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## **Separate but Equal? The History of Aboriginal Health Care Policy in Canada**

by

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### **Abstract**

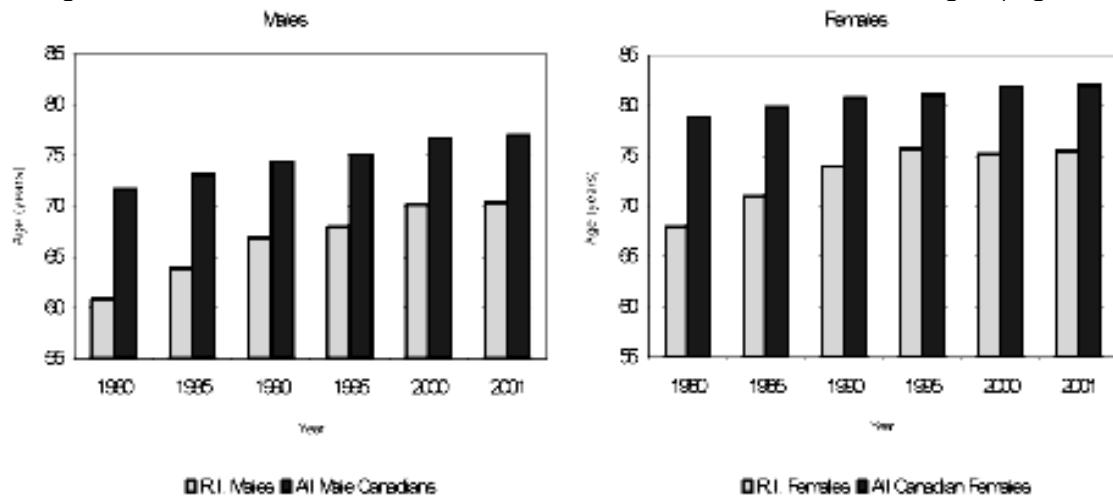
The health of aboriginal Canadians has long lagged behind that of the majority of the Canadian populace. Because of constitutional reasons, aboriginal health care has developed separately from the health care for other Canadians. It is worth looking at this separation and its historical development to learn if there are reasons for the disparity in health outcomes of Aboriginal Canadians.

Aboriginal health care policy began with a complete absence of policy in the years after confederation. Early promises of minor medical services during treaty negotiations formed the underpinnings of aboriginal health care policy. Evolution of health care policy led to expansion from these humble beginnings until today when aborigines, at least theoretically, enjoy more health care coverage than the rest of Canadians. A recent trend in aboriginal health care is their increasing self-provision of services.

This historical overview reveals five themes that have governed aboriginal health. First, their separation, geographically and culturally, from the rest of Canadian society has hindered their enjoyment of health care services. Second, they have always been and have grown increasingly dependent on others for health care services. Third, research into aboriginal health care has been sorely lacking and makes improvement of their care difficult. Fourth, health care has been poorly linked to other aboriginal social services, and so a holistic approach to health care has been compromised. And fifth, there has been a lack of focus and political will by the federal government to improve the stock of aboriginal health.

## Introduction

Aboriginals have worse health outcomes than the Canadian average (Figure 1).



**Figure 1.** Life Expectancy by Gender of Registered (Status) Indians and Canadian Population (Indian and Northern Affairs, p. 24).

In addition to the aforementioned difference in outcomes, Aboriginal health care is also distinct in that:

1. Aboriginal health care is an area of federal jurisdiction whereas health care for other Canadians is an area of provincial jurisdiction.
2. Aboriginals enjoy some different rights by virtue of treaties and by virtue of their heritage; these rights have been entrenched in Section 35 of the *Constitution Act*.
3. Status Aboriginals (*i.e.* Status Indians) are publicly insured for a different set of health services than the rest of Canadians.
4. Local Aboriginal communities are increasingly running their own health services, which is not the case in the rest of Canada.

Because of these differences, the federal government's role in addressing the health of Aboriginal Canadians is of great interest. Although government policy is always in flux, this essay identifies eight periods of differing Aboriginal health care policy approaches:

1. At Confederation (1867-1870)
2. Transition of Lifestyle (1870s-1890s)
3. Formal Health Care Begins (1890s-1910s)
4. Awaking to the Problem (1910s-1920s)

- a. 1930s
- b. Post War Social Program Expansion (1945-1960s)
- c. Universal Health Insurance Begins (1970s)
- d. Devolution of Health Services (1980s-present).

This essay explores government policy towards Aboriginal health care through these eight periods and highlights separateness and dependence as common themes that have characterized policy on Aboriginal health.

### **Definition of Aboriginal Peoples and Scope of this Essay**

Legally, the word “Aboriginal” in Canada refers to four different lineage groups: North American Indians, *Métis*, *Inuit*, and those who claim lineage from some combination of the previous three (Canadian Census figures also denote an “undefined” group who self-identify as Aboriginals, but do not indicate from which lineage). North American Indians are those who descend from the pre-1500 A.D. inhabitants of the southern parts of Canada (approximately those who lived in what are now the ten provinces). *Métis* are those who have partial North American Indian heritage, and partial European heritage. *Inuit* are those who descent from the previous inhabitants of the northern parts of Canada (approximately those who lived in what are now the three territories).

Another legal division that applies to North American Indians is the distinction between “Status Indians” and “Non-status Indians”. Status Indians are those who are registered with the Department of Indian Affairs and Northern Development according to criteria in the *Indian Act* and future amendments to that Act. Status Indians enjoy special rights and are entitled to treaty obligations from the government of Canada.

**Table 1:** Aboriginal Population by Groups (Statistics Canada, Census 2006)

Group	Status	Non-Status	Totals
North American Indians	623,780	74,245	698,025
<i>Métis</i>		389,780	389,780
<i>Inuit</i>		50,480	50,480
Multiple/Undefined		34,500	34,500
Totals	623,780	549,005	1,172,790

A final division that should be mentioned is that some Status Indians live on a reserve, while others do not. Often residence on a reserve is needed for access to the privileges of having status under the *Indian Act*. Non-status Indians and *Métis* are also divided into

those who live on reserve and those who do not, but residence on a reserve has fewer implications for Non-Status Indians and Métis. In general, most Status Indians live on reserves, and most Non-Status Indians live off reserve.

For this essay, the focus of this essay will be on Status Indians. Unless otherwise explicitly indicated, any statements about “Aboriginals” in this essay will refer to Status North American Indians. This less precise terminology is used since North American Indians dislike the term “Indian” and since “Aboriginal” is a shorter and convenient term.

### **Aboriginal Health Care at Confederation (1867-1870)**

Aboriginal health care in the first years after Confederation was characterized by the absence of any specific policy. What care did exist was not provided by the government, but rather by missionaries as a charitable act (and perhaps to buy good will) and by fur traders who wanted to buy good will for commercial interaction, and who had a vested interest in the health of their trading partners (Waldrum *et al.*, p. 173).

### **Transition of Aboriginal Lifestyle (1870s-1890s)**

During the last three decades of the nineteenth century, the government engaged in negotiating land surrender treaties with Aboriginal groups. In return for allowing the federal government to control and govern the land without restriction, Aboriginal groups were given ownership of reserve land, and were promised various privileges.

Treaty Six (1876) surrendered the land of the middle parts of Alberta and Saskatchewan is important for containing explicit health care clauses (Waldrum *et al.*, p. 174):

That in the event hereafter of the Indians comprised within this treaty being overtaken by any pestilence, or by a general famine, the Queen ... will grant to the Indians assistance [...] deem[ed] necessary and sufficient to relieve the Indians for the calamity that shall have befallen them.

That a medicine chest shall be kept at the house of each Indian agent for the use and benefit of the Indians, at the discretion of such Agent.

The government's rationale for this treaty-making is outlined in this quote by Prime Minister John A. MacDonald (Waldrum *et al.*, p. 177f.):

Of course the system is tentative and it is expensive, especially in feeding destitute Indians, but it is cheaper to feed them than to fight them, and humanity will not allow us to let them starve for the sake of economy.

Another government official outlined the government's overall goal with respect to health care for Aboriginals (Waldrum *et al.*, p. 176):

I cannot promise that the Government will feed and support all the Indians; you are many, and if we were to try to do it, it would take a great deal of money, and some of you would never do anything for yourselves [...] that the sympathy of the Queen, and her assistance, would be given to you in any unforeseen circumstance.

Government policy thus seems to have been to provide health care on a very minor basis unless there was a major outbreak. Their goal seems to have been to meet humanitarian standards, encourage surrender of their land, and prevent dependence of Aboriginals to the government from taking root. In practice, health care tended to be more than access to a medicine chest and included visits by doctors when the government came to provide other treaty services (Waldrum *et al.*, p. 181). Otherwise, Aboriginals had to pay for their own health care.

### **Establishment of Formal Aboriginal Health Care (1890s-1910s)**

With Canada now controlling the prairies and settlers moving there, the North-West Mounted Police (N.W.M.P.) was created. As the government presence in these lands, the N.W.M.P. provided health care for Aboriginals on behalf of the government which was concerned about reports of poor health of Aboriginals (Waldrum *et al.*, p. 182). The military established outposts during this time, and it did much the same with health care.

In 1880, the Department of Indian Affairs was created and by 1900, it provided some free health care to Aboriginals. In 1904, Dr. Peter H. Bryce (1858-1932) was appointed the first General Medical Superintendent of the Department, and by 1905, four physicians were on the Department's retainer to serve Aboriginals' needs (Waldrum *et al.*, p. 188).

### **The Government Awakes to the Aboriginal Health Care Problem (1910s-1920s)**

Peter Bryce, early in his tenure, commissioned a report to assess the state of Aboriginal's health. After 15 years of studying the problem, the report, *The Story of a National Crime: an Appeal for Justice to the Indians of Canada* was published concluding that Aboriginals were overrun with diseases such as TB and Measles. The report recommended that school nurses were needed, as well as better sanitation, diet, and exercise. It noted that rationing had led to malnourishment and illness. It also recommended that the Department of Health subsume responsibility for Aboriginal health (Waldrum *et al.*, p. 189). Unfortunately, the report fell on deaf ears in both the government (who wanted to avoid new expenditures) and the church (who ran schools and were responsible for many of the health failings). Dr. Bryce soon resigned.

Bryce did however have some impact during his two decades in office. He created mobile nursing programs, administered health education in Aboriginal languages, issued regulations to help Indian Agents improve health status, and contracted local physicians to provide care. Bryce's successor, Col. E.L. Stone continued these incremental improvements focusing on poverty and sanitation, and establishing a formal Medical Branch to administer Aboriginal health care (Waldrum *et al.*, pp. 190-192).

### **Aboriginal Health Care in the 1930s**

The 1930s were a time of economic depression and Aboriginal health care suffered from budget cuts. However, during this time there were still eleven medical officers, eleven field nurses, and seven small hospitals in operation (Waldrum *et al.*, p. 193), and with the Inuit and Métis becoming destitute, the government began assuming responsibility for their care.

### **Aboriginal Health Care in the Post-War Period (1945-1960s)**

With the massive expansion of social programs in the post-war period, Aboriginals began to enjoy improved health care services. In 1945, the Department of National Health and Welfare took over Indian & Northern Health Services from the Department of Indian Affairs. As well, with expansion of military bases, particularly in the North, all Aboriginals and particularly Inuit enjoyed more military-provided care. The rapid expansion of services is highlighted in Table 2. By 1960, there were 39 field medical officers, 43 hospital medical officers, 11 dental surgeons, 106 field nurses, and 232 hospital nurses providing care to Aboriginals (Waldrum *et al.*, p. 197).

**Table 2:** Health Care Statistics in 1956 & 1960 (Waldrum *et al.*, p. 197).

	1956	1960
Hospitals	18	22
Nursing Stations	33	37
Health Centres	65	83

It is interesting to observe that during this time, a government official noted that the government's interest in health care of Aboriginals as follows (Waldrum *et al.*, p. 178):

Although neither law nor treaty imposes such a duty, the Federal Government has, for humanitarian reasons, for self-protection, and to prevent spread of diseases to the white population, accepted responsibility for health services to the native population [...].

So the government provided care for humanitarian and self-beneficial reasons, but they felt they had no actual duty to care. Litigation during the 1960s attempted to change this absence of duty largely asking the Courts to reinterpret clauses in treaties, particularly those addressing health care in Treaty 6 (Waldrum *et al.*, pp. 179). Litigation had seen some successes but was largely inconclusive when in the 1970s everything changed.

### **The Emergence of Universal Health Insurance (1970s)**

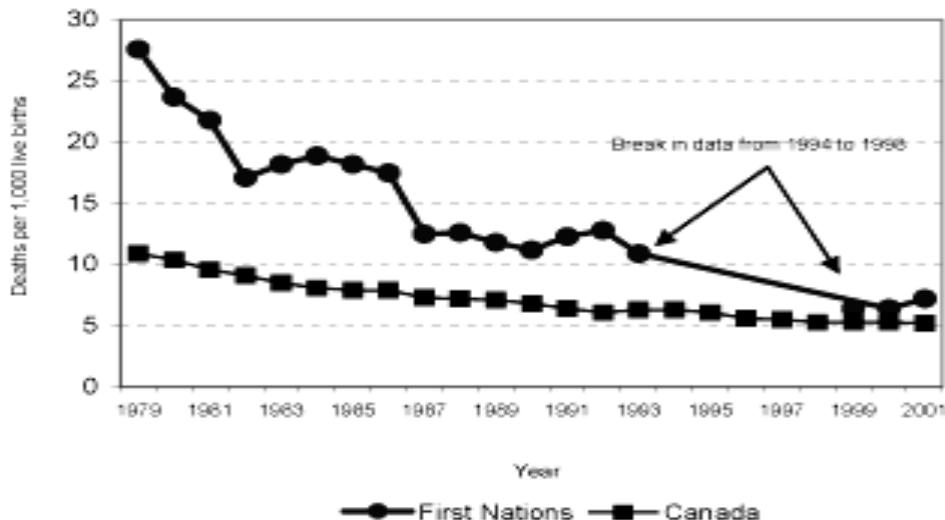
With the arrival of Medicare in the late 1960s, by the 1970s Aboriginals were entitled to free health care. However, the provincial governments were now in charge of providing health care to all Canadians. The federal government would pay the premiums for Aboriginals, but otherwise its role shifted away from providing formal health care. The federal government also paid for non-insured health benefits for Aboriginals, and provided some specialized services such as addiction services, and ran health care centres in remote areas (Waldrum *et al.*, p. 198).

### **Devolution of Aboriginal Health Services (1980s to Present)**

In 1979, a new Indian Health Policy recommended devolving health care administration to individual bands. Beginning with the first devolved service in 1988, more and more health services are provided on reserves by band directly (Waldrum *et al.*, pp. 167-169).

### **Theme: Separateness**

Most Aboriginal communities are small and many are either rural, or not integrated with the nearby population centres. In this sense, they are separate from the rest of the Canadian population. Their health is governed differently than from the rest of Canada being governed federally rather than provincially. Historically, their health care system was different as well and it was governed by a different government department. Aboriginals have always been treated differently when it comes to health care. In the 1970s, when Aboriginals were integrated into the general health care system they saw an increase in their health outcomes (Figure 2). While Aboriginals are different from other Canadians and what's appropriate for other Canadians may not be idea for Aboriginals, it needs to be analysed if Aboriginals separation from other Canadians is best for equality of health care.



**Figure 2.** Infant Mortality Rates, Canada and North American Indians on Reserve (1979-2001). (Indian and Northern Affairs, p. 30).

## Conclusion

Aboriginals have always been dependent on other Canadians for their health care. They were forced into treaties because they needed Canadian support for survival. They later became dependent on rations from the government which were inadequate and led to illness. While original government policy was to prevent dependence, Aboriginals have instead become dependent. While devolved health services are a step towards independence, they are still dependent on government money.

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