaborate effectively across provinces and local or regional authorities, but also demands that the federal government work constructively with First Nations.<sup>266</sup>

Twenty years later, the Public Health Agency of Canada confirmed that the tuberculosis rate among Canadian-born Aboriginal people remained at 23.8 cases per 100,000 population in 2011 as compared with the overall Canadian rate of 4.7 cases per 100,000 population.<sup>267</sup> As a result, although there was a reduction in the rates from 49 per 100,000 population to 23.8 per population, the 1992 National Tuberculosis Elimination strategy was not successful in achieving

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<sup>263</sup> Michael Orsini, *Jurisdictional ambiguity or lack of political will? Intergovernmental relations, public health, and tuberculosis control among Aboriginals in Manitoba and Saskatchewan* (Kingston, Institute of Intergovernmental Relations Queen's University, 2000): 12.

<sup>264</sup> *Ibid.*

<sup>265</sup> Orsini, *Jurisdictional ambiguity or lack of political will? Intergovernmental relations, public health, and tuberculosis control among Aboriginals in Manitoba and Saskatchewan*, 13.

<sup>266</sup> *Ibid.*, 15.

<sup>267</sup> Public Health Agency of Canada, *The Chief Public Health Officer's Report on the state of Public health in Canada 2013 - Infectious Disease: The Never-ending Threat*, 55.

its goal and should have presented itself as an opportunity to analyze the “failures” as they prepared to renew the strategy.

## V- FROM INDIGENCE TO SOCIAL CITIZENSHIP

Marshall introduced the notion that citizenship represents the status that is bestowed on those who are full members of a society, and that “societies in which citizenship is a developing institution should create an image of an ideal citizenship against which achievement can be measured and towards which aspiration can be directed.”<sup>268</sup> Within the context of the constitutional reforms and rhetoric of the ‘Canadian ideal’, the claims to Indigenous self-government and self-determination in the 1980s should have been implemented with these principles in mind.

Culhane Speck argues that it was assimilationist goals that were the driving force behind the 1979 Indian Health Policy, that First Nations were a temporary phenomenon, and that their members were a transitional category of persons:

In line with Indian policy, Indians were to be assimilated and through that process, distinct Indian health services would become redundant, naturally. On this basis, assimilationist policies may be defined as those that do not recognize First Nations rights to health care as flowing from a basis in distinct legal or political rights, and that favour integrating Native with non-Native consumers of services. This is the position that has consistently guided federal government strategy negotiations with First Nations regarding health care.<sup>269</sup>

Set within the political ideology of historical colonial policies, Indigenous health policies weave together three different perspectives: the people; the health care system; and the policy. Since the federal Indigenous health policy expected Indigenous peoples to integrate into the rest of the population to access provincial health services, it would follow that the federal government

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<sup>268</sup> Marshall, *Citizenship and Social Class*, 28.

<sup>269</sup> Culhane Speck, "The Indian Health Transfer Policy: A step in the right direction, or revenge of the hidden agenda", 191-192.

expected that their responsibility for Indigenous health would come to an end. Second, the growing network of provincial health systems that developed in the 1960s provided an ideal default position from which the federal government could plan the delivery of Indigenous health services until full integration occurred. Third, Indigenous health policies could simply focus on what was necessary during the transition as a stop-gap measure as opposed to developing a slate of health programs as a matter of rights.

Marshall had also cautioned against what he called “the invidious operation of official discretion” and had suggested that citizenship implies that there should be no stigma attached to the use of public services and no public attitudes condemning dependency.<sup>270</sup> Within that context, the removal of the indigence criterion in the 1979 Indian Health Policy appeared to be a step in the right direction. However, the federal government continued to refuse to acknowledge that non-insured health services were being provided to Indigenous peoples as a recognition of their rights. The name that they attached to the national program that flowed from this policy, the Non-Insured Health Benefits Program, further supports the position that they were interpreted and defined by the federal government to be benefits, not rights. As Brodie explains, government benefits are subject to fluctuations in policy decisions, making them “vulnerable to unilateral changes in political priorities within neo-liberal states, as was the case with the erosion of government-wide social programs in the latter decades of the 20<sup>th</sup> century.”<sup>271</sup>

Since the responsibility for Indigenous health was located within a separate department from DIAND, the federal government was well positioned to advance policies that supported assimilationist goals on matters of health without appearing to be in contravention with the

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<sup>270</sup> Julia Parker, *Social Policy and Citizenship* (pp.145-6) as cited in Note 26 in King and Waldron, *Citizenship, Social Citizenship and the Defence of Welfare Provision*, 422.

<sup>271</sup> Janine Brodie, “The Social in Social Citizenship.” *Recasting the social in citizenship* (2008): 23.

principles of self-government that were espoused at DIAND. What was at odds with this approach were the individuals who, for purposes of self-government policies, were recognized as Indigenous citizens for the administration of specific rights such as land claims, yet on matters of health policies, were considered as provincial citizens-in-waiting, with no recognition of Indigenous rights to health.

Even in the midst of the high-level discussions on self-determination between Indigenous leaders and the federal government, the 1979 Indian Health Policy did nothing to sway the federal government from its goal of ending involvement in health care. The target, under the guise of increasing Indigenous interest for self-determination, simply shifted from transferring responsibility to the provinces, to transferring to responsibility to the Indigenous communities themselves. The motivation, federal withdrawal from Indigenous health care, remained the same:

A decade after its inception, the broader promise of the 1979 Indian Health Policy, to address health care in communities, was abandoned for an exclusive focus on federal transfers to First Nations for some aspects of health care delivery. As Minister Jake Epp told the Assembly of First Nations health transfer conference in 1987, ‘We, in Health and Welfare, and many others in the health field, are convinced that the future health of the Indian people rests in your hands, not in ours... God bless you all.’ Author Dara Culhane Speck wondered if the Minister’s statement was a threat or a promise.<sup>272</sup>

Lavoie argues that the scope of the Indian Health Policy lacks clarity as it does not specify whether it applies to registered and non-registered Indians, and it makes no mention of Inuit.<sup>273</sup> In 1979, the Indian Health Policy was a short 2-page document, and its stated goal was also brief: “... the goal of Federal Indian Health Policy is to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities

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<sup>272</sup> Maureen K. Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s*, (Toronto, University of Toronto Press, 2016); 194-195.

<sup>273</sup> Josée G. Lavoie, "Policy silences: why Canada needs a National First Nations, Inuit and Métis health policy." *International Journal of Circumpolar Health* 72 (2013): 3.

themselves.”<sup>274</sup> Although the wording of the stated goal and the three pillars remain the same, the influence of the self-determination discussions that dominated Indigenous policy decision-making during the 1980s is reflected in the narrative that now frames the preamble of the 1979 Indian Health Policy as it currently appears on the Health Canada website:

Policy for federal programs for Indian people, (of which the health policy is an aspect), flows from constitutional and statutory provisions, treaties and customary practice. It also flows from the commitment of Indian people to preserve and enhance their culture and traditions. It recognizes the intolerable conditions of poverty and community decline which affect many Indians, and seeks a framework in which Indian communities can remedy these conditions. The Federal Government recognizes its legal and traditional responsibilities to Indians, and seeks to promote the ability of Indian communities to pursue their aspirations within the framework of Canadian institutions.<sup>275</sup>

It is a statement that is, at best, suited to sowing confusion, and at worst, to promote its assimilationist objectives ‘within the framework of Canadian institutions.’ The 1979 Indian Health Policy ends with the equally optimistic statement that “These three pillars of community development, the traditional relationship of the Indian people to the Federal Government, and the interrelated Canadian health system provide the means to end the tragedy of Indian ill- health in Canada.”<sup>276</sup> Arguably, in light of the persistent inequalities in the rates tuberculosis between Indigenous and non-Indigenous communities, the federal government’s fragmented approach is not providing the leadership and commitment that is required for accomplishing these goals. Inequalities in health confirm there is in fact a ‘disconnect’ between policy and reality:

Considering that Aboriginal Peoples experience an overall inferior health status when compared to the non-Aboriginal population, it is not surprising that various recent studies on Aboriginal health and health care have found a “disconnect” between Aboriginal Peoples and Canadian Governments that accounts for this poor health status.<sup>277</sup>

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<sup>274</sup> As cited in: Lavoie, Josée G. "Policy silences: why Canada needs a National First Nations, Inuit and Métis health policy." *International Journal of Circumpolar Health* 72 (2013): p. 3.

<sup>275</sup> Health Canada website: [http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli\\_1979-eng.php](http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli_1979-eng.php)

<sup>276</sup> Health Canada. Indian Health Policy 1979. Available at the Health Canada website: [http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli\\_1979-eng.php](http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli_1979-eng.php)

<sup>277</sup> University of Saskatchewan et al, *First Nations, Métis and Inuit Health Care: The Crown's Fiduciary Obligation*, 31.

There are five underlying reasons that are identified for this disconnect: competing constitutional assumptions; fragmented funding for health services; inadequate access to health care services; poorer health outcomes; and different cultural and political influences.<sup>278</sup> In light of the persistent health inequalities in Indigenous peoples, it becomes evident that the true nature of the disconnect lies beyond the written word in policy statements and is expressed in the way in which the intentions of these policies are implemented into actions and programs. Marshall observed that 20<sup>th</sup> century citizenship, with its inherent claims of equality, was at odds with the capitalist class system and its in-built economic inequalities. The result was inequality in social and economic conditions among citizens. Citizenship, therefore, did not guarantee full equality beyond the list of specific civil and political rights in a capitalist society.<sup>279</sup>

## **VI- CONCLUSION**

The government's insistence on the medical approach to respond to the high rates of Indigenous tuberculosis in the latter decades of the 20<sup>th</sup> century did not reflect the notions of equality and Indigenous self-determination that had dominated the political and constitutional discussions in the decades that followed the 1969 White Paper. In spite of the federal government's self-determination narrative, MSB's actions brought no significant changes to the way that Indigenous health policies were developed. Instead, Indigenous health policies continued to be framed within exclusionary approaches that would facilitate the transfer of Indigenous health care to provincial responsibility. When that did not seem possible then the federal government took the view that individual communities should take responsibility for the

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<sup>278</sup> Romanow, *Building on values: the future of health care in Canada* (20 *supra* note 6 at 212) as cited in: University of Saskatchewan et al, *First Nations, Métis and Inuit Health Care: the Crown's Fiduciary Obligation*, 31.

<sup>279</sup> Marshall, *Citizenship and Social Class*, p. 29.

health care of members through a transfer of funds to band councils.

A Foucauldian perspective on the power relations between the federal and provincial governments and Indigenous citizens provides some clarity on the elements of subjectivity of Indigenous peoples within Canadian society. Looking at Foucault's use of the three modes of dividing practices, which include scientific classification, and subjectification to objectify the subject, it can be seen that they can directly apply to Indigenous-government relations. First, the recognition of Aboriginal peoples in Section 35 of the *Constitution Act* did not improve equality between Indigenous and non-Indigenous peoples. For policy purposes, the federal government continued to form specific Indigenous identities through dividing practices (such as status Indians, non-status Indians, on-reserve, off-reserve, etc) to determine an individual Indigenous person's eligibility and access to specific health care programs.<sup>280</sup> Second, the Health Transfer Policy served to operationalize First Nations into new categories based on scientific categorization that were developed by the government to assess First Nations' capabilities to adapt and assimilate into the health care system. The third mode, subjectification, involves the fact that the final authority on First Nations competence to assume control over their community health resided in the Health Canada bureaucracy, not in the communities.

While Section 35 did not create Aboriginal peoples, it nonetheless confirmed their existence.<sup>281</sup> Thus, Aboriginal peoples were considered as a vanished traditional society and culture whose surviving individuals were recognized for policy purposes as beneficiaries of government programs and services.<sup>282</sup> Section 35 presented the opportunity to change that

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<sup>280</sup> Foucault, "The Subject and Power," 708.

<sup>281</sup> From University of British Columbia Indigenous Foundations : [http://indigenousfoundations.arts.ubc.ca/constitution\\_act\\_1982\\_section\\_35/](http://indigenousfoundations.arts.ubc.ca/constitution_act_1982_section_35/)

<sup>282</sup> Waldram et al, *Aboriginal Health In Canada: Historical, Cultural, And Epidemiological Perspectives Second Edition*.

assumption. From a policy decision-making perspective, however, political assumptions continued to be based on the premise that it was the federal government who created and recognized Indigenous identity. The recognition of ‘Aboriginal peoples’ in Section 35 did not resolve that issue. The 1996 Final Report of the Royal Commission on Aboriginal Peoples (RCAP) sought to address this issue by trying to clarify conflicting assumptions in the way that Indigenous Peoples were defined.

The term Aboriginal peoples refers to organic political and cultural entities that stem historically from the original peoples of North America, rather than collections of individuals united by so-called 'racial' characteristics. The term includes the Indian, Inuit and Métis peoples of Canada (see section 35(2) of the Constitution Act, 1982).<sup>283</sup>

Citizenship is a complex concept that revolves around the issue of membership, and there is an exclusionary nature to the concept of universality and equality in Marshall’s concept of citizenship. Lister argues that the process which determines which citizens are to be included for purposes of social rights also leads to the exclusion of other citizens.<sup>284</sup> The federal government’s recognition of Aboriginal peoples and Aboriginal rights in the 1982 *Constitution Act* did not clearly identify who defines the membership process to determine who is a First Nation, Inuit or Métis person, and for which rights and obligations they are entitled to be considered for purposes of access to health care services. It was left to the federal government to provide this clarity through health policies. Since the federal policy process is based on its interpretation of Section 91(24) of the *Constitution Act*, they were in the position to decide which Indigenous individuals would be their responsibility. Provincial responsibility could then be identified to extend to those Indigenous peoples that the federal government did not deem to be covered. If we accept

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<sup>283</sup> RCAP Report Volume 1, Looking Forward, Looking Back, A note about terminology, p.iii:

<http://data2.archives.ca/e/e448/e011188230-01.pdf>

<sup>284</sup> Ruth Lister, “Inclusive citizenship: realizing the potential”. *Citizenship Studies*, Vol II, Issue I, February 2007; Ruth Lister, *Citizenship: feminist perspectives*. (New York, NYU Press, 2003): 13.

Romanow's depiction of the federal government as payer of last resort, then the federal responsibility for Indigenous health was meant to last only as long as the provincial governments refused to provide health services to First Nations.

The Health Transfer Policy is an example where the federal government dictated the definition for inclusion and exclusion. Culhane Speck captures the sense of Indigenous anxiety about the federal government's motives. When Health Canada announced the Health Transfer Policy, it claimed that it had evolved from consultations with First Nations. This claim was rejected by First Nations leaders who maintained that they had not been consulted on the details of the Health Transfer Policy which appeared contrary to the demands that they had been making with respect to health.<sup>285</sup> The National Chief of the AFN noted in 1986 that a key strategy of the federal government had been to "use our language, but not the concepts they are meant to convey, in program and policy formation."<sup>286</sup>

As the National Chief's comments demonstrate, the political ideologies of the federal government had not transformed to incorporate the Indigenous worldview of who they were as peoples. The federal government continued to define Indigenous peoples in order to limit their responsibility and to decide which individuals would be included and excluded in that definition. In other words, the parameters of Indigenous society continued to be based on colonial assumptions inherent in the wording of Section 91(24) of the *Constitution Act* that federal responsibility extended to 'Indians and Lands Reserved for Indians'.<sup>287</sup>

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<sup>285</sup> Culhane Speck, "The Indian Health Transfer Policy: A step in the right direction, or revenge of the hidden agenda", 199.

<sup>286</sup> Georges Erasmus, "Comment: Indian Policy in the New Conservative Government, Part II: The Nielsen Task Force in the Context of Recent Policy Initiatives" as cited in Culhane Speck, "The Indian Health Transfer Policy: A step in the right direction, or revenge of the hidden agenda", 53-63.

<sup>287</sup> A copy of the *Constitution Act* from 1867 to 1982 is available from the Justice Canada website: <http://laws-lois.justice.gc.ca/eng/const/page-4.html>

As the 20<sup>th</sup> century came to an end, the higher rates of tuberculosis in Indigenous communities did not constitute a federal priority. The federal government adopted a position of complacency throughout the 1980s, choosing to rely on a public health education approach that focused on awareness strategies which they expected would lead the rates to magically drop to the levels in non-Indigenous communities. This approach was not successful against the global resurgence of the disease in the early 1990s that led the World Health Organization to declare it a global emergency in 1993.<sup>288</sup> In Canada, there was a corresponding spike in the number of cases in Indigenous communities where the rates became more elevated while the national rates remained low. The government's response was the *National Tuberculosis Elimination Strategy*<sup>289</sup> in 1992 that focused program and medical personnel on strengthening the tuberculosis treatment and control programs to drastically reduce the prevalence of the disease within twenty years.

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<sup>288</sup> World Health Organization. *The World Health Report 1998. Life in the 21<sup>st</sup> Century. A vision for all.* (Geneva. World Health Organization, 1998): 54.

<sup>289</sup> Health Canada. *National Tuberculosis Elimination Strategy.*

## CHAPTER 5

### POLICY-POLITICS DISCONNECT: TUBERCULOSIS IN THE 21<sup>ST</sup> CENTURY (2000-2015)

#### I - INTRODUCTION

As Canada embarked into the new century, the message about tuberculosis remained the same – the rates in Indigenous communities were higher than in the rest of the Canadian population. Although it may be too soon to assess the government’s actions over the first decade and a half of the 21<sup>st</sup> century to determine their impact on Indigenous tuberculosis, there were, however, policy trends that emerged.

There were six federal elections in the first 15 years of the 21<sup>st</sup> century that included three consecutive minority governments in 2004, 2006 and 2008.<sup>290</sup> Gagnier explains that minority governments create political uncertainty for the public policy process because they are viewed as transitional in nature as they must work to maintain the confidence of the House.<sup>291</sup> As such, the government’s priorities are focused on doing whatever is necessary to remain in power until such time as they can return with a majority government. However, Canadians favour minority governments as they are believed to be more responsive because

they have to take the views of their own members and that of the other parties to ensure passage of legislation. They are, in a word, more apt to be responsive to public opinion. This is partly true but the reverse side of the coin is that the focus is as much a question of what it takes to get to a launch platform in an acceptable time frame to allow a return to majority.<sup>292</sup>

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<sup>290</sup> Results available at: [www.elections.ca/content.aspx?section=ele&dir=pas&document=index&lang=e](http://www.elections.ca/content.aspx?section=ele&dir=pas&document=index&lang=e)

<sup>291</sup> Daniel Gagnier, “Majority or Minority Government: A Personal Perspective.” *Policy Options*. October 1, 2011. (Montreal, Institute of Research in Public Policy, 2011).

<sup>292</sup> *Ibid*, 4.

This ideological belief may be the legacy of the Liberal minority governments of Prime Minister Lester B. Pearson during the 1960s when he was successful in entrenching legislation for the national universal social programs that were key elements of the Welfare State in Canada: the Canada Pension Plan Act in 1965; the Canada Assistance Plan Act in 1966; and the Medical Care Act in 1966.<sup>293</sup> From the perspective of Indigenous policy, the minority governments of the early 21st century came close to repeating a similar legacy. Unfortunately, the result was a period of uncertainty as the promise of a renewed Government-Indigenous relationship with the *Kelowna Accord* under the short-lived Liberal minority government in 2004-2005 came to an abrupt halt when the election of the Conservative minority government in 2006 began the dismantling of these progressive Indigenous policy directions.<sup>294</sup>

It is against this political backdrop that the higher rates of tuberculosis in First Nations and Inuit communities came to the attention of the House of Commons Standing Committee on Health. On March 11, 2010, under the direction of the Chair, MP Joy Smith, the Committee passed the following motion:

It was agreed - that the committee conduct a study of the elevated rates of tuberculosis infection in First Nations and Inuit communities and report its conclusions, including recommendations toward a national strategy to eradicate this disease, to the House of Commons, and that this topic be added to the priority list for consideration when all parties' lists have been reviewed or received.<sup>295</sup>

It was the renewal of the 1992 *National Tuberculosis Elimination Strategy* that was at the centre of the committee's study, but there had also been recent media coverage by the Winnipeg

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<sup>293</sup> Information on federal electoral results available from the Library of Parliament website: <http://www.lop.parl.gc.ca/ParlInfo/compilations/ElectionsAndRidings/ResultsParty.aspx>

<sup>294</sup> Lisa Patterson, *Aboriginal roundtable to Kelowna Accord: Aboriginal policy negotiations, 2004-2005*. (Ottawa, Parliamentary Information and Research Service, 2006): 2.

<sup>295</sup> Parliament of Canada website: <https://www.ourcommons.ca/DocumentViewer/en/40-3/HESA/meeting-1/minutes>

Free Press on the tuberculosis crisis in a northern Manitoba First Nation that had come to the attention of federal politicians.<sup>296</sup> On June 8, 2010, the Committee tabled its Final Report entitled *The Way Forward: Addressing The Elevated Rates of Tuberculosis Infection In On-Reserve First Nations and Inuit Communities*,<sup>297</sup> in which they presented 14 recommendations that Health Canada should address as part of a renewed strategy. Health Canada released its renewed tuberculosis strategy in 2012.

## II – TUBERCULOSIS – THE STANDING COMMITTEE ON HEALTH

In his 2013 *Report on the State of Public Health in Canada: Infectious Disease – The Never-ending Threat*, Butler-Jones, Canada’s Chief Public Health Officer (CPHO), confirmed that while Canada’s overall rate, at less than 5 cases per 100,000 people compares favourably with those in other developed countries, the majority of cases in Canada occurs in two demographic groups: Indigenous peoples and individuals who were born outside of Canada. He reported that while the greatest number of cases is among foreign-born individuals, the incidence rate per 100,000 population has consistently been highest among Canadian-born Indigenous individuals.<sup>298</sup>

Health Canada did not meet the interim tuberculosis reduction targets that they set in in the 1992 *National Tuberculosis Elimination Strategy* to eliminate tuberculosis in Indigenous communities by the year 2010. They were equally unsuccessful in reaching the interim target to reduce the disease to less than 20 cases per 100,000 population by the year 2000 with an average

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<sup>296</sup> Jen Skerritt, *The Forgotten Disease. TB epidemic plagues the North*. Winnipeg Free Press. Published 10/31/2009. <http://www.winnipegfreepress.com/special/TBspecial/TB-epidemic-plagues-the-North-66561007.html>

<sup>297</sup> Joy Smith, *The way forward: addressing the elevated rates of tuberculosis infection in on-reserve First Nations and Inuit communities*. Report of the Standing Committee on Health. June 2010, 40th Parliament, 3rd Session. Ottawa. 2010.

<sup>298</sup> Pamela Orr, et al, *Canadian Tuberculosis Standards 7th Edition*. (Ottawa, Public Health Agency of Canada, 2014).11.

annual rate of decline of 15%.<sup>299</sup> In epidemiology, a disease is considered to be eliminated when it reaches the incidence rate of 1 case per 1 million population.<sup>300</sup> These targets were not met. In 2014, although they made up only 4% of the total Canadian population, Indigenous People accounted for 21% of reported cases with a corresponding incidence rate of 20.4 per 100,000 population when compared to the incidence rate 0.6 per 100,000 population in the Canadian-born non-Indigenous population.<sup>301</sup>

*The House of Commons Standing Committee on Health (the Committee)*

At a public hearing of the Committee on April 20, 2010, Health Canada officials confirmed that they were in the process of renewing the 1992 *National Tuberculosis Elimination Strategy* and reiterated the federal position on Indigenous health.

Our mandate at Health Canada is to provide or support the provision of health services in on-reserve first nations communities south of the 60th parallel. In addition, we currently provide funding for TB prevention and control in Nunatsiavut in Labrador. The three northern territories, as you all know, are responsible for all health program service delivery there, and this incorporates TB prevention and control activities for all territorial residents, including the First nations and Inuit. Health Canada and the Public Health Agency of Canada provide funding to support certain health promotion and disease prevention activities in the territories.<sup>302</sup>

Although the name of the First Nations and Inuit Health Branch (FNIHB) to whom the officials report implies a responsibility for both First Nations and Inuit populations, the description of their mandate with respect to tuberculosis policy was not inclusive. With respect

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<sup>299</sup> Health Canada, *National Tuberculosis Elimination Strategy*. Working Group on Tuberculosis, 2.

<sup>300</sup> Michael Clark, *Tuberculosis in First Nations Communities 1999*. (Ottawa, Health Canada, 1999): 2-3.

<sup>301</sup> Ibid, 2.

<sup>302</sup> Parliament of Canada. *Evidence Tuesday April 10, 2010*. Standing Committee on Health - Number 010, 3<sup>rd</sup> Session, 40<sup>th</sup> Parliament. 2010: 2. Available at:

<http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=e&Mode=1&Parl=40&Ses=3&DocId=4443113>

to First Nations, the policy excluded responsibility for First Nations located in the territories and First Nations who live off-reserve south of the 60<sup>th</sup> parallel. With respect to Inuit, it excluded all Inuit who live in the territories yet included Nunatsiavut, an Inuit land claim area located in Newfoundland and Labrador, and made no mention of Nunavik an Inuit land claim area located in northern Québec. Even within those geographically-based population groups that they had identified as their responsibility, it was not the case of Health Canada delivering a national tuberculosis program, it was simply a list of health services for which they would assume responsibility. These included the provision of *health services* in the case of on-reserve First Nations communities south of the 60th parallel, the funding for tuberculosis *prevention and control services* in Nunatsiavut in Labrador, and the funding to support *certain health promotion and disease prevention* activities in the territories, which includes First Nations and Inuit.<sup>303</sup>

This complex delineation of responsibility was more of a shopping list of health care services than a comprehensive tuberculosis program, and was based on the assumption that these communities had access to the full complement of services from other sources. It also reflected a fundamental shift in Indigenous health policy in the 18 years since the 1992 *National Tuberculosis Elimination Strategy* was released since this document used the term “Aboriginal Peoples” inclusively to encompass “status and non-status Indians, Inuit and Métis” within the scope of their mandate. The rationale that they had made was that the high incidence of the disease was shared among all these peoples “just as are many of the factors which contribute to the transmission of infection and the development of the disease.”<sup>304</sup> The renewal of the strategy, therefore, reflected not only a reduction in target rates of tuberculosis but also changing organizational goals at the federal level, with a marked narrowing in scope for its mandate.

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<sup>303</sup> Health Canada, *Health Canada’s Strategy Against Tuberculosis for First Nations On-reserve*.

<sup>304</sup> Health Canada, *National Tuberculosis Elimination Strategy*. Working Group on Tuberculosis, 2.

It is important at this point to explore these organizational shifts and the way that they would influence Health Canada's approach to the renewal of their tuberculosis policy. In 1992, the tuberculosis policy had also stated that, "Like the disease itself, the concentrated effort required to eliminate tuberculosis must cross political and service jurisdictional lines."<sup>305</sup> This inclusive mandate across all Indigenous peoples and the goal to concentrate efforts across 'political and jurisdictional lines' represented the need for an overarching national perspective on tuberculosis. By 1997, it was clear that the target of eliminating Indigenous tuberculosis would not prevail and Health Canada acknowledged the need to revise it to a target that would instead see the rates at less than 1 case per 100,000 people in Indigenous communities by the year 2010.<sup>306</sup> Since the 2014 rates stood at 20.4 per 100,000 population, this revised target was also not met.

The use of the word 'Aboriginal' as the target population for the tuberculosis policy in 1992, representing an inclusive approach to the three Indigenous groups, did not endure into the 21<sup>st</sup> century. By 2004, Health Canada confirmed a more limited mandate and that

... First Nations and Inuit should receive services in a seamless way through integration of federal/provincial/territorial programs; First Nations and Inuit should have access to the same quality and availability of service as the rest of the population living in similar geographic areas...<sup>307</sup>

Health Canada's efforts were once again directed to First Nations and Inuit rather than Indigenous peoples in general, and the goal was that Indigenous health would be assimilated into the provincial health care system. Arguably, a seamless integration into the provincial health

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<sup>305</sup> Ibid.

<sup>306</sup> Health Canada, *Performance Report Health Canada For the Period Ending March 31, 1997, Improved Reporting to Parliament – Pilot Document*. Ottawa, Public Works and Government Services Canada, 1997: 52.

<sup>307</sup> Health Canada, *Departmental Performance Report 2003-2004*. Ottawa, Public Works and Government Services Canada, 2004: 77.

systems implies that the federal government could withdraw from Indigenous health as soon as Indigenous peoples accessed the same provincial programs as other Canadians living in ‘similar geographical areas’.

There were two organizational changes at Health Canada that are major factors in defining the way that Indigenous health would fit into federal priorities. The first was in 1997 when Treasury Board replaced departmental annual reports with Performance Reports to modernize the reporting of departmental program outcomes against expenditure budgets approved by Parliament in the yearly Main Estimates.<sup>308</sup> Program priorities were now identified as Business Lines with expected goals and outcomes. A review of Health Canada’s reports indicates that while addressing health inequalities between Indigenous and non-Indigenous peoples was recognized as a goal, the reporting was focused on process descriptions of program activities outlining the number of transactions, number of staff and use of resources rather than on health outcomes.<sup>309</sup>

The second organizational change was in 2000 when, as part of improvements for the management of the departmental business lines, the Medical Services Branch (MSB) was reorganized as the First Nations Inuit Health Branch (FNIHB). Its objective was

To assist Aboriginal communities and people in addressing health inequalities and disease threats and in attaining a level of health comparable to that of other Canadians, and to ensure the availability of, or access to, health services for registered First Nations people and Inuit.<sup>310</sup>

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<sup>308</sup>Health Canada, *Performance Report Health Canada For the Period Ending March 31, 1997, Improved Reporting to Parliament – Pilot Document*, Foreword.

<sup>309</sup> Health Canada, *Performance Report Health Canada For the Period Ending March 31, 2002*. (Ottawa, Public Works and Government Services Canada, 2002).

<sup>310</sup>Health Canada, *Performance Report Health Canada For the Period Ending March 31, 1997, Improved Reporting to Parliament – Pilot Document*, Foreword.

It is interesting to note that while the federal government was still maintaining the reference to ‘Aboriginal peoples’ with respect to the overall goal of health equality, the choice of the words ‘to assist’ and ‘to ensure the availability of’ health services was restricted to First Nations and Inuit. By 2004, FNIHB’s goals no longer referred to Indigenous peoples:

Sustainable health services and programs for First Nations and Inuit communities and people that address health inequalities and disease threats so that they may attain a level of health comparable with that of other Canadians, and in collaboration with the provinces and territories.<sup>311</sup>

In the period from 2001-2005, Health Canada’s performance reports made only passing reference to the fact that tuberculosis infection rates remained six times higher than the Canadian general population.<sup>312</sup> The rest of the Performance Reports until 2015 focused on tuberculosis program activities that FNIHB was funding on-reserve and in Inuit communities, without reference to any improvement or deterioration in the prevalence of tuberculosis.

*The Final Report of the House of Commons Standing Committee on Health*

On June 8, 2010, the Committee tabled its Final Report, *The Way Forward: Addressing The Elevated Rates of Tuberculosis Infection In On-Reserve First Nations and Inuit Communities* (Final Report) in the House of Commons.<sup>313</sup> The report was divided into four sections in which the first two sections outlined factual background information on the tuberculosis problem in Canada and the federal government’s role in addressing this problem. In the third section, the Committee presented what they heard from the witnesses about the best ways to address the high

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<sup>311</sup> Canada. Health Canada. *Performance Report 2003-2004*. (Ottawa, Public Works and Government Services Canada, 2004): 75.

<sup>312</sup> Canada. Health Canada. *Performance Report 2004-2005*. (Ottawa, Public Works and Government Services Canada, 2005): 77.

<sup>313</sup> Smith, *The way forward: addressing the elevated rates of tuberculosis infection in on-reserve First Nations and Inuit communities*.

rates of tuberculosis, and the final section offered four main areas of action that Health Canada should address as part of a renewed strategy:

- 1) Improve existing TB strategies and programs by developing national goals, targets and performance indicators measured on an annual basis to hold all players to account in their efforts to address this problem.
- 2) *Address jurisdictional challenges* in providing seamless TB prevention and treatment programs to First Nations and Inuit communities.
- 3) Ensure the involvement of First Nations and Inuit communities in the development of TB strategies and programming to promote equality, community ownership and capacity building.
- 4) Include measures to *address the social determinants of health as a key component of a TB elimination strategy* for on reserve First Nations and Inuit communities.<sup>314</sup> (*italics added for emphasis*)

The Committee brought attention to the variations in the rates of tuberculosis among Indigenous peoples as an indication that tuberculosis impacts First Nations and Inuit peoples differently across different geographical and jurisdictional areas, and observed that efforts to control the disease were compromised by overcrowded housing and poverty on reserves and in remote regions. The Committee also questioned the capacity of the health care system in remote and isolated communities where tuberculosis control programming, surveillance and diagnosis is often limited due to understaffing and/or rapid turnover of staff and to the lack of access to appropriate health services and facilities.<sup>315</sup>

Witnesses had highlighted that Health Canada's tuberculosis programs were disorganized across Canada. They criticized the division of responsibilities between the federal and provincial governments for tuberculosis prevention and control activities which had resulted in a fragmented system. For example, in Manitoba data required to support tuberculosis prevention and control programming was not easily shared between the two levels of government, whereas

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<sup>314</sup> Ibid, 17.

<sup>315</sup> Ibid, 4-5.

in Alberta, collaboration between the different levels of government in tuberculosis prevention and control programming had been achieved. They observed that where such collaboration had been successful, as in the case of Alberta, it had been due to the commitment of the regional individuals managing the programs rather than the result of Health Canada's oversight.<sup>316</sup>

With respect to jurisdiction, the Committee captured the complex nature of the federal government's position that lies at the intersection of health and Indigenous policies.

While the federal government does not have direct responsibility in the delivery of health care, it does have primary jurisdiction over "Indians and Land reserved for the Indians," under section 91 (24) of the *Constitution Act, 1967*. In 1939, the Supreme Court decision *Re Eskimos* further brought the Inuit within the meaning of "Indians" under section 91(24). However, while section 35 of the *Constitution Act, 1982*, defines Aboriginal peoples as including the "Indian, Inuit and Métis peoples of Canada", the status of the Métis and the non-registered Indian population under section 91(24) remains undetermined. The federal government therefore maintains that it does not have exclusive responsibility for these groups and its financial responsibilities for these groups are thus limited.<sup>317</sup>

It concluded that, although "federal jurisdiction over First Nations and Inuit means that the federal government has the exclusive authority to enact legislation over First Nations and Inuit",<sup>318</sup> the federal government had instead purposely chosen to provide select programs and services as a matter of policy, using the 1979 Indian Health Policy as the basis for involvement.

The Committee's observation is particularly significant to this research project since it juxtaposes the federal government's jurisdictional obligations under Section 91(24) against the policy commitments that it chose to put forward in the 1979 Indian Health Policy to share responsibility for Indigenous health within an integrated health care system:

It identifies the federal role in the interdependent health care system as including: "public health on reserves, health promotion, and the detection and mitigation of hazards to

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<sup>316</sup> Parliament of Canada. *Evidence Tuesday April 10, 2010*. Standing Committee on Health - Number 010, 3<sup>rd</sup> Session, 40<sup>th</sup> Parliament. 2010: 13.

<sup>317</sup> Smith, *The way forward: addressing the elevated rates of tuberculosis infection in on-reserve First Nations and Inuit communities*, 6.

<sup>318</sup> *Ibid.*

health in the environment.” Meanwhile, the provincial and private role includes the diagnosis and treatment of acute and chronic disease and the rehabilitation of the sick.<sup>319</sup>

By contrast, the scope of the 1992 *National Tuberculosis Elimination Strategy* had been much broader, referring to the needs of all indigenous peoples, regardless of where they live.<sup>320</sup>

Witnesses at the public hearing testified that the lack of a coordinated Health Canada management approach for tuberculosis programs throughout regional offices had not ensured an integrated approach that cut across jurisdictional lines.

### III - TUBERCULOSIS - THE GOVERNMENT RESPONSE

On October 6, 2010, the Conservative government tabled the *Response Of The Government Of Canada To The Standing Committee On Health Report, The Way Forward: Addressing The Elevated Rates Of Tuberculosis Infection In On-Reserve First Nations And Inuit Communities*<sup>321</sup> (*the Response*) which consisted of a list of fifty-five factual points to address the issues raised in the *Final Report*. The federal government chose to restrict the scope of their obligation to “the small number of communities where TB has been found to be hyper-endemic” meaning those communities with the highest incidence of tuberculosis.<sup>322</sup> Point by point, the *Response* served to clearly define the limits of federal government actions within the jurisdictional framework of the health care system, and to narrowly define tuberculosis as a health care problem that could be delegated to provincial authority. It was clear that the federal government had no intention to promote national program standards:

10. Under the strategy, national responsibilities include policy-making and surveillance.

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<sup>319</sup> Ibid, 7.

<sup>320</sup> Health Canada, *National Tuberculosis Elimination Strategy*. Working Group on Tuberculosis, 2.

<sup>321</sup> Canada. Parliament of Canada, *Response of The Government Of Canada To The Standing Committee On Health Report, The Way Forward: Addressing The Elevated Rates Of Tuberculosis Infection In On-Reserve First Nations And Inuit Communities*. 40th Parliament, 3rd Session. Ottawa. October 6, 2010.

<sup>322</sup> Ibid, 7.

... TB program activities vary across Regional offices according to the unique needs and circumstances of the populations served, and in collaboration with the respective provincial TB regimes.<sup>323</sup>

The *Response* did nothing to address the witnesses' claims about the unequal access to services and resources and the poor quality of care under the current programs, and did not acknowledge that the federal position could have been a contributing factor in this unequal access. While the *Response* recognized the higher incidence of tuberculosis in Manitoba, in a blatant disregard for the concerns that the Committee specifically brought forward about the inefficient management in that regional Health Canada office, the *Response* re-iterated its program efforts and even put a price on tuberculosis cases as a shining example of their commitment. "It is noteworthy that in Manitoba, the site of some of the First Nations communities most affected by TB, Health Canada invests more than \$55,000 per on-reserve TB case through enhanced collaboration with First Nations and the Province."<sup>324</sup> It made no mention as to whether this expenditure was effective in controlling tuberculosis. With respect to the successful approach in Alberta that witnesses claimed as an example of effective collaboration between the federal and provincial departments, the federal government credited their programs, rather than the leadership actions of certain individuals, for the success.<sup>325</sup>

In spite of the declaration in the 1992 *National Tuberculosis Elimination Strategy* about the need to work for all Indigenous peoples across jurisdictions, the *Response* echoed the position that Health Canada representatives had put forward at the Public Hearing that its involvement was limited along jurisdictional lines.

4. Under Health Canada's National TB Elimination Strategy, the Government of Canada (GOC) provides access to equitable, culturally appropriate and timely diagnostics, treatment and follow-up care to on-reserve First Nations. For Inuit living in Nunatsiavut

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<sup>323</sup> Ibid, 2.

<sup>324</sup> Ibid, 4.

<sup>325</sup> Ibid, 3-4.

in Labrador, Health Canada enhances TB programming delivered by the province. All Health Canada programming is managed in close collaboration with provincial TB control regimes, scientific experts and a range of other TB partners. The provision of TB treatment to Inuit living in Nunavik, Quebec and to off-reserve Aboriginal people (including FN/I living in the territories) is managed by the respective provincial and territorial governments.”<sup>326</sup>

After almost twenty years, the 1992 *National Tuberculosis Elimination Strategy* was not meeting its elimination target, and based on the witnesses’ accounts, there was no indication of a standard level of service for tuberculosis programs that was available to all Indigenous peoples across Canada. The *Response*’s list of specific geographical areas where they provided a limited range of tuberculosis programs to specific peoples was based on one criteria: no other level of service is present in these areas. Witnesses had expressed strong concerns about the inconsistent application of tuberculosis prevention and control programs across the different FNIHB regions.<sup>327</sup> Yet, in response to these concerns, the federal government chose to narrow the scope of their preferred course of action even further by focusing on what they identified as hyper-endemic communities:

The GoC has long acknowledged the complexity of TB and the need for coordinated efforts by multiple partners to reduce the burden of this disease. Despite significant reductions in TB rates among First Nations over the past 30 years, more work needs to be done. *Health Canada’s renewed 1992 National TB Elimination Strategy will target the small number of communities where TB has been found to be hyper-endemic; it will use indicators and evaluations to inform program decision making; and, it will be complementary to the PHAC National Strategy to reduce TB rates across Canada. Health Canada will ensure that interventions are effective and coordinated with First Nations and Inuit partners, and provincial, territorial, regional or local jurisdictions.*”<sup>328</sup> (*italics added for emphasis*)

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<sup>326</sup> Ibid,1.

<sup>327</sup> Smith, *The way forward: addressing the elevated rates of tuberculosis infection in on-reserve First Nations and Inuit communities*, 8.

<sup>328</sup> Parliament of Canada, *Response of The Government Of Canada To The Standing Committee On Health Report, The Way Forward: Addressing The Elevated Rates Of Tuberculosis Infection In On-Reserve First Nations And Inuit Communities*, 11.

The federal government's *Response* echoes their position on matters of public health rather than their responsibility for Indigenous peoples. Orsini argues that public health activities in a federal system are particularly complicated by governance problems. In his review of the Naylor Report on the 2003 SARS epidemic, he identified some public health system weaknesses that are relevant to the tuberculosis problem. For example, he identified that Health Canada does not have a clear legal mandate to require provinces and territories to share health surveillance data with each other and the federal government. "As is evident in the real world of health politics, these types of exchanges occur voluntarily and depend upon on the good will of officials."<sup>329</sup> This corroborates the Public Hearing witnesses' observations that collaboration among health officials from different levels of government not only varied from province to province, but "that successful collaboration between different levels of government in tuberculosis prevention and control programming had been achieved in some provinces only due to the force of the personalities of those running the various programs."<sup>330</sup>

### *The renewed tuberculosis policy*

In 2012, Health Canada released *Health Canada's Strategy Against Tuberculosis for First Nations On-Reserve (2012 Strategy)* as the renewal policy to replace the 1992 *National Tuberculosis Elimination Strategy*. The *2012 Strategy* suggested that while the rates of tuberculosis in First Nations on-reserve had fallen from 74.1 to less than 30 cases per 100,000 during the 1990s, the rates had not shown any significant further decline since 2000. It acknowledged that by 2005, the federal government had concluded that the original goal for the

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<sup>329</sup> Michael Orsini, *Jurisdictional ambiguity or lack of political will? Intergovernmental relations, public health, and tuberculosis control among Aboriginals in Manitoba and Saskatchewan*. (Kingston, Queen's University, 2000): 12.

<sup>330</sup> Smith, *The way forward: addressing the elevated rates of tuberculosis infection in on-reserve First Nations and Inuit communities*, 13.

elimination of tuberculosis by 2010 would not be possible, and that that the 2012 Strategy would be the policy instrument to provide a renewed focus and new approaches to further reduce tuberculosis in First Nations.<sup>331</sup>

There are, however, significant differences between the two strategies that speak more to the political context of the federal role in Indigenous health than to the public health objectives of reducing the incidence of an infectious disease. First, the term ‘elimination’ was removed from its goal and replaced with Health Canada’s commitment “to reduce the rates of TB in First Nations on-reserve” as part of its overall national goal of 3.6 cases per 100,000 population in Canada.<sup>332</sup> Although laudable, this falls short of the original focus to eliminate tuberculosis among Indigenous peoples, and more importantly, it subsumes this goal within the national reduction target. At best, the federal government’s revised commitment has the potential of burying the inequalities by ignoring the fact that a reduction in both the total population most likely means that the Indigenous rates would remain higher. At worst, it is resignation to the fact that the rates of tuberculosis among the Indigenous population will never be equal to the non-Indigenous population, and that this is an acceptable situation in spite of Health Canada’s goal of “attaining a level of health comparable to that of other Canadians”.<sup>333</sup>

The *2012 Strategy* confirmed that the federal government’s position is guided by its strict interpretation of the division of powers under sections 91 and 92 of the 1982 *Constitution Act*: health is a provincial responsibility and the federal responsibility is limited to ‘Indians’ on-reserve. Even within that framework, the scope of application put forward in the strategy is not clear:

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<sup>331</sup> Health Canada. *Health Canada’s Strategy Against Tuberculosis in First Nations On-Reserve*, ii.

<sup>332</sup> *Ibid*, 5.

<sup>333</sup> Health Canada, *Performance Report Health Canada For the Period Ending March 31, 1997, Improved Reporting to Parliament – Pilot Document*, Foreword.

Provinces and territories have the legislated authority for TB prevention and control within their jurisdictions. Territories are solely responsible for TB prevention and control for their entire populations, while in the provinces, the responsibility is shared among partners. Health Canada is mandated to either provide TB services or assure they are accessible to First Nations living on-reserve.<sup>334</sup>

This was the same political narrative that persisted throughout the 20<sup>th</sup> century. Provinces and territories have a ‘legislated authority’ for tuberculosis programs within their jurisdictions, whereas Health Canada is instead ‘mandated’ to either provide, or assure access to, services for First Nations living on-reserve. This interpretation, and the use of the word ‘either’, not only provides the federal government with discretionary powers to determine if and when they will provide tuberculosis services, but also to what extent. This policy approach is in fact a divergence from their own 1979 Indian Health Policy:

For First Nations on-reserve, TB prevention and control is a shared responsibility that varies across Health Canada’s regions based on each region’s level of collaboration with provincial governments and transferred organizations/communities. *These partnerships are influenced by the respective provincial public health acts, the burden of TB disease in communities, geographic circumstances and local public health program structures.*<sup>335</sup> (*italics added for emphasis*)

Yet, this is in contrast to the third pillar of the 1979 Indian Health Policy (which remains a current federal health policy) that recognizes the specialized and interrelated elements of the Canadian health care system. Of note, is the federal role assigned for public health:

The most significant federal roles in this interdependent system are in *public health activities on reserves*, health promotion, and the detection and mitigation of hazards to health in the environment. The most significant Provincial and private roles are *in the diagnosis and treatment of acute and chronic disease and in the rehabilitation of the sick.*<sup>336</sup> (*italics added for emphasis*)

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<sup>334</sup> Health Canada, *Health Canada’s Strategy Against Tuberculosis in First Nations On-Reserve*, 4.

<sup>335</sup> Ibid.

<sup>336</sup> Health Canada. *Indian Health Policy 1979*. Ottawa. 1979. Available at [http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli\\_1979-eng.php](http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli_1979-eng.php)

As tuberculosis is considered a public health disease, it would seem obvious that the federal government is responsible for managing the disease on-reserve on two counts: first, as the area of responsibility that they recognize under Section 91 (24) of the *Constitution Act*, and second, as a matter of policy under the third pillar of the *1979 Indian Policy*. The *1979 Indian Policy* not only recognized the challenges inherent in the health care system, it anticipated a federal leadership role in looking after the interests of Indigenous peoples:

Of course, this does not exhaust the many complexities of the system. The Federal Government is committed to maintaining an active role in the Canadian health system as it affects Indians. It is committed to encouraging provinces to maintain their role and to filling gaps in necessary diagnostic, treatment and rehabilitative services.<sup>337</sup>

It is apparent that the federal government missed the opportunity to exercise such a leadership role as there is a disconnect between the 1979 Indian Health Policy and the 2012 Strategy in the federal government's interpretation of their role in addressing the elevated rates of tuberculosis in the Indigenous population. Whereas the 1979 Indian Health Policy stated that the federal government is responsible for public health on reserve, the 2012 Strategy instead relinquished the role to the provinces' legislation in public health.

#### **IV - SHIFTING TRENDS IN INDIGENOUS POLICY**

##### *Closing the Gap – The Kelowna Accord*

In 2004, the federal Liberal government under Prime Minister Paul Martin launched an 18-month negotiation process to pursue a high-level coherent, coordinated, and modern approach to addressing Indigenous issues. The process began with a Canada-Aboriginal Roundtable that

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<sup>337</sup> Canada. Health Canada. *Indian Health Policy 1979*. Ottawa. 1979. Available at [http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli\\_1979-eng.php](http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli_1979-eng.php)

was held on April 19, 2004 where Indigenous representatives were invited to “sit down on the same side of the table, as partners.”<sup>338</sup> The federal government was represented by Cabinet members, and senior officials from both provincial and territorial governments were invited to participate as observers.

Indigenous representatives included elders, Indigenous associations, foundations, councils, and other organizations. The five National Aboriginal Organizations spoke for Indigenous peoples across Canada: the Assembly of First Nations for the vast majority of First Nations (members of over 600 Indian bands); Inuit Tapiriit Kanatami representing Inuit irrespective of where they live; the Métis National Council representing Métis living in Ontario and westwards; the Native Women’s Association of Canada advocating for First Nations and Métis women throughout Canada; and the Congress of Aboriginal Peoples advocating for off-reserve Aboriginal peoples throughout Canada.<sup>339</sup>

The April 19, 2004 Roundtable was followed by seven two-day sessions that took place between November 2004 to January 2005. Each session addressed a specific policy theme, led by the Minister of the relevant federal government department. Health was one of the themes under review. The work undertaken at the Roundtable and sectoral sessions formed the basis for a two-day First Ministers' Meeting in Kelowna, BC, on November 24-25, 2005. The First Ministers reached agreement on an accord for action entitled *First Ministers and National Aboriginal Leaders Strengthening Relationships and Closing the Gap (Kelowna Accord)* which outlined an ambitious 10-year plan to significantly improve health, education, housing and infrastructure, economic opportunities, accountability, and the relationship between Indigenous peoples and the

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<sup>338</sup> Patterson, *Aboriginal roundtable to Kelowna Accord: Aboriginal policy negotiations, 2004-2005*, 2.

<sup>339</sup> *Ibid.*

federal government.<sup>340</sup>

These were exciting times for Indigenous health. The collaborative effort between Health Canada, provincial health officials and Indigenous representatives resulted in a separate 29-page *Blueprint on Aboriginal Health: A 10-year Transformative Plan* (Blueprint),<sup>341</sup> that was presented at the First Ministers Meeting as a work in progress. The Blueprint contained overarching principles that included three distinct frameworks one each for First Nations, Inuit, and Métis. Specifically, the document recognized that “despite improvements in many health indicators and promising initiatives in a number of regions, current health strategies have had limited effect in closing the gap.”<sup>342</sup> The press release issued by the Office of the Prime Minister on November 25, 2005 announced that it would seek approval for \$5 billion in spending over five years which included \$1.3 billion for health services to meet its goals of reducing the rates of infant mortality, youth suicide, childhood obesity, and diabetes.<sup>343</sup>

Although the inclusive nature of the Kelowna process was cause for optimism, there were also political concerns. Some First Nations remained suspicious that the federal government might use this opportunity to devolve federal fiduciary responsibilities to other levels of government. The AFN also shared the concerns of many First Nations about “Aboriginalization” initiatives, that is the trend to collapse ‘Indian’, ‘First Nation’, and ‘band’ into ‘community’ and ‘Aboriginal’ that may have the effect of undermining their historical and legal relationship with the federal Crown.<sup>344</sup>

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<sup>340</sup> Tabitha Marshall T. *Kelowna Accord*. Canadian Encyclopedia. Published online July 23, 2013.

<http://www.thecanadianencyclopedia.ca/en/article/kelowna-accord/>

<sup>341</sup> Available at: <http://healthycanadians.gc.ca/publications/health-system-systeme-sante/blueprint-aboriginal-plan-autochtones/alt/blueprint-aboriginal-plan-autochtones-eng.pdf>

<sup>342</sup> Canada. Health Canada, *Blueprint on Aboriginal Health A 10-Year Transformative Plan*. (Ottawa, Health Canada, 2005): 3.

<sup>343</sup> Marshall, *Kelowna Accord*, <http://www.thecanadianencyclopedia.ca/en/article/kelowna-accord/>

<sup>344</sup> Patterson, *Aboriginal Roundtable to Kelowna Accord: Aboriginal policy negotiations, 2004-2005*. Ottawa, 15.

From a federal political perspective, there was also cause for concern as the hope and optimism that had started with the first Roundtable in April 2004 came to an abrupt end a few days after the First Ministers' Meeting in Kelowna.<sup>345</sup> The Liberal minority government was defeated on a motion of non-confidence, and Parliament was officially dissolved on November 29, 2005. The fate of the Kelowna Accord was uncertain as funding had not been approved before the Governor General dropped the writ for a federal election to be held on January 23<sup>rd</sup>, 2006. Prime Minister Paul Martin was unsuccessful in his attempt to return to power, and the Conservative Party, under Prime Minister Stephen Harper, formed a minority government. In their 2006 budget, the Conservatives chose to not honour the financial commitments of the previous government. Whereas the Kelowna Accord would have dedicated \$600 million in 2006 to improve health, education and housing, Prime Minister Stephen Harper's 2006 Federal Budget allocated \$150 million for similar projects.<sup>346</sup>

Beyond the differences in funding commitments for Indigenous health, there were also fundamental differences between the previous government and the new Conservative government's approach to Indigenous health. The Conservative government maintained the position was that it had no legal or treaty obligation to provide Indigenous health care as the fundamental principle underlying their role or responsibility. Consequently, Indigenous health services were again subject to discretionary political motives that would target these services for transfer to the provinces.

After seven years of successive minority governments, the Conservative government returned to power with a majority government in 2011, at which time it proceeded with cuts to Indigenous programs and services, proving just how uncertain was the nature of government

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<sup>345</sup> Ibid

<sup>346</sup> Marshall, *Kelowna Accord*. <http://www.thecanadianencyclopedia.ca/en/article/kelowna-accord/>

support for Indigenous health policy.

*The Truth and Reconciliation Commission*

Responding to pressures from Indigenous leaders, the Prime Minister delivered a formal apology in the House of Commons on June 11, 2008 for its role in the residential schools policy.

Prime Minister Stephen Harper stood in the House of Commons and, with Indigenous leaders present, stated the following on behalf of all Canadians:

The government recognizes that the absence of an apology has been an impediment to healing and reconciliation. Therefore, on behalf of the Government of Canada and all Canadians, I stand before you, in this Chamber so central to our life as a country, to apologize to Aboriginal peoples for Canada's role in the Indian Residential Schools system... A cornerstone of the Settlement Agreement is the Indian Residential Schools Truth and Reconciliation Commission.<sup>347</sup>

The Indian Residential Schools Truth and Reconciliation Commission (TRC) was established on June 1, 2008, with a mandate to reveal to Canadians the complex truth about the history and the ongoing legacy of residential schools, and to guide and inspire a process of truth and healing, leading toward reconciliation within Aboriginal families, and between Aboriginal peoples and non-Aboriginal communities, churches, governments, and Canadians generally.<sup>348</sup>

The Commission held events across Canada, including 238 days of local hearings in seventy-seven communities. The Final Report, which was published on December 15, 2015<sup>349</sup> and containing 94 calls to action, was delivered in a special ceremony to Prime Minister Justin Trudeau who had recently won a Liberal majority government in the October 25, 2015 election.

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<sup>347</sup> Canada. Statement of apology to former students of Indian Residential Schools. Available at: <https://www.aadnc-aandc.gc.ca/eng/1100100015644/1100100015649>

<sup>348</sup> Truth and Reconciliation Commission of Canada. *Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. Truth and Reconciliation Commission of Canada, 2015: 23.

<sup>349</sup> *Ibid*, 25.

In his address, the Prime Minister opened the door to a new Government-Indigenous relationship:

Today, on behalf of the Government of Canada, I have the honour of accepting the Commission's Final Report... We recognize that true reconciliation goes beyond the scope of the Commission's recommendations. I am therefore announcing that we will work with leaders of First Nations, Métis Nation, Inuit, provinces and territories, parties to the Indian Residential School Settlement Agreement, and other key partners, to design a national engagement strategy for developing and implementing a national reconciliation framework, informed by the Truth and Reconciliation Commission's recommendations.<sup>350</sup>

Although it is too soon to assess the impact of the Prime Minister's commitment to honour the Final Report's calls to action, there was an optimistic initial step in that direction when the Minister for Aboriginal Affairs and Northern Development addressed the United Nations Permanent Forum on Indigenous Issues announced on May 10, 2016.

We are now a full supporter of the declaration, without qualification... We intend nothing less than to adopt and implement the declaration in accordance with the Canadian Constitution.<sup>351</sup>

The Truth and Reconciliation Commission's call to action #43 called upon "federal, provincial, territorial, and municipal governments to fully adopt and implement the United Nations Declaration on the Rights of Indigenous Peoples as the framework for reconciliation."<sup>352</sup> The statement was enthusiastically received by Indigenous leaders and went a long way towards honouring the Prime Minister's commitment to implementing a national reconciliation framework that would be informed by the Truth and Reconciliation Commission's

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<sup>350</sup> *Statement by Prime Minister on release of the Final Report of the Truth and Reconciliation Commission.* December 15, 2015. Available at: <http://www.pm.gc.ca/eng/news/2015/12/15/statement-prime-minister-release-final-report-truth-and-reconciliation-commission>

<sup>351</sup> *Canada officially adopts UN declaration on rights of Indigenous Peoples.* CBC News, May 10, 2016. <http://www.cbc.ca/news/indigenous/canada-adopting-implementing-un-rights-declaration-1.3575272>

<sup>352</sup> Truth and Reconciliation Commission of Canada. *Truth and Reconciliation Commission of Canada: Calls to Action.* Truth and Reconciliation Commission of Canada, 2015: 4.

recommendations.<sup>353</sup>

## V - CONCLUSION

The fate that befell the Kelowna Accord serves as a significant reminder of the hold of colonial government ideology on Indigenous policy. Since Indigenous health is not rooted in constitutional or legal obligation, federal governments have the power to implement, cancel and amend policies to suit ideological motives.

When Prime Minister Paul Martin undertook the negotiating process in April 2004, there was no legal obligation to do so. It was based on a moral and political imperative. His focus on the glaring inequalities between Indigenous peoples and the rest of Canadians in all indicators of socio-economic status was acknowledgement, by the federal government, that the current system was not working. With respect to Indigenous health, the concept of equality was also challenged as it became a discussion of health outcomes. This discussion echoed the concerns that had been expressed by the Royal Commission on Aboriginal Peoples (RCAP) a decade earlier, that where there were inequalities in health status, the goal of having equal access to health services did not necessarily mean that they are being treated ‘equally’. They argued that equality required both “the pursuit of equity in access to health and healing services and in health status outcomes.”<sup>354</sup>

While the Conservative minority governments of 2006 and 2008 began the dismantling of the progressive Indigenous policy directions that had been inspired by the *Kelowna Accord* it was the election of a majority government that provided them with the mandate to carry out the

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<sup>353</sup> *Statement by the Prime Minister on release of the Final Report of the Truth and Reconciliation Commission*. December 15, 2015. Available at: <http://www.pm.gc.ca/eng/news/2015/12/15/statement-prime-minister-release-final-report-truth-and-reconciliation-commission>

<sup>354</sup> Royal Commission on Aboriginal Peoples. *Report of the Royal Commission on Aboriginal Peoples, Vol. 3: Gathering Strength*, 203.

reversal of the processes and systems established earlier in the century to build a new Indigenous-government relationship. On matters of Indigenous health policy, this meant that the Conservative government could return to the assimilationist goal of transferring the responsibility for Indigenous health to the provinces. Health Canada's 2012 Indigenous tuberculosis policy, *Health Canada's Strategy Against Tuberculosis in First Nations On-Reserve* reflected this lack of progressive leadership and confirmed the assimilationist goals of the Conservative government's political ideology. The intent of the 2012 Strategy was to carve out geographical areas of the country where Health Canada agrees to assume responsibility for specific First Nations and Inuit hyper-endemic communities when services are required, as in the case of an outbreak of the disease. All other Indigenous peoples, First Nations, Inuit and Métis, are expected to obtain health services from other levels of government, confirming that there is no national Indigenous tuberculosis policy even though the prevalence of the disease remains consistently higher than in non-Indigenous population.

The election of Conservative governments dampened the optimism of the *Kelowna Accord*, as Indigenous policy returned to a traditional approach that relied on a colonial-influenced network of processes and institutions. It demonstrated yet again that, where there is no clear legal or constitutional obligation, federal governments have the power to govern based on political and ideological imperatives. On matters of Indigenous health, the traditional approach relied almost exclusively on the government's interpretation of the federal-provincial division of powers under Section 91(24) in the *Constitution Act* to determine the level of inclusivity and exclusivity of their policies. Although the division of powers and responsibilities appears relatively clear, for Indigenous peoples, federal-provincial jurisdictional ambiguities can have the effect of creating

serious barriers to accessing care, and jurisdictional disputes can have tragic consequences.<sup>355</sup>

Lavoie argues that these jurisdictional ambiguities are unique to Indigenous peoples and can lead to the interpretation, or misinterpretation, of federal policies to the detriment of the individuals seeking health care.<sup>356</sup> The case of Jordan River Anderson, a Manitoba Cree child who was born in 1999 with a rare neuromuscular disorder and required care from multiple service providers, is an example. After living the first two years of his life in a hospital in Winnipeg, he was a candidate to be released to go home on the condition that he had access to home care. His case became the centre of a jurisdictional funding dispute between federal and provincial officials who could not agree on who would cover the costs for his home care. While the officials argued the case, he was prevented from leaving the hospital to receive continuing care at home. When Jordan died in hospital in 2005, the funding dispute had still not been settled.

At the core of Jordan's case lies a rights issue that is beyond the simple case of a funding dispute over access to a health care service. Jordan was an Indigenous child who was denied the right to life-sustaining health care because he lived on reserve. His status as a First Nations child excluded him from accessing provincially-funded home care because his home was on land (the reserve) under federal jurisdiction in accordance with section 91(24) of the *Constitution Act*. The federal government's position, however, was that health care is a provincial responsibility, in accordance with Section 92 of the *Constitution Act*, and that they had no legal obligation to provide these services. Using Marshall's notion of citizenship, Jordan's exclusion from the provincial system and the federal government's refusal to provide the service meant that he was

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<sup>355</sup> Josée G. Lavoie, et al, "Negotiating barriers, navigating the maze: First Nation peoples' experience of medical relocation." *Canadian Public Administration* 58, no. 2 (2015): 295-314.

<sup>356</sup> Josée G. Lavoie, "Policy sciences: why Canada needs a national First Nations, Inuit and Métis health policy." *International Journal of Circumpolar Health*. 72, 22690. 2013.

not treated equally as a citizen of Canada, simply because he was Indigenous.

In a prescient statement a decade earlier, RCAP discussed the effects of similar jurisdictional policy problems. Even at that time, it was evident that the “jurisdictional tangle makes some health and social problems almost impossible to solve. For example, the problems of Aboriginal people with disabilities cannot be dealt with by any one level of government in the absence of co-operation from the others.”<sup>357</sup> Although they could not have foreseen Jordan River Anderson’s fate, they were nonetheless raising a cautionary note about circumstances that sadly led to the same outcome. RCAP also recognized that government policy not only created inequalities between Indigenous peoples and the rest of the Canadian population, but also inequalities among Indigenous peoples. “The arbitrary regulations and distinctions that have created unequal health and social service provision depending on a person’s status as Indian, Métis or Inuit (and among First Nations, depending on residence on or off-reserve) must be replaced with rules of access that give an equal chance for physical and social health to all Aboriginal peoples.”<sup>358</sup>

RCAP recognized Indigenous peoples’ concerns that access to health care should also mean access to quality services that respect Indigenous language and culture, and are not based on racist stereotypes. In order to address these issues, RCAP encouraged the professional training of Indigenous peoples in health and social services, and recommended that educational institutions involved in the training of health and social services professionals, and the professional associations involved in regulating and licensing these professions, be sensitized to

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<sup>357</sup> Royal Commission on Aboriginal Peoples. *Report of the Royal Commission on Aboriginal Peoples, Vol. 3: Gathering Strength*, 205.

<sup>358</sup> *Ibid*, 204.

the importance and legitimacy of Indigenous knowledge and experience.<sup>359</sup>

The notion of including Indigenous ‘voices’ in the federal policy process had symbolised the nature of the Indigenous-Government relationship under Prime Minister Paul Martin. It was a promising feature of national consultation process that led to the *Kelowna Accord*. In her May 2006 paper, written shortly after the Conservatives under Prime Minister Stephen Harper came to power, in the legacy of the *Kelowna Accord* Patterson recognized the importance of political will:

It therefore stands as another critical juncture in the history of Canada-Aboriginal relations... The Kelowna Accord calls for both the means *and the political will to realize Aboriginal peoples’ vision of their place in this country*. In terms of *closing the socio-economic gap between Aboriginal and non-Aboriginal Canadians*, it is a vision that the First Ministers evidently share. The Kelowna Accord aimed to forge a new relationship between the parties. At the very least, it clearly identified a destination they intend to reach in ten years. It outlined a new approach but it did not chart a clear course to that destination.<sup>360</sup> (*italics added for emphasis*)

Patterson’s observations are significant in the way that they frame two basic principles of citizenship that appear to be fundamental to the process that produced the *Kelowna Accord*. The first observation, to address ‘the political will to realize Aboriginal peoples’ vision of their place in this country’, brings to mind the second meaning of citizenship as categorized by Isin and Turner. They assert that citizenship is the possession of ‘nationality’ under a specific state where some basic rights are protected.<sup>361</sup> The second observation, the First Ministers’ vision of ‘closing the socio-economic gap between Aboriginal and non-Aboriginal Canadians’ recalls Marshall’s theory that “social rights were a means to addressing the economic inequalities that he had observed among the different social classes in Britain.”<sup>362</sup>

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<sup>359</sup> Ibid, 260-262.

<sup>360</sup> Patterson, *Aboriginal roundtable to Kelowna Accord: Aboriginal policy negotiations, 2004-2005*, 16.

<sup>361</sup> Isin and Turner, "Citizenship studies: An introduction." In *Handbook of citizenship studies* 1, no. 4 (2002): 105.

<sup>362</sup> Marshall and Bottomore. *Citizenship and social class*. Vol. 2, 6.

Patterson's observations would seem to indicate that, even after the rejection of the proposed assimilation approach in the 1969 White Paper and, even after being recognized as peoples with special rights in Section 35 of the 1982 *Constitution Act*, Indigenous peoples were still not considered on an equal footing with other Canadian citizens. The deliberate political actions of Prime Minister Stephen Harper's Conservative government not only ignored the health disparities between Indigenous and non-Indigenous peoples, they served to exacerbate the situation by cutting off funding and thwarting access to improved services. The message was clear – the federal government wanted to get out of its commitment for Indigenous health and there was no intention to improve conditions on reserve. The only option for improvement was to integrate into the provincial jurisdiction. In other words – to assimilate.

## CHAPTER 6

### CONCLUSIONS AND RECOMMENDATIONS FOR FUTURE POLICY ACTION

Ileen Kooneeliusie died of tuberculosis, a treatable, curable disease. She was diagnosed far too late. Had the 15-year-old been living in the slums of Mumbai or a *favela* in Rio de Janeiro, she likely would have had a good chance of being diagnosed and treated promptly. But Ileen lived in Nunavut, in the hamlet of Qikiqtarjuaq.<sup>363</sup>

#### I - INTRODUCTION

Ileen Kooneeliusie died in Ottawa on January 13, 2017. In an interview with the CBC, Ileen's mother, Geela, describes how she sought medical care for two years when her daughter complained of headaches and shortness of breath, but nurses at the local health centre diagnosed it as panic attacks. On December 27 2016 she was flown to Iqaluit where was diagnosed as having pneumonia and flown to Ottawa for treatment. The correct diagnosis of tuberculosis was confirmed only hours before Ileen passed away. There is a Coroner's investigation under way into the circumstances surrounding the death. Asked what needs to happen to prevent another death like Ileen's, Geela indicated that health centres need Inuit staff who speak Inuktitut.<sup>364</sup> Her observation mirrors the Inuit Tapiriit Kanatami's observations in the 2013 *Inuit-Specific Tuberculosis Strategy* that cites overcrowded housing, lack of food security and barriers to accessing health care, such as geography and language, as factors in the high rate of tuberculosis among Inuit.<sup>365</sup>

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<sup>363</sup> André Picard, When tuberculosis strikes in the North, complacency is deadly, *Globe and Mail*, March 27, 2017. Available at: <https://www.theglobeandmail.com/opinion/when-tuberculosis-strikes-complacency-is-the-big-killer/article34435132/>

<sup>364</sup> Nick Murray, "She was my only girl: Nunavut teen's death sheds light on failures in fighting TB. CBC. March 23, 2017. Available at: <http://www.cbc.ca/news/canada/north/tb-nunavut-teen-death-ileen-kooneeliusie-1.4036205>

<sup>365</sup> *Ibid.*

From a policy perspective, the tragic tuberculosis death of a 15 year old Inuit from Nunavut raises even more questions. The circumstances of Ileen’s death came to public attention because of a CBC article. Although the federal government purports to have a special relationship with Indigenous peoples, there was no federal outcry about the senseless death from a disease considered to be treatable by modern day medicine. Yet, in his 2015 Mandate Letter to the Minister of Health, Prime Minister Justin Trudeau stated that “No relationship is more important to me and to Canada than the one with Indigenous Peoples. It is time for a renewed, nation-to-nation relationship with Indigenous Peoples, based on recognition of rights, respect, co-operation, and partnership.”<sup>366</sup> The 2015-2016 Health Canada Performance Report includes a statement from the Minister that “The Department also continues to work with First Nations, Inuit, provinces and territories to identify and pursue options for improving health outcomes for First Nations and Inuit”, and the departmental ‘Raison d’être’ maintains that the Department “works with partners to support improved health outcomes for First Nations and Inuit.”<sup>367</sup> Yet, the federal government’s silence is deafening considering that access to quality health care appears to have been a contributing factor to her death.

### *Tuberculosis in indigenous communities*

The recent tuberculosis death in Nunavut is just one step on the long road of developments in Indigenous tuberculosis, and for many reasons, is not surprising, and unfortunately, it is likely not the last step. Tuberculosis has been around for a long time in Canada and it was a major epidemic in the early 1900s. The period following the end of World

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<sup>366</sup> Since Minister Philpott has since changed portfolios, the 2015 letter is no longer available at the government website. An archived copy is available at: [http://www.assembly.gov.nt.ca/sites/default/files/td\\_282-182.pdf](http://www.assembly.gov.nt.ca/sites/default/files/td_282-182.pdf)

<sup>367</sup> Canada. Health Canada. *Performance Report 2015-2016*. (Ottawa, Public Works and Government Services Canada, 2016): 1.

War II in 1945 coincided with improvements in public health and the discovery of an effective antibiotic treatment. By the 1950s, the rates of tuberculosis were dropping. Long term residential stays in sanatoria for tubercular patients were replaced with a treatment protocol that instead required only a short hospital stay for the infectious active stage of the disease that was followed by longer term community-based public health treatment for the non-infectious latent stage of the disease. Throughout this time, the rates of tuberculosis in Indigenous communities also dropped, but Indigenous communities did not benefit from the advancements in medicine and in public health to the same degree as in non-Indigenous communities. The rates in the Indigenous population consistently remained higher than in the non-Indigenous population, and this inequality in the rates of tuberculosis persist into the 21<sup>st</sup> century.

A contributing factor that is unique to the Indigenous population is the federal position on its responsibility for Indigenous peoples within the framework of the national health care system. Following the end of WWII, the development of a national health care system was a political priority. The federal government entered into negotiations with the provinces that lasted until the national *Medical Care Act* was enacted in the House of Commons in 1966. The national health care system was a network of provincial health care insurance plans that are linked by principles of equal access, by all Canadians, to hospital and physician care services at no cost to them. Some provincial plans required the payment of a premium for the insurance, and provinces offered assistance for indigent citizens to defray these costs as a social benefit in order that they could access health services.

From the start, the federal government worked on the assumption that Indigenous peoples would access health services from the provincial agencies in the provinces in which they reside. For the federal government, their role was to provide health services only until such time as

Indigenous peoples accessed services directly from the provinces. Since individual provincial systems sometimes varied in the delivery of services, this meant that Indigenous peoples had access to different levels of health care services depending on where they lived in Canada.

Tuberculosis care presented unique challenges. In the early 20<sup>th</sup> century, when the death rates of tuberculosis among Indigenous peoples were ten to twenty times higher than in non-Indigenous communities, the federal government became involved in tuberculosis programs on humanitarian grounds based on provincial fears that Indigenous tuberculosis patients posed a threat to the rest of the population. This position confirmed the predominant colonial values that Indigenous peoples were inferior to the European settlers and that they needed to assimilate.<sup>368</sup> By the 1970s, the federal's position on its role in Indigenous health shifted to the notion of indigence. The federal government no longer saw their role as providing health services on humanitarian grounds, and expected Indigenous individuals to access services from the provinces. The federal government provided the resources, or where appropriate the services, only for those indigent individuals who could not afford the costs associated with accessing provincial services (such as for example, the costs of prescriptions, or travel to urban centres). The federal position was met with strong political resistance by Indigenous leaders who regarded access to health services as a right, not a government social benefit. The indigence criteria for accessing Indigenous health services were withdrawn in 1979 and replaced with medical criteria as approved by a medical professional. However, according to the *Indian Health Policy*, which still forms the basis of the federal government's position, the notion of integration of Indigenous health into the national health system remains one of the underlying principles.

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<sup>368</sup> Kelm, *Colonizing bodies: Aboriginal health and healing in British Columbia, 1900-50*: 100-108. Tobias, "Protection, civilization, assimilation: An outline history of Canada's Indian policy" 138.

## II- THE PROBLEM WITH THE FEDERAL POSITION ON INDIGENOUS HEALTH

This tragic case of a young girl's death of tuberculosis in 21<sup>st</sup> century Canada goes beyond the access to quality health care which she was denied. A coroner's inquest will likely address those issues. It is the role that federal Indigenous health policies played in that death that should also be examined. For over a century, from William Osler in 1902 to the Chief Public Health Officer in 2014, the message has been consistent: the root causes of tuberculosis are social – the disease thrives where there are conditions of poverty, inadequate housing and food insecurity. Even with the advent of public health interventions and medical treatments innovations, tuberculosis has not been an equal opportunity disease: globally, inequalities in the prevalence of the disease continue to exist between developing and developed countries, and in Canada, between Indigenous peoples and the rest of Canadians.

The Canadian government, like most developed countries, thought that it had beaten tuberculosis in the 1980s, and became complacent as it was expected that the rates would run their natural course and continue to drop. That was not the case. The World Health Organization (WHO) declared tuberculosis an epidemic at the global level as the rates started to rise again, especially in targeted populations primarily in developing countries. In Canada, the resurgence of the disease targeted Indigenous populations, and the federal government's response reflected colonial perspectives of European superiority. Although the government's assimilationist 1969 White Paper had failed, and even after the federal government recognized Aboriginal rights in the 1982 *Constitution Act*, the underlying political ideology that prevailed with respect to dealing with Indigenous tuberculosis continue to be assimilationist. Federal health policies are based on the underlying premise that the only way that Indigenous peoples will receive equal services and will have health outcomes that are equal to other Canadians, is if they integrate into provincial and

territorial health care systems. The government sees no other option. Former Prime Minister Jean Chrétien's answer, in April 2016, to a CBC reporter's question about the possibility of moving the community of Attawapiskat to address the high rates of suicide in that community, confirms that this assumption is still very much part of Canadian values. Chrétien, who was also the minister responsible for Indigenous affairs from 1968 to 1974, suggested that the solution for some First Nations may be that they will have to leave their isolated communities. His comments were later denounced by opposition members in the House of Commons.<sup>369</sup>

This notion that Indigenous peoples are expected to leave their communities to access equal care is still evident in Health Canada's *2012 Strategy Against Tuberculosis in First Nations On-Reserve*. Although the case of Ileen Koonelusié's death involves an Inuit from a community in Nunavut, and not from a First Nation, the exclusionary nature of the 2012 Strategy is a factor. It specifically excludes Inuit who live in Nunavut from their responsibility, and states that tuberculosis care for Inuit in Nunavut is the responsibility of the territorial government.<sup>370</sup> Arguably, the federal government achieved their assimilationist goal in this case – they have withdrawn from providing health care to Inuit in Nunavut, and have transferred that responsibility to another level of government. If the goal was that this arrangement would lead to Inuit achieving equality in health care, Geela's account of the tragic consequences of language barriers to accessing equal health care services is an indication that this was not the case. For Inuit, even when accessing health care services in one of the official languages of the territory, inequalities in the quality of care were not alleviated by integrating into another level of government. And the federal government is silent on the issue.

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<sup>369</sup> Susana Mas, *Jean Chrétien's comments on Attawapiskat criticized in Commons*. CBC News, April 13, 2016. Available at: <http://www.cbc.ca/news/politics/chretien-attawapiskat-1.3533331>

<sup>370</sup> Health Canada. *Health Canada's Strategy Against Tuberculosis in First Nations On-Reserve*.

At the core of the problem is Romanow's notion of 'payer of last resort'.<sup>371</sup> When it comes to Indigenous peoples accessing health care services, the federal government assumes that the provinces will provide the services. The insidious nature of this argument is that the federal government expects Indigenous peoples themselves to make that decision, essentially by physically moving to off-reserve areas that are under provincial jurisdiction. When Indigenous peoples move to areas under provincial control, they are absorbed into the body politic of that jurisdiction, where the priorities of the general population prevail. The case of Jordan River Anderson, the young First Nation boy in Manitoba, is an example of what happens when the health care priorities of provincial governments clash with those of the federal government.<sup>372</sup> Requiring Indigenous peoples to move off-reserve to access better health care could be considered a subtle form of the assimilation approaches that were practiced over a century ago when the federal government implemented official enfranchisement provisions under the *Indian Act*. Although technically, Indigenous peoples are no longer required to relinquish their rights when they leave their reserve, they do lose access to federal health services, and become subject to the priorities of the provincial governments in allocating these services.

#### *Federal Indigenous health policies and social citizenship*

The concept of 'equality' should mean that the rates of tuberculosis in Indigenous communities are equal to those of other Canadian-born citizens. But they are not. This is despite public health advancements, medical discoveries, government resources to 'eliminate' the

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<sup>371</sup> Romanow, *Building on Values: Report of the Commission on the Future of Health Care in Canada*: 212.

<sup>372</sup> Background information on Jordan River Anderson and 'Jordan's Principle' is available at: First Nations Child and Family Caring Society, *Jordan's Principle* <https://fncaringsociety.com/jordans-principle>; and Indigenous Affairs and Northern Development Canada, *Jordan's Principle*, <https://www.aadnc-aandc.gc.ca/eng/1334329827982/1334329861879>

problem, and policies to include Indigenous peoples in decision-making. The rates have always been higher, and this pattern continues well into the 21<sup>st</sup> century. Yet, it is considered a curable disease. In a developed country like Canada, where the overall national tuberculosis rate has stabilized at 5 cases per 100,000 population<sup>373</sup> it should be a viable target to reduce it to the epidemiological standard of elimination which is 1 case per 1 million population. However, it is not happening.

Elimination of tuberculosis would require that all factors that have been identified as contributing to the inequalities in Indigenous rates be addressed. Yet, the rates of tuberculosis in Indigenous communities are equivalent to those of populations in developing countries.<sup>374</sup> What is it that Indigenous communities have in common with these populations rather than with non-Indigenous Canadians? The answer is the socio-economic conditions that contribute to ill health and the proliferation of infectious diseases such as tuberculosis: poverty, inadequate housing, food insufficiency, and challenges to accessing health services. In a competitive neo-liberal environment such as in Canada, it is assumed that the individual is responsible for his/her own success and that this notion is based on personal choice. In Indigenous health, the federal position encapsulates this concept of choice from a different perspective – Indigenous individuals have the choice to leave their reserve if they want better health services.

Citizenship theories challenge these choices and these challenges are evident in government policies and in the way that governments treat certain individuals. Marshall argues that social rights are a means to addressing the economic inequalities that he had observed among the different social classes in Britain. His notion of social citizenship was intended to cover “the whole range from the right to a modicum of economic welfare and security, to the right to share to the

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<sup>373</sup> Gallant et al, “Tuberculosis in Canada - Summary 2015” in *Canada Communicable Disease Report* 2017;43(3):77.

<sup>374</sup> Ibid.

full in the social heritage and to live the life of a civilized being, according to the standards prevailing in the society.”<sup>375</sup> It was his opinion that existing political and civil rights did not go far enough in guaranteeing what an ideal society should offer to all its citizens:

...there is a kind of basic humanity associated with the concept of full membership of a community – or, as I should say, of citizenship – which is not consistent with the inequalities which distinguish the various economic levels in the society. In other words, the inequality of the social class system may be acceptable provided the equality of citizenship is recognized.<sup>376</sup>

Marshall’s observations that inherent injustices of inequalities of class are juxtaposed with the perceived equality of citizenship inspired him to identify that social rights were an integral part of citizenship rights. He argued that citizenship represents the status that is bestowed on those who are full members of a society, and that those who possess this status should be considered equal with respect to the rights and duties that flow from that status. According to Romanow, Canadians view the national health system not only with pride, but with its principle of equal access to health services, also as a symbol of Canadian citizenship.<sup>377</sup> In light of the persistent inequalities in the rates of tuberculosis in Indigenous communities, it is appropriate to ask what the place of Indigenous peoples in Canadian society truly is. In the case of citizenship, the federal government’s policies have the effect of exerting power over Indigenous peoples that is different than with non-Indigenous Canadians.

Foucault argues that state power manifests itself not only in terms of hierarchical, top-down edicts, but also in terms of social control over segments of the population.<sup>378</sup> In Canada, the federal bureaucracy responsible for the *Indian Act* and the Indian Reserve system form a disciplinary institutional system where the government exercises social control and power over Indigenous

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<sup>375</sup> Ibid, 8

<sup>376</sup> Ibid, 6.

<sup>377</sup> Cite

<sup>378</sup> Michel Foucault, “Governmentality”, *The Foucault Effect*, Eds. Graham Burchell, Colin Gordon & Peter Miller (Chicago: The University of Chicago Press, 1999), 87-104.

peoples through the use of policy instruments. In the case for Jordan River Anderson and Ileen Kooneeliusie, federal policies not only restricted their access to health services, they were a contributing factor in their deaths. Foucault argues that scientific advances in medicine, psychiatry, and some social sciences led to "normalization" in the discourse of what is to be considered normal in a given population, rather than adherence to absolute measures of right and wrong.<sup>379</sup> In both these cases, there is a danger that this level of health care is considered 'normal', and in the sentiment that former Prime Minister Jean Chrétien expressed, they have a choice to leave.

### III - RECOMMENDATIONS FOR FUTURE ACTION

After the extensive review of past and existing government policies on matters of Indigenous health undertaken for this research project, it seems intimidating to offer some recommendations as to what actions that the federal government should take that would improve the situation. There have been many reports over the years that have offered extensive recommendations on how to improve the health and living conditions of Indigenous peoples, and it is questionable as to whether they have achieved any marked improvements. It is uncertain that recommendations using current policy approaches and within existing authority frameworks will result in a different outcome, a sentiment that was shared by RCAP 20 years ago.

In our review of past commissions and task forces we discovered many well-founded recommendations for improving the situation of Aboriginal people in Canada. Yet in the 30 years since a comprehensive survey of Indians in Canada was published in the Hawthorn report, the gains that are recognized as widely accepted indicators of well-being have been very modest... We understand the growing support in many parts of Canadian society for greater opportunities for control by Aboriginal people of decisions that affect their collective lives, but we see the need to go beyond a reorganization of existing structures and jurisdictions... We believe firmly that the time has come to resolve a fundamental contradiction at the heart of Canada: that while we assume the role of

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<sup>379</sup> Michel Foucault, "The subject and power." *Critical inquiry* 8, no. 4 (1982): 777-795.

defender of human rights in the international community, we retain, in our conception of Canada's origins and make-up, the remnants of colonial attitudes of cultural superiority that do violence to the Aboriginal peoples to whom they are directed. Restoring Aboriginal nations to a place of honour in our shared history, and recognizing their continuing presence as collectives participating in Canadian life, are therefore fundamental to the changes we propose.<sup>380</sup>

These disparities in health and social conditions in between Indigenous communities and the non-Indigenous population persist: the rates of tuberculosis in Indigenous communities have remained consistently higher than in the non-Indigenous population. In order to bring about a significant transformation in the health inequalities that exist today it is changes in in the existing structures and jurisdictions, as noted by RCAP, that are required.

On that basis, that there is a need for fundamental changes that lie beyond the scope of this research project, the following suggestions for policy action are offered:

1. Revisit the information and recommendations put forward in Volume three of the RCAP final report. The Commission's observation that there had been only modest gains in Indigenous well-being in spite of the many recommendations that had been put forward raises serious concerns about the federal government's commitment to Indigenous health. Volume three identifies the connections between health and social conditions in Indigenous communities, linking inadequate access to water, sanitation and housing to the spread of diseases such as tuberculosis. A full twenty years later, there are still inequalities in social and health conditions, regrettably confirming that even the RCAP's own recommendations for improved well-being have provided only limited gains.
2. Transfer the responsibility for the First Nations Inuit Health Branch from Health Canada to the Minister of Indigenous and Northern Affairs Canada. This would place the

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<sup>380</sup> Royal Commission on Aboriginal Peoples, *Final Report - Volume 1, Looking Forward, Looking Back*, (Ottawa: Royal Commission on Aboriginal Peoples, 1996): 14.

responsibility for health under the mandate and control of the department that is responsible for the management of the socio-economic conditions that contribute to health inequalities. Health Canada's health policies and guidelines should be examined to ensure they no longer reflect the outdated colonial relationship. On August 28, 2017, the federal government announced the division of Indigenous and Northern Affairs Canada into two separate departments.<sup>381</sup> The first is the Department of Crown-Indigenous Relations and Northern Affairs. The second, the Department of Indigenous Services which will include, after a period of consultation with Indigenous peoples, the transfer of services located in other departments, including health services. The federal government stated that the ministerial restructuring acknowledges the RCAP recommendation that a new relationship requires new structures. Of concern, is the Prime Minister's statement that the restructuring is the next step toward ending the *Indian Act* which evokes memories of the failed 1969 Draft Indian Policy (White Paper). The federal government should carefully review, in collaboration with Indigenous peoples, past federal government policy attempts and failures to improve the delivery of Indigenous services within the context of self-determination and self-government.

3. Officially recognize all Indigenous groups as 'Indians' under Section 91(24) as per the 1939 and 2016 Supreme Court of Canada decisions that the definition of 'Indians' under Section 91(24) includes Inuit, Métis and non-Status Indians. Programs, services and resources would be available to all three groups on the same basis. The announcement of the new Department of Indigenous Services appears to commit the federal government to improving the quality of services to all three Indigenous peoples. What is not clear is the

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<sup>381</sup> Prime Minister Justin Trudeau, August 28, 2017: <http://pm.gc.ca/eng/news/2017/08/28/new-ministers-support-renewed-relationship-indigenous-peoples>

federal government's commitment to non-Status Indians and those Indians, as defined in the *Indian Act*, who choose to live off-reserve. What the federal government will need to do for an inclusive approach is to revise their interpretation of who is an "Indian" under the *Indian Act* and Section 91(24) of the *Constitution Act*. They should also recognize health as a protected treaty right, pursuant to the provisions of Treaty Six, under Section 35 of the *Constitution Act*.

3. Enact a separate federal *First Nations and Inuit Health Care Act*, or even, in anticipation of the federal government acting on the Supreme Court decision on the Métis and non-status Indians, an *Indigenous Health Care Act*. This would remove the geographical and jurisdictional divides and offer a guarantee that Indigenous peoples can still access federal programs when they leave the reserve. It would also resolve the issue of payment by accepting full responsibility for the cost of provision of health services to Indigenous peoples.
4. Engage in Government-Indigenous Roundtables to discuss how to close the gap in health and social conditions between Indigenous and non-Indigenous peoples. In other words, revive the *Kelowna Accord* negotiation process where Indigenous peoples will be at the table, their voices will be heard and their knowledge will be recognized.

#### **IV - CONCLUSIONS**

The notion of social citizenship, as conceived by Marshall, remains a critical factor in Indigenous health policies. This research project has shown that a model of citizenship that doesn't include the protection of social rights offers no guarantee of equality among citizens.

Marshall recognized the impact of socio-economic inequalities on citizens' ability to fulfill their full citizenship rights and introduced social rights as a means to address these barriers. This was the case in Canada. The health and social inequalities in Indigenous communities did not disappear after they were given the political franchise in 1960. The federal government's use of the jurisdictional division of power between the federal and provincial governments as the basis for determining eligibility is flawed. In practice, it relies on a set of inclusions and exclusions that are applied in an ad-hoc fashion across Canada depending on the Indigenous status of the individual and his/her geographical location. This 'payer of last resort' approach is a reactive strategy and does not address the fundamental inequalities in Indigenous health care. The cases of Jordan River Anderson and Ileen Koonceeluisie are testimony to the fact that accessing provincial and territorial health care is no guarantee of improved access to health care.

The anthropology of public policy approach offered an important insight into the way that the federal government interpreted its role in Indigenous health has shifted over the past seven decades. In the mid-20<sup>th</sup> century, the federal government was involved for humanitarian reasons. In the case of tuberculosis, the high mortality rates were the impetus for government intervention. With the shift of responsibility to the new Department of National Health and Welfare in 1945, the post-war efforts were decidedly health-focused with the provision of primary care in Indian hospitals and sanatoria and public health vaccination programs for children. With the introduction of antibiotic treatment, health program intervention shifted to a public health approach. This mirrored what was happening in the general population. Although there was a downward trend in the rates of tuberculosis, in Indigenous communities, the rates remained comparatively higher.

In NHW annual reports from the 1950s, 1960s and 1970s, the federal government was confident that the medical model would lead to tuberculosis rates that would be comparable to the national average. When these expectations did not materialize, the federal approach turned to public health education ensure that Indigenous communities understood the severity of the disease. When public health education programs did not result in improved results, the narrative shifted to one of blaming the communities for the poor conditions, stressing that hygiene, inadequate housing and poverty were at the root cause of the disease. There was no recognition of the federal role in addressing these problems.

By the 1970s and 1980s, tuberculosis was seen as being under control except for reported outbreaks in isolated communities. As the humanitarian crisis was perceived as being over, the focus of the mandate in annual reports shifted to establishing a temporary federal role until such time Indigenous individuals accessed provincial health programs, in recognition of the provincial expertise in the national health care system. The annual reports were clear that Indigenous peoples were expected to make this transition, with the goal being the eventually withdrawal of the federal government from health care. This position did not reflect the views of Indigenous peoples who maintained the treaty and an Aboriginal right to federal health services.

Although Aboriginal rights were recognized in Section 35 of the *Constitution Act*, they were never defined and there was no clarity as to whether they included the right to health. As a result, the 'rights' discussions that took place between Indigenous leaders and the federal government did not bring a solution to health inequalities, as there was a disconnect between the overall Indigenous self-determination policies under Indian Affairs and Northern Development (DIAND) and the health policies at NHW. With the responsibility for Indigenous health under the Minister of NHW, came the expectation that all health matters were under the aegis of the

provincial health insurance programs and that Indigenous groups would have to deal with the provinces on that matter. The mandate of NHW Indigenous health programs were temporary in nature and their goal was to be out of health care delivery to Indigenous peoples.

While changes in government policies have changed the narrative about Indigenous health over the past seventy years, the problems remain fundamentally the same: inequalities persist between Indigenous and non-Indigenous Canadians. Political attempts to close the gap between Indigenous and non-Indigenous, however, failed when the *Kelowna Accord* was cancelled in 2006. In spite of attempts to develop progressive self-determination Indigenous policies during the 1980s and 1990s, the government maintains control over the narrative, and the policies/program/funding initiatives are implemented to support that federal position, not Indigenous goals. One example is the 1989 Health Transfer Policy that was criticized by Indigenous leaders as promoting the federal goal of getting out of the health business rather than advancing the community health goals on Indigenous communities.

In the 21<sup>st</sup> century, it is the failed *Kelowna Accord* that stands out as a significant missed opportunity. We will never know if Prime Minister Paul Martin's proposal to close the gap in Indigenous inequalities in 10 years would have achieved positive results. More importantly, the lost opportunity was also to the collaborative and inclusive approach to the Government-Indigenous relationship that developed the *Kelowna Accord*. It was marked by federal leadership to establish a new way to look at Indigenous issues that: included the three Aboriginal groups in the discussions; brought the provinces to the table; and, reached out to Indigenous knowledge holders such as elders and community representatives as well as national Indigenous organizations.

This collaborative approach all came to an end during the Conservative governments of 2006-2015 who reverted back to a narrative that was based on pre-1969 White Paper principles of

colonial relationships. Funding and resources were cut to national organizations that supported the development of a national capacity for Indigenous voices. These actions led to the closure of the National Aboriginal Health Organization that was established in 2000, and the political decision to not renew the mandate of the Aboriginal Healing Foundation that was due to expire after eleven years. During their short mandates, these Indigenous-led organizations had conducted valuable research and published Indigenous perspectives on health inequalities and abuses in Indian Residential schools.

Bowing to Indigenous pressure, in 2008, Prime Minister Stephen Harper did deliver an apology on behalf of the federal government for its role in the residential school policy. As part of the implementation of the Indian Residential Schools Settlement Agreement that resulted from legal claims by former residential school students, the Truth and Reconciliation Commission (TRC) began in September 2007 with a mandate to conduct research and create an historical record of Indian Residential School policies. The TRC delivered its final report in December 2015 to the newly elected Liberal government under Prime Minister Justin Trudeau. Although the new government has embraced the recommendations put forth by the TRC and indicated a willingness to work on a renewed relationship, it is too soon to assess if it will carry through on those commitments.

Yet, the rates of tuberculosis have consistently remained elevated in Indigenous communities. The disparities persist. The political narrative may have changed over the decades, but the problem remains the same. Part of the reason that tuberculosis rates remain elevated is because the recognition of Indigenous status under Section 35 of the *Constitution Act* has not changed the basic principle of assimilation that remains entrenched in federal Indigenous health policy today. Policies reflect government priorities that “seem incapable of conceiving a society in

which Indigenous values and practices are promoted and placed on equal footing with European ones”<sup>382</sup> There is a tendency to develop programs designed to replicate provincial initiatives that appear to simply duplicate European social and political practices. Rather than promoting Indigenous ideals, these types of programs instead serve to ensure the continuity of mainstream programs. Indigenous communities have opposed this type of approach. “Given local beliefs and traditions, European systems simply make no sense.”<sup>383</sup> There has been a growth in Indigenous health research by Indigenous scholars who are documenting Indigenous perspectives to health and social issues.<sup>384</sup> Using that knowledge to inform the development of federal Indigenous health policies is recognized as an important role for knowledge translation.

A key to using research to develop new health programs is specifically embedding a process for knowledge translation into all Aboriginal health research. It recognizes that policy makers are critical to success of improving health through new evidence based programs and need to be involved in a knowledge translation process to ensure that new ideas can be the basis for innovative programs and policies which aim for improving Aboriginal health.<sup>385</sup>

With respect to tuberculosis, government complacency in the 1980s played a major role in the resurgence of the disease in the 1990s. Government actions and inactions were based on the assumption that tuberculosis was no longer a problem. Worry maintains that it is equally important to look at the role of ‘indifference’ about Indigenous inequalities in the work of policymakers and bureaucrats whose main functions are to develop Indigenous policies. Indifference is relevant in this context because it acts as a deliberate defense mechanism that allows individuals to turn the other way when confronted with others who are less fortunate than they are. It might help explain

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<sup>382</sup> Wayne Worry, *Ending denial: understanding Aboriginal issues*. (Peterborough, Broadview Press, 2007): 36.

<sup>383</sup> Ibid

<sup>384</sup> For more information about the work of Indigenous researchers: <http://www.cihr-irsc.gc.ca/e/8668.html>. For publications about Indigenous health: <http://www.nccah-ccnsa.ca/34/Publications.nccah>

<sup>385</sup> Jeff Reading, *The crisis of chronic disease among Aboriginal peoples: a challenge for public health and social policy*. (Victoria. University of Victoria, 2010): 3.

the NHW annual reports in the 1970s and 1980s that blamed Indigenous individuals for the poor conditions in their communities. Warry argues that, as it relates to inequalities, “the continuing poverty and marginalization of Indigenous peoples in a country where wealth abounds is incomprehensible unless we understand our indifference.”<sup>386</sup>

More importantly, policies are fundamentally political in nature. They are a tool that governments use to advance their own ideologies. In the case of the *Indian Act*, it gives the federal government the power to determine a class of citizens in Canada. It is with government registries and with strict regulations that ‘Indians’ are identified for government benefits. It is not Indigenous peoples who decide whether or not they are an ‘Indian’ under the definition in the *Indian Act*. In matters of Indigenous health, this definition is important as it shapes policies, such as the 2012 Health Canada *Strategy Against Tuberculosis in First Nations On-Reserve* that acts in large part to exclude certain groups of Indigenous peoples. The federal government can sanction this exclusion, because the legislation gives them the power to do so.

Government power is also exercised by political will, a major factor in establishing policy directions. The federal government’s withdrawal of the 1969 White Paper was an example of a government policy reversal action that was dictated by public opinion, in this case, of Indigenous peoples. By contrast, the failure of the *Kelowna Accord* is an example of political will that was dictated by ideological perspective. Based on its election to power, the Conservative Government took the position that it was speaking for Canadians and imposed its political will. It proceeded to not only thwart a shift in Government-Indigenous relationship, but to also dismantle federal programs and to quash opportunities for Aboriginal voices. The government was able to do this based on their claim that there is no legal or constitutional obligation for the federal government to

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<sup>386</sup> Warry, *Ending denial: understanding Aboriginal issues*, 36.

provide health services to Indigenous peoples. And since they provide these services as a matter of policy, they can adopt, adapt and cancel policies as they see fit within their policy mandate.

For any significant improvement to occur in Indigenous health, the fundamental issue that must be addressed is that Indigenous peoples have an inalienable *right* to health care and all future policies must respect that entrenched and resolute right.

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