

AN ANALYSIS OF THE POTENTIAL FOR
PRIMARY HEALTH CARE AS A DEVELOPMENT
STRATEGY IN CANADIAN NATIVE COMMUNITIES

A Thesis Submitted in Conformity With the Requirements of
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The natural law will prevail regardless of man-made laws, tribunals and governments. People in Nations who understand the natural law are self-governing, following the principles of love and respect that ensure freedom and peace. We come together because we are alarmed by the destruction of our vital life structures. Our faith is intertwined with on another: what affects one will affect all.

Oren Lyons, 1989 -

To Jann with love

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CHAPTER I: INTRODUCTION

There are in Canada today well over one million Aboriginal peoples scattered across the country from the largest urban centres to the most remote of Arctic ice. Each Canadian Aboriginal, or Native person as they are often called, is a full Canadian citizen. He or she is, accordingly, entitled to most of the same rights and privileges as other Canadians: the right to vote, the right to assemble, freedom of political choice and expression, the right to live and work in any province or territory, freedom of religious choice and the right to challenge authority. The Canadian Indian is, in this respect, like all other Canadians and equal to them.

Canada's efforts to ensure the equality of all its citizens is one of two major themes in Canadian society that has persisted since Confederation and which has grown increasingly important in recent years with the entrenchment of a Charter of Rights and Freedoms in the repatriated Canadian Constitution, in 1982.

In addition, however, Canadian law recognizes the distinctiveness of our Aboriginal peoples. The law, therefore, assigns to Aboriginal Canadians certain rights and privileges that most non-Natives do not share. For example, Native peoples have special rights to the land they occupy, access to many special federal and provincial programs, and

special hunting and fishing rights. Herein lies an example of a second major theme in Canadian society: general respect for the ethnic and religious distinctiveness of one's fellow citizens.

The relationship of Canadian Indians to the so called "dominant society" in Canada provides an excellent example of both of these major themes, equality and specificity. Moreover, the history of Indian affairs in Canada, which has involved reconciling the "special rights" of Indians with the universal rights of Canadians, serves to highlight the somewhat conflicting nature of these themes.

The "uneasy relationship" between the Canadian objectives of equality and specificity shall be referred to throughout this paper with the intent of placing a relatively specific issue - Native health - in its larger Canadian political context.

Despite all of their so-called rights and privileges, the socio-economic condition of Canada's Native peoples today is desperate. Generations of extreme poverty, inadequate education, poor housing, massive unemployment and poor health have caused Canada's Native communities to become highly dependent, consumption-oriented and predominately unproductive. This tragic situation persists despite ongoing efforts by the federal government, the provinces and the Native peoples themselves to alter the status quo.

Nowhere is the plight of Canada's Native peoples more

evident than with respect to their extremely poor health. The poor health of Canadian Indians, who constitute a large number of Canada's Aboriginal peoples, is well documented (Morrison, 1986; Nielsen, 1985; Penner, 1984; Siguer, 1960; DIAND, 1980; Berger, 1980; Groscoe, 1977; MIB, 1970; Hawthorn, 1969; Schmitt, 1966).

There have been many reports published by individual health care planners, physicians, other health care workers, sociologists, anthropologists, Indian groups, and by various levels of government that examine a wide range of health-related issues. These independent studies, addressing such areas as Native infant mortality (Morrison, 1986), tuberculosis (Hodgson, 1982; Galbraith et al., 1969), drug and alcohol abuse (NNADAP, 1980) and Indian health politics, (Spect, 1987; Jarvis and Boldt, 1987,) have helped to bring the Indians' serious condition to the attention of other professionals and academics, the Canadian public, international organizations, and the Canadian government.

The first comprehensive study of Indian health conditions was conducted by Hawthorn in 1966 and 1967. Hawthorn found that in general, Canada's Indian peoples had a very poor level of health.

Ten years later, in 1979, the Conservative government of Joe Clark issued its new Indian Health Policy in which it acknowledged the "tragedy of Indian health". The following year, Justice Thomas Berger presented David Crombie, the

Minister of National Health and Welfare, with the Report of the Advisory Committee on Indian and Inuit Health Consultation. The Advisory Committee's findings reported that "notwithstanding the dedication of MSB Medical Services Branch of the Department of Health and Welfare Canada and its staff, and the expenditures of these (aforementioned) sums, the grievous state of Indian health today is plain for all to see." (Berger, 1980:3). Also in 1980, the Department of Indian Affairs and Northern Development (DIAND) produced a 15-page study entitled, Indian Conditions: A Survey in which it cited empirical evidence to demonstrate clearly that the health status of Canada's Indian peoples was indeed very poor, relative to the health of non-Native Canadians (DIAND, 1980:passim).

More recently, in 1985, the Report of the Special Committee on Indian Self-Government identified Indian health as one of "three areas of critical concern" to be addressed by federal Indian policy (Penner, 1985: 53-55). Even the highly conservative Nielsen Task Force on Program Delivery, reporting in 1985, concluded that Native Canadians was one of "three priority target groups" to be considered in future Canadian health policy. The other two target groups were the disabled and the elderly (Nielsen, 1985: 27-8). In its summary of Indian and Northern health, the Nielsen Task Force concluded that, "in general, the level of health of the Native population of Canada continues to be below that of other Canadians." (Ibid.: 324).

Finally, in 1988, MSB commissioned a review of Health Status Indicators from Vital Statistics of Native Indians, 1978-86, in which the researchers concluded that, despite the difficulties in compiling and comparing accurate Indian health statistics, the evidence available shows that the vast majority of Indians continue to suffer from poor health (Harris and McCullough, 1988).

The general trends in Native health that are consistently reported reflect a high infant mortality rate, shorter life expectancy, malnourishment and malnutrition, respiratory diseases and an alarmingly high rate of deaths due to accidents, violence, poisonings and suicides (cf. Grescoe, 1977). When one considers that these health problems generally occur in communities with crowded housing, inadequate or non-existing plumbing and heating, poor sanitation, high unemployment, poverty, stress and general discontent and disillusionment, it is not surprising that Canada's Native peoples have poor health.

That a minority population in a large society should experience some degree of inequality with respect to its comparative health status is not in itself surprising. What is surprising, however, is that the health of the Canadian Indian population remains well below the national average despite years of exceptional expenditures on Native health care services and persistent efforts by the federal government to improve Indian health (Nielsen, 1987).

Clearly, something is wrong.

In this thesis, I will examine the development of Indian policies in Canada and, within that development, situate the socio-economic status of the Indians, particularly with respect to their health. In focusing on the health of Canada's Indian peoples, I will examine the question as to why it is that current federal initiatives in the area of Indian health care are ineffective. Then, based on the evidence I provide, I will argue that the Canadian government, in cooperation with the provinces should work with Indian (and other Native) communities to develop, implement and exercise a network of decentralized Native health care services founded on the internationally recognized and Canadian-endorsed principle of primary health care (PHC).

The argument begins in chapter II with an overview of the general relations between Canada's Indian peoples and broader Canadian society from the sixteenth century to the present.

Chapter III reviews the development of the Canadian government's Indian health policy since Confederation. In the second half of chapter III, the virtual failure of the Canadian Indian health care service is examined and the prospects for improving the status quo are considered.

The origins of the primary health care strategy are

presented in chapter IV and an argument is made to support the thesis that the PHC strategy offers a philosophical, practical and politically palatable solution to many of the health related problems of Canada's Indians.

In chapter V, Canada's attempts to apply PHC-type initiatives to the existing Canadian health services are examined. The evidence suggests that such federal initiatives have amounted to little more than "tinkering" with the existing health care services and have therefore been ineffective in meeting PHC-type objectives (eq. community participation, self-help, appropriate technology). A case is made to demonstrate that the federal government, for a variety of reasons, lacks the essential "political will" to pursue PHC-type initiatives effectively. The conclusion is drawn: if PHC would be good for the Indians and the federal government is unwilling or unable to introduce comprehensive PHC in Indian communities, then, the Canadian government should make it possible for the Indians to be able to pursue PHC themselves.

Chapter VI provides evidence to show that if the Indians were able to implement PHC themselves, they could well avoid the impediments that have precluded effective federal PHC initiatives. The chapter then reviews the Indians' recent attempts to achieve self reliance through self-government and concludes that the type of autonomy the Indians will require to pursue their own PHC initiatives is only likely to occur

in the foreseeable future on a limited, band-by-band basis.

The second to last chapter examines problems related to the implementation of the PHC strategy recommended. This chapter draws particular attention to the unresolved equality/specificity dilemma of Canadian federalism.

The thesis concludes with the view that, despite its problems, as a development strategy, PHC holds good potential for improving the socio-economic conditions of Native communities in Canada.

The reader is asked to keep in mind that there are many groups of "Aboriginal peoples" of Canada, including the Indians, or "Status" Indians, the "non-Status" Indians, the Inuit, and the Metis. In order to restrict the scope of this study, however, the general references made to "Aboriginal peoples" and "Native peoples" in this paper refer more specifically to the Status Indians of Canada (the terms "Status" and "non-Status" Indian, Metis and Inuit are explained in the following chapter).

CHAPTER II: NATIVE-DOMINANT SOCIETY RELATIONS IN CANADA

In order to understand the difficulties that face Canada's Indian peoples today, it is necessary to consider the economic, social and political events that have led to their current condition. This chapter begins with a brief description of who the original Canadian Indians were and how they lived. It then examines the profound impact that the early European traders, soldiers, missionaries and settlers had on the Indians in Canada, both in the early years of contact and subsequently. In the third and final section, the historical development of federal policy with respect to Canada's Indian peoples is reviewed from the period of Confederation to the present day.

In setting the current state of Indian affairs in Canada in its historical context, this chapter will provide the reader with a good overview of the manner and extent to which Canada's Indian peoples have been influenced by the laws, customs and politics of the dominant society. This chapter will also reveal the dramatic extent to which Indian affairs in Canada have changed over the past two decades.

THE FIRST CANADIANS

The People

The need to review the historical evolution of the "Indian problem" in Canada is particularly important in light of the fact that many people today continue to discriminate

against Canadian Indians in the belief that the "Indians" are biologically and socially inferior to other Canadians (Spect, 1987:101). The following discussion reveals the extent to which this fallacy has contributed to the radical evolution of Indian society in Canada.

The Canadian Indian peoples do not, and have never constituted a homogeneous group (Penner, 1985:11; Spect, 1987:21n.1). For millennia prior to European exploration and colonization, the North American continent was inhabited by many different indigenous peoples, organized in a wide variety of political entities and groupings based on common languages and cultural traditions (Penner, 1985:11-15). They were self-sufficient, extremely well adapted to their environment, and they had developed a wide variety of languages, religions, laws, customs and political institutions (ibid., 1985:11).

Canada's Native peoples can be roughly divided into 7 geographical groups: the West Coast Indians, the Indians of the Cordillera, the Plains Indians, the Indians of the Yukon and Northwest Territories, the Woodland Indians, the East Coast Indians and the Inuit of the Arctic and sub-Arctic (Jenness, 1964:vi-vii). Originally, there were over 50 tribes of Indians in Canada, each with its own dialect, customs and defined hunting territories. Though somewhat isolated from one another, trade both within and between tribes formed an important part of each Native group's local

economy.

The Indians of the West Coast occupied the coast of present-day British Columbia, including Vancouver Island and the Queen Charlotte Islands. Foremost among these tribes were the Haida, the Bella Coola, the Nootka and the Coast Salish (Ibid.:337-47). Because of their proximity to the sea, these Indians were predominately fishermen and sea-hunters, working from well-established shore bases. As a result of their relatively sedentary lifestyles, the Indians of the West Coast were able to build permanent villages and developed some enduring forms of political and social organization (Ibid.:337). Most celebrated among the West Coast Indian social and political traditions was the Potlatch: a form of ceremonial assembly, conducted by community or tribal leaders as a means of redistributing wealth and installing new leaders. At the Potlatch political councils were held, names given and recorded, history recalled and instructed and spiritual guidance given. It proved to be a well-developed, effective socio-economic and political institution which served to ensure all the essential elements of good government (Penner, 1981:10).

The predominant tribes comprising the Cordilleran Indians were the Interior Salish, the Kootenay, the Chilcotin and the Carrier. These Indians were a migratory people and therefore did not develop social and political structures to the same extent as some of the more sedentary coastal tribes.

They were, however, organized according to well established practices and had their own laws, spiritual beliefs and customs (Jennoss, 1965: 351-376).

The Yukon and the Northwest Territories were inhabited by seven major tribes who spoke Tinneh or Dene. These were the Slavey, Dogrib, Hare and Yellowknives in the Mackenzie lowlands, the Nahani and Loucheux on the north-eastern fringes of the Cordillera and the Chipewyan who lived east of Great Slave Lake and Great Slave River. These tribes were widely dispersed over a large expanse of land and survived by following large migrations of caribou. They spoke Athapaskan, but because of their migratory lifestyle, their social and political institutions were simple (ibid.: 377-404).

The major Plains Indians were the Blackfoot, the Sioux, the Assiniboine, the Plains Cree and the Plains Ojibwa (DIAND, 1984a:1-9). Like the Indians of the Cordillera and the Mackenzie Valley, the Plains Indians were nomadic, gathering berries and roots and hunting deer and buffalo. Apart from a little tobacco, the Indians of Canada's plains had neither the knowledge nor the tools required to till the rich lands they occupied. Like other nomadic groups, the Plains Indians did not develop any extensive political or social organization (DIAND, 1974a:3; Driver, 1964:290). The simple forms of organization developed among them were

limited to continuity of religious beliefs, social practices, and traditional customs (Grenness, 1964:118-119).

The Indians of the eastern woodlands of Canada (from the northern shore of Lake Superior to the Atlantic coast) spoke Algonkian, and occupied much of the Canadian shield and the Appalachian Highlands. From west to east, the major divisions were the Blackfoot, the Cree, the Ojibwa, the Ottawa, the Algonkian, the Montagnais, the Neshapí, the Abenaki, the Micmac and the Malecite. The Algonkian group was nomadic but its members developed important political and social systems (DIAND, 1973b:5).

The St. Lawrence lowlands and Upper New York States were occupied by the Iroquoian peoples. These included the Onandaga, the Cayuga, the Seneca, the Mohawk and the Oneida, of the Iroquoian Five Nations Confederacy (which later included the Tuscaroras) as well as the Huron, the Neutralis and the Petun.

In contrast to their Algonkian neighbours, the Iroquoian were relatively sedentary, having developed the necessary skills for growing corn, squash, sunflowers, beans and peas. These crops were supplemented by fishing and hunting. The more sedentary lifestyle of the Iroquoian facilitated the development of social and political organization, unsurpassed by the other Indian peoples of Canada (Driver, 1969:302). Of these, the tribes of the Five Nations Confederacy were the most highly developed politically. Each

tribe consisted of smaller units, or clans which appointed members (sachems) to a general council. Although the tribes and even the clans were essentially independent, they united in the face of common danger (See two essays by Lyons and Porter in Little Bear, 1984:15-21).

In Newfoundland, the original inhabitants were known as the Beothuks. They were distinct from other Native groups in Canada. After years of ceaseless persecution by the Micmacs and, in particular by the early European visitors, they were eliminated in the early nineteenth century (Fidenes, 1988:10).

In the Arctic and sub-Arctic regions of Canada the Native people refer to themselves as "Inuit", which means "men". Early Europeans, however, adopted the derogatory Cree word "Estimo", which means "eaters of raw meat", to distinguish the Inuit from other Native groups. The Inuit were, and remain, relatively fewer in number and more dispersed than the Indians occupying Canada's more southerly regions, but they had learned to live well in a hostile environment, covering a vast area. They were well organized in the sense of developing an important code of conduct, a unique religion, folklore, games, sports, ingenious methods of hunting and fishing, of preserving food and other essential political and social elements of community living (Ibid.:10-24; Price, 1979:66-70; Driver, 1969:288).

It would be erroneous to describe the lifestyle of the Canadian Indian or Inuit, prior to the arrival of the Europeans, as having been ideal. There were always many hardships to overcome and the Native peoples frequently engaged in armed conflict with one another (Price, 1979:69; Driver, 1969:ch.18). Nonetheless, it is important to realize that Canada's Aboriginal peoples were not uneducated, poorly organized and irresponsible, as colonial myths have portrayed them. At the time when the Europeans first encountered Canada's Indian peoples, the Indian societies were highly developed and complex (Little Bear, 1984:xi).

Early Health

The general health of the Indians in the fifteenth century, relative to their contemporaries, is believed to have been good. They did, after all, exist in a relatively harsh environment and their perpetual struggle for survival and for a better quality of life required that they be hearty. Trigger notes that the development of Aboriginal medical knowledge prior to the arrival of Europeans in Canada suggests that the Indians were not necessarily as healthy as many commentators have stated (1985:144). By the same token, however, the Indians' European contemporaries had a relatively low health status. In any event, there is no need to attempt a comparison here that would be impossible anyway.

The practice of medicine among the early Canadian Indians was inextricably linked to their religion. Medical

attention was provided by the community shaman or medicine man whose medical knowledge was based on both empirical experience and the teachings of his predecessors. Many Indian groups, such as the Huron, attributed the possible causes of illness to both natural and spiritual sources (Trigger, 1985:244-46). The shaman was responsible for diagnosing the cause of the illness and then prescribing the appropriate cure.

While the Native peoples had little understanding of anatomy and physiology, medicine men were remarkably successful in their attempts to cure the sick (ibid.: 46). According to Graham-Cumming, the medicine men had a well developed understanding of how to use a wide variety of herbs, both internally and externally, to produce analgesia, circulatory stimulation, coagulative and laxative effects and other desired tonic and toxic effects (Graham-Cumming, 1967:120). Moreover, they were aware of the virtues of vitamin-rich plants, they could recognize and immobilize a fractured bone, they had methods for handling some forms of hemorrhaging and asphyxia, inducing hypnosis and post-hypnotic suggestion and even practised mouth-to-mouth resuscitation (which they called "putting the spirit back").

There is evidence that some Canadian Indians were capable of various forms of surgery including, in some cases, amputation and even the delivering of children with recourse

to caesarian section (Hiddes, 1965: 401). Above all, many of the shamen had developed an effective understanding of the basic therapeutic principles of psychology (ibid.).

While one must be cautious not to exaggerate the capabilities of the Indian medicine men by suggesting that all of these medical techniques were widely known and widely practised, it is important to realize that Canada's Native peoples were capable of looking after their health long before the arrival of the Europeans.

THE ARRIVAL OF THE EUROPEANS

The single greatest factor affecting the evolution of Indian societies in Canada was the arrival of the Europeans in the sixteenth and seventeenth centuries. From the East Coast Indians' first contacts with Inacque fishermen through to the establishment of the North American fur trade, Christian missions and European settlement, Canada's Indian peoples were both encouraged and forced by the Europeans to change virtually every aspect of their indigenous way of life.

The Fur Trade

Prior to the beginning of the sixteenth century, European interest in Canada was restricted primarily to the charting of a westward sea route to the Orient and to the exploitation of Canada's rich fishing waters off the coast of Newfoundland and Labrador. The French were among the first Europeans to establish on-going relations with Canada's indigenous people, but for many years, contact was restricted

to the coastal areas. Toward the middle of the sixteenth century, following the voyages of Jacques Cartier to New France, in 1534, 1535 and 1541-42, the French established contact with Indians living in the interior of Canada.

It was not until the establishment of the fur trade toward the end of the sixteenth century, however, that French interest in Canada became significant. The succession of Henry IV in 1598, brought an end to the religious wars of Francis I and ushered in a period of relative peace and prosperity for France. At the same time, felt hats came into fashion in France creating a strong demand in Europe for furs, and in particular beaver pelts, from New France (McInnes, 1959: 26).

Initially, French merchants in search of Canadian furs traded almost exclusively with the Montagnais Indians who occupied an eastern portion of the St. Lawrence Valley. The Montagnais traded their furs with the French in exchange for a variety of European goods ranging from metal instruments and clothing to glass beads and liquor. In 1600, Pierre de Chauvin de Tonnetuit established the first permanent trading post in New France, at Tadoussac, at the mouth of the Saguenay River (*Ibid*:18).

The best furs in New France came from the regions lying to the northwest of Tadoussac. The Montagnais and the neighboring Algonquians obtained many of these furs by trading

with other Indian groups. They then sold the superior furs to the French at Tadoussac. McInnes suggests that the French would have preferred to trade directly with the Indian groups to the north and west of Tadoussac, but in the early years of the fur trade they were prevented from doing so by the Montagnais who wished to retain their privileged position as intermediaries (*ibid.*:176).

In 1602, Chauvin received royal assent to broaden French relations with other Indians along the St. Lawrence River. In 1608, Samuel de Champlain founded a permanent settlement at Stadacona (which he renamed Quebec) and from there the French managed to establish contact with other Indian groups, most notably with the Huron of western Quebec and the Iroquois of northern New York state. By the winter of 1616, Champlain had established direct trade relations with the Hurons, the Petuns and the Nippisings, thereby ending the brief monopoly of the St. Lawrence Montagnais and the Algonquin.

Meanwhile, the influential Iroquois tribes to the south of New France had begun to compete with other Native groups for a share of the lucrative fur trade. The Indian groups who traded with the French opposed this, fearing that the more powerful Iroquois might eventually dominate all trade with the French. In order to ensure continuing good relations with their Indian trade partners, therefore, the French did not trade with the Iroquois. Eventually, the

Iroquois managed to establish on going trade with British and Dutch merchants in and around New Amsterdam (Ibid.:180).

It has been suggested by a number of writers that the Europeans' relative technological superiority led Canada's Native peoples to hold the former in awe and allowed the French to exploit the Natives easily (Ibid., see also Frideres, 1973:Introduction). Trigger suggests, however, that while the Indian peoples of Canada may have considered such things as European fire arms, fine art, superior tools, literacy skills and scientific knowledge as products of magical powers, there is no evidence that the Indians considered the Europeans to be innately superior to themselves in the early seventeenth century (1985:224-25). The Indians believed that they too possessed magical powers, similar to those demonstrated by the Europeans, which permitted them to carry out a number of important tasks (Ibid.:224).

Moreover, the Indians found much to criticize about the European newcomers. They considered them to be greedy and contemptuous, disrespectful of their fellow men and impatient. In addition, the Europeans often proved to be slow to learn the ways of the Indians: to respect their customs, to speak their languages and to use their canoes and snowshoes, all of which indicated to many Indians that the Europeans were not as clever as they pretended to be. In

fact, it was not so much a question of adapting to the European way of life that troubled Canada's Indian population in the early seventeenth century as it was a question of adjusting to the increasing changes to Indian society brought on by the fur trade. (Ibid.:149).

The traditional patterns of subsistence and survival of many Indian peoples were radically altered by the fur trade. As European demand for furs grew, so too did the Indians' desire to obtain larger supplies of European goods. Accordingly, many Indians devoted an increasingly greater amount of time to trapping and curing furs, with the result that they had less time available for the collection of food and community affairs. In addition, the Europeans introduced Indians to alcohol, guns and to various other foreign vices which, in conjunction with the economic incentives of the fur trade, contributed substantially to the alteration of traditional values and mores of many Native people (McInnes, 1959:15).

Early Colonization

The establishment of permanent European settlements in Indian territory was the second and the most significant change brought about by the fur trade in Canada. By the middle of the seventeenth century France had decided that the best way to ensure her dominance over the territories she claimed in eastern North America was to colonize them. To this end, from 1670 Champlain, as French Viceroy in New

France, devoted himself entirely to the development and administration of New France. He actively encouraged the Montagnais to become farmers, to learn to speak French and to convert to Christianity. The Viceroy even went so far as to declare himself legally responsible for appointing Indian chiefs to tribes wishing to trade with the French (Trigger, 1985:199-200).

Initially, many of the Native groups who traded with the French welcomed the French settlements both as a means of increasing trade and as a guarantee of protection against their hostile Iroquois neighbors (McInnes, 1969:13-14).

However, as the following discussion reveals, colonization resulted in the confiscation of Indian lands by white settlers, a decline in Native religion, changes in the lifestyles of Indians who came to live in the settlements, and the destruction of thousands of Native people due to European diseases and increased warfare (Ibid.:13).

The Christian Mission

The formal introduction of Roman Catholicism in Eastern Canada in the seventeenth century had a profound impact on the Indian peoples living there. As the French insisted that the Indians abandon their pagan ways and embrace Christianity, many Indians became divided and confused with respect to their religious convictions and their personal allegiances.

The Recollets established their first mission, at Quebec, in 1615 (Trigger, 1985: 900). After 1617, however, the French government decided that only the Jesuit Order would be permitted to carry out missionary work in New France (ibid.: 227). From 1634 to 1634, the work was done primarily in Huron country. A large mission was begun at St. Marie-Among-the-Hurons (near present day Midland, Ontario) in 1637 and from there the Jesuits succeeded in establishing other, lesser missions throughout the region. Subsequently, the French missions were extended, with limited success, into Iroquois country, along the St. Lawrence lowlands and Upper New York State (Trigger, 1985: 289-90). Eventually, the French insisted that they would only conduct trade with those Indian groups who would allow the Jesuits to establish missions in their respective communities. In many cases, the Indians were made to promise that they would, in time, convert to Christianity, although it is likely that most did not truly understand what this meant (ibid.: 29).

Although they were often well meaning in their intentions and extremely devoted to their work, the French missionaries found it extremely difficult to convert the Indians to Christianity. They failed to appreciate the breadth, complexity and general significance of the Native religions they were trying so hard to abolish. Spiritualism permeated every aspect of Indian life and could not easily be erased (Lyons in Little Bear, 1984:5-10). Thus, in order to attract more Indians, the French sweetened the prospects of "Christian salvation" by offering such things as preferential trade prices and, after 1641, guns for any Indian who was willing to adopt Christianity in lieu of his traditional beliefs (Trigger, 1985:144-55).

In time, many Indians complied with the wishes of the French, often without properly understanding the long term implications of what they were doing. As a result, the Indians of the east coast became polarized into antagonistic groups of Christians and non-Christians. The long term impact of the missionaries' work was extremely disruptive to the Indians' indigenous ways of life. The introduction of Christianity not only divided the Indians philosophically, but it also undermined many of the values and beliefs fundamental to Indian society in general (*ibid.*).

The European Diseases

The Europeans not only brought new technology, new

religions and new customs to Canada, they also brought with them European diseases which were to have a devastating, long term impact on Canada's Indian populations.

The first historically recorded instance of an epidemic disease of European origin in eastern Canada corresponded with the arrival of the Jesuit priests in Huron country in 1634. Over the following 7 years at least four such epidemics were to plague the Hurons and their neighbours (Trigger, 1980:250). Due to the rudimentary state of medical knowledge at the time, it is not possible to ascertain exactly what all the diseases were. What is clear, however, is that the epidemics were of European origin and included such diseases as influenza, measles, smallpox and tuberculosis (Graham Cumming, 1969:526). The diseases were likely introduced to Indian country by infected ships, merchants and/or settlers and then spread by infected European and Indian traders and missionaries who might travel great distances and come into contact with many people in the course of a summer (Trigger, 1985:230).

The fact that the diseases were not endemic to Canada meant that the Native Canadians had had no opportunity to acquire immunities to the diseases. As a result, the diseases decimated much of Canada's Native population shortly after European contact. The extent of the damage remains uncertain, but Trigger suggests that there may have been as much as a 50 percent reduction in the size of Canada's

eastern Native populations in the mid-seventeenth century (Ibid.:272).

As a result of the diseases, many Indian communities were crippled by the loss of their actual and future leadership. Moreover, the diseases were introduced to Canada at the very time when many Native peoples were adopting Christianity. These people were forbidden by the Church from seeking medical attention from their traditional Native healers. Instead, many Indians received little more than the blessings of the Catholic Church and the "white man's" promise of eternal salvation. This is not to suggest that the Indian medicine men of the seventeenth century were able to cure the diseased, but being well-versed in the Natives' traditional ways, they offered greater care and comfort to the infirmed at that time than did the Europeans (Graham Cumming, 1967:121).

The "Indian Wars"

The Indians' involvement with the Europeans eventually led them into prolonged armed conflict between each other and other European powers. This had a devastating effect on the Indian population, and their respective ways of life.

By the middle of the seventeenth century, the Indians' dependency on European goods had grown so strong that they were no longer able to do without them (Trigger, 1985:254). Thus, despite the trauma brought about by European

interference and disease, the Hurons and other Native groups in eastern North America continued to trade with the French throughout this period. European goods were treasured by the Canada's Indian peoples initially because of their presumed supernatural significance, and subsequently, for their relative utility (Ibid.:189). In time, they became a widely accepted measure of an individual's or a community's relative wealth and increasing numbers of Native groups sought to obtain greater amounts of European goods. Eventually, the Indians began to deplete their environment and ultimately engaged in destructive inter-tribal wars in a futile effort to satisfy their changing needs.

As the fur trade expanded in eastern North America, the French became increasingly aligned with the Montagnais, the Algonquins and the Hurons while the British strengthened their ties with various Iroquois tribes, most notably the Mohawk. This fact has led some commentators to conclude that, through their interest in trading with the Canadian Indians, the French and British became locked into previously existing mutually hostile alliances (Ibid.:181).

Trigger, however, argues convincingly that, in fact, it was the fur trade itself, instigated and directed by the European powers, that polarized Indian enmity and precluded any opportunity for peaceful coexistence between certain European-allied Indian groups (Ibid.:182). The "Indian wars", as the battles between the French and the British and

their respective Indian allies during the late seventeenth to mid-eighteenth centuries became known, caused further widespread destruction of Canada's Native populations (McInnes, 1969:57).

Westward Expansion

The European traders, soldiers and colonists continued their disruption of the Indians' indigenous way of life, westward, well into the nineteenth century, until most of the original Indian communities had been either forever altered, or destroyed completely.

In 1763, the Treaty of Paris brought an official end to the English and French conflicts in North America. That same year, in order to allow westward settlement to proceed peacefully, the British Crown issued a Royal Proclamation which designated the unoccupied lands to the west of the Ohio River to the Indians for their exclusive use (Fenner, 1983: 6).

At the time, the British government felt that by reserving lands for the Indians the latter would be able to retain their traditional lifestyles and remain loyal to the Crown, without causing difficulties for the white settlers (McInnes, 1969:148). Indian loyalty was particularly important to Britain at the time as the American colonies had become openly rebellious. The Royal Proclamation of 1763 did not, however, make any specific mention with respect to

government obligations to provide social or economic assistance to the Indians (Elliot in Morse, 1986:55-56).

The American War of Independence broke out in 1765 and the subsequent creation of the United States of America, along with the rapid influx of United Empire Loyalists into Canada exacerbated the Native peoples' territorial problems. As settlements moved increasingly westward across North America, conflict between the Native peoples and the encroaching settlers continued.

In an attempt to appease the Indians and facilitate the progress of westward settlement, the British government and later the Canadian government negotiated a series of agreements with various independent Indian groups whereby the latter relinquished their claim to the land they occupied in exchange for such things as cash, annuities and subsequent promises of government-supported reserve lands (DIAND, 1984a: 14-25). Today, these are known as the Indian treaties (the 11 Indian treaties contracted after 1867 are known as the "Numbered treaties") and they continue to play an important role in the determination of the federal government's legal responsibilities to Canada's Indian population (ibid.:17-18; Ponting: 1986:6; DIAND, 1986:57-8; IFROCP, 1986:ch.4).

After 1860, the Plains Indians and later the Indians of the west coast came into frequent contact with European traders and settlers along with many displaced Indians. Among other things, the newcomers brought with them the same

diseases which only a few generations earlier had wiped out a great number of eastern Canadian Indians. In addition, the Europeans were largely responsible for the rapid destruction of the plains buffalo (often hunted for pleasure), upon which the Plains Indians were wholly dependent.

As a result of the depletion of the buffalo, the Plains Indians' lifestyle changed dramatically over a very short period. By the turn of the century they had become more sedentary and were forced to eat government rations of salt pork and white flour bannock in place of buffalo, pemican and other traditional foods. Many Plains Indians were unable to survive the onslaught of disease, poverty and famine, while those that did remained destitute and demoralized (Graham-Cumming, 1967:132-33).

Summary of the Pre-Confederation Impact

Canada's original Indian societies were well developed socio-economically, culturally, and politically. They were very distinct from one another, but at the same time, they shared many similarities: a common ancestry, religious beliefs based in animism, colouration and relatively good health.

The arrival of the Europeans in the sixteenth century, however, changed all that. The French founded their first permanent fur trading post in Canada in 1600. By 1650, just a few decades later, untold numbers of Native Canadian

people had been killed as a direct or indirect result of their contact with the Europeans. By the mid-1800s, the devastation had been carried right across the continent. For those Indians who managed to survive the ravages of disease, war and colonization, much of their indigenous way of life was gone forever.

Despite their struggle to retain control over their lands, customs, religions, languages and personal identities, by the end of the nineteenth century, Canada's Indian peoples had been almost completely overwhelmed by the European traders, colonizers and statesmen. Disease, expropriation, religious persecution, economic dependence, encroaching settlers, unfriendly neighbors and, most of all, a completely altered way of life rapidly reduced the first Canadians to a weak, largely dependent minority in Canada.

For their part, the Europeans did not consider their "discovery" and subsequent colonization of North America to be wrong. In the first place, European activities in North America in the seventeenth century were almost exclusively dictated by economic, fiscal and political events in Europe. Furthermore, since the Enlightenment, much of Western Europe ascribed to a hierarchical view of society. Despite the writings of a minority who praised Native civilizations, an assumption prevailed among Europeans regarding their own natural superiority. As in all cases of colonization, this feeling led them to believe that they had the right, indeed the mission, to interfere directly in the spiritual, social and economic lives of Canada's Native peoples (Frideres, 1988:ch 1; Upton, 1973:58).

Accordingly, while early British Indian policy in Canada was designed primarily to retain the Indians as allies in the fur trade and British-American politics, this focus changed dramatically in the early nineteenth century. After 1830, as the fur trade moved west and tensions between Britain and the United States eased, the Crown ceased to regard the Indians as particularly useful to the safety or prosperity of the young colony. From that point on, Britain adopted a largely paternalistic policy toward the Canadian Aborigines.

Officially, late British Indian policy in Canada sought to "protect" the Native peoples from the "evils inherent in white society", while at the same time, it sought to

"civilize" the Indians by encouraging them to adopt the beliefs and customs of the non-Indians (DIAND, 1986a:54-55). Over time, the vast majority of Indian peoples were assigned to reserves where the government pursued its "protect and civilize" policy for well over a hundred and fifty years (Daugherty and Madill, 1980:10).

That the consequences of the European conquest of North America would be catastrophic for Canada's Native peoples could not be anticipated in the seventeenth and eighteenth centuries, but by a few critics of society. It was, however, the very destruction of much of Native Canadian society that made possible the subsequent domination of North America by the European peoples (Frigger, 1985:250).

CONFEDERATION TO THE PRESENT

As was mentioned earlier in this section, the Native peoples relationship to the so-called "dominant society" in Canada has been characterized by the uneasy marriage of the conflicting liberal views of equality and specificity. This fact is particularly evident in the hundred years that followed Confederation, wherein Canadian law and politics sought at once to include and exclude Canadian Indians from mainstream Canadian society. An examination of those law and the rationale behind their conception reveals a great deal about the nature of Native non-Native relations in

Canada today.

On July 1, 1867, the Dominion of Canada was created. The newly formed government of Canada was immediately confronted with serious problems of national unification, economic development and military security. While the question of what was to be done about Canada's impoverished and declining Native populations was of concern to many of the Dominion's early politicians, it was not paramount. The so-called "Indian Problem" was to be dealt with over time, if and when necessary (Oughterty and M dill, 1980: Introduction).

In the meantime, the Dominion government pursued essentially the same Indian policy as its British predecessor had followed since 1840. Paramount in the Canadian Indian policy, however, was the intention that the Indian people should eventually be assimilated by the dominant society. This aspect of Canadian Indian policy, which Ponting refers to as "internal colonization", remained virtually unchanged until 1975 and must be considered as integral to the exacerbation of the many social, economic and political problems of Canada's Native people today (Ponting, 1986:85; cf. Speck, 1987:89-90).

The Indian Act

The British North America Act (BNA Act, now known as the Constitution Act, 1867) granted the government of Canada jurisdiction over "Indians and lands reserved for Indians"

(sec. 91(24)). This power has been subsequently exercised through the provisions of a special federal statute, dealing exclusively with with Canada's Indian peoples and consolidated in 1876, known as the Indian Act. The Indian Act sets forth a complex system for registering Indians, administering their lands and regulating their lives (Morse, 1984:126; Ponting, 1980:12; DIAND, 1986:60-61).

The Indian Act was originally formulated with a view to the eventual assimilation of the "racially-inferior" Indian people into mainstream Canadian society. The Superintendent General of the federal Department of Indian Affairs stated in 1876, that the Indian Act was necessary because the,

true interests of the aborigines and of the State alike require that every effort should be made to aid the Red man in lifting himself out of his condition of tutelage and dependence and that is clearly our wisdom and our duty . . . to prepare him for a higher civilization by encouraging him to assume the privileges and responsibilities of full citizenship (cited in Daugherty and Madill, 1980:4; cf. Ponting, 1980:15)).

The government maintained that in order to be successfully integrated, the "Indian" had to be first "civilized". It became government policy to encourage, and in fact, require the Indians to abandon their traditional lifestyles, religions, cultures and languages before assuming their place as full Canadian citizens. In short, in order to ensure that the Indian peoples would eventually become "equal" to non-Native Canadians, the Indians were to first

lose their "distinctiveness".

Accordingly, four main sections of the Indian Act were designed specifically to expedite the process of Indian "civilization" and assimilation. As recently as 1985, these were: (1) registration requirements for Indians; (2) an elective system designed and implemented strictly for the Indians; (3) enfranchisement incentives to encourage Indians to abandon their special status under the Indian Act; and (4) federal government control of Indian lands (Ponting, 1980: ch.1).

The Indian Act applies only to those persons who have registered as Indians with the federal government. One's right to register as an Indian is determined through an arbitrary definition of "Indian" devised by the federal government (Fideros, 1988:10). These people are known as either "Registered" or "Status" Indians. As a result of the narrow definition of Indian found in the Indian Act, many Canadians who, on account of their physical appearance,

parentage, religious beliefs, languages and lifestyles, would normally be regarded as "Indian" are not considered to be Status Indians under the Indian Act (Section 2 of the Indian Act). These "Indians without status" often suffer from the same discrimination and poor living conditions as the Registered Indian population, but because they are not covered by the Indian Act, they are not entitled to any of

the limited benefits it provides (Morse, 1985: 1; Daugherty and Madill, 1980). In addition to non-Status" or "non Registered" Indians, the Indian Act excludes Canada's other Aboriginal peoples, the Inuit and the Metis (Canadian Aboriginals of mixed ancestry).

In his essay "The Comfortable Crisis", Waubageshiq suggests that the federal government's arbitrary division of Aboriginal peoples into two legally distinct blocs was done in order to facilitate their civilization/assimilation (Waubageshiq, 1970: 97, 143-44). This was to be accomplished first, by factionalizing the Native peoples' opposition to the federal government over the years, and second, by forcing the "unprotected" non-Status Indians to join the dominant society (see also, Ponting, 1986:21; Morse, 1985:4).

Despite the legislation, however, non-Status Indians did not disappear in the broader society. Consequently, the Canadian government has had to enact legislation specifically for the "non-Indian Indian," in accordance with Section 91 (24) of the British North America Act. Contrary to diminishing, Native affairs in Canada have become increasingly complex over the years (Ponting, 1986:11).

The second major section of the Indian Act which was clearly intended to lead to the eventual assimilation of Canada's Indian people is the elective systems provisions (Daugherty and Madill, 1980). For many years, the Canadian government was convinced that the Indians' numerous

traditional tribal political systems, which varied throughout the country, were impediments to the "civilizing" of the Indian people (Penner, 1985:14). The federal government therefore decided to replace gradually the Indians' own political systems with a form of elected local government.

The Registered Indians were assigned to new political units known as "bands" and were eventually required to follow a strict legal procedure for electing their councillors and leaders. (Daugherty and Modill, 1980:4-5) Because this was deemed to be an advanced form of political organization, only some of the bands were assigned the elective system in the early years of the Indian Act. Moreover, for many years, all decisions taken by the band council were subject to approval by the Governor General. Even today, Indian bands, which until recently were the only form of Indian political association, possess little meaningful political autonomy (Little Bear, 1984: xiv-xv). This subject will be dealt with in detail in chapter IV.

The enfranchisement provisions constituted the third major section of the Indian Act which was designed to bring about the assimilation of the Indian people (Ponting, 1980: 15-17). Until 1960 Indians registered under the Act were not considered Canadian citizens and therefore were not entitled to vote in federal or provincial elections, to send their children to public schools, to benefit from provincially managed social welfare programs, to join the clergy, to

obtain a university degree or even to join the armed forces (DIAND Annual Report 1984-85: 12).

In order to obtain these "privileges" an Indian had to first become enfranchised. Once enfranchised, a person was "deemed not to be an Indian" (Sec. 110, Indian Act). The enfranchised Indian gained the legal rights of a full Canadian citizen, for whatever good they could do him, but, at the same time, he forfeited the benefits that resulted from his Indian status, namely: access to special federal programs, tax exemptions, residence on reserves and treaty rights (Morse, 1987:4-5).

Over the years, many Registered Indians were encouraged to become enfranchised and join the mainstream society. Those who did were paid a lump sum representing any treaty annuities they would have received over the next 20 years, along with one per capita share of band funds held in trust by the federal government. In addition, until 1985, Section 12(1) of the Indian Act stated that an Indian woman who married a non-Indian automatically relinquished her legal status of Indian and the legal status of her children under 21 years of age (Frideres, 1988:12).

It is widely recognized today that a great many of the Indians who became enfranchised did so either to acquire the basic rights of Canadian citizens, for easy money, or simply because they or their mother chose to marry a non-Indian.

(ibid., Native Council of Canada in Neubagessing, 1974:145). The enfranchisement provisions of the Indian Act strongly discriminated against the Registered Indian population Canada and was clearly designed to expedite the government's policy of assimilation.

In 1985, the federal government passed Bill C-31 and thereby amended the Indian Act so as to ensure that no Indian would be forced to relinquish his Indian status unwillingly. Bill C-31 also includes a provision which allows enfranchised Indians to apply to their band to have their status as Registered Indians restored (DIAND, Annual Report, 1985).

The irony with regard to Indian women here is interesting. Until 1985, an Indian woman who married a non-Indian was deemed 'not to be an Indian' according to the Indian Act. This was not in any way related to the manner in which Indian men traditionally regarded their women; it was simply a legislated means by which the federal government was able to exert tremendous influence over the composition of Indian society. Today, the passage of Bill C-31 has permitted countless Indian women to seek the reinstatement of their heritage by their bands. Surprisingly, many male-dominated bands have refused to accept this new provision in the Indian Act on the grounds that it impinges on the band's right to establish its own membership, despite the fact that, the Indians' traditional customs are egalitarian and therefore non-sexist and the fact that the "band-" they

wish to restrict membership to its non-Indian institution. Thus, some Indian women who have applied for reinstatement into their bands have been denied it. This example serves to demonstrate the tremendous influence that the dominant societies institutions have had on the composition and even the values of many Indian groups.

The fourth section of the Indian Act designed to regulate Indian lives and encourage their assimilation restricts the Indians' use of their reserve lands. The Indian Act excludes Indians living on reserves from taxes, liens, mortgages or loss of possession through debt. As appropriate as these might once have been for the indigent Indian of the nineteenth century, today these same provisions make it virtually impossible for Indians to raise private investment capital. As a result, the Indians have continued to depend on the federal government purse for development opportunities. This has seriously impeded the progress of Indian self-reliance (Gibbins in Ponting, 1984:22).

As discussed, the Indian Act has long been criticized by Indian groups as a restrictive and regressive piece of legislation. The Act's arbitrary and inaccurate definition of "Indian" has contributed to the factionalism of the Aboriginal peoples. The Act treats Registered Indians as a homogeneous group and, until 1985, much of it was based on sexual discrimination. It's principal intent was to bring

about the assimilation of the Indian peoples and, finally, because the Act regulates virtually all aspects of Indian life for those to whom it applies, it has been a major impediment to the social and economic development of many Indian communities (Donner Report, 1984:14-19).

Paradoxically, while they may be frustrated by the Indian Act in many respects, Status Indians continue to depend on the Indian Act to preserve their special economic and social rights (Hudon:1; DIAND, 1986a:38). Thus, until very recently, most groups representing status Indians have been opposed to the abolishment of the Indian Act (Indian Chiefs of Alberta, 1969; Starblanket, 1979, cited in Berger, 1980: Appendix B).

According to Morse, between 1945 and 1975 approximately 2,666 Native people gave up the right to be considered Indians under the law (Morse, 1984:17). Ponting maintains that, in fact, this is not a large number and concludes that the assimilationist aspirations of the Indian Act legislation have failed (Ponting, 1986:10).

Regardless of its effectiveness, it must be noted that the assimilationist focus of the Indian Act illustrates well the inherent contradiction in a Canadian political culture that seeks at once to ensure the equality of all Canadians and, at the same time, the legitimacy of their respective distinctiveness.

The 1969 White Paper and the Nishga Land Claim Dispute

As Canadian society changed in the post-war period, so too did Native-non Native relations in Canada change. In particular, the widespread rejection of the federal government's infamous "white paper" in 1969 and the Supreme Court of Canada's ruling on the Nishga Land Claim decision signalled a new era of Native affairs in Canada.

In the first three decades following the end of the Second World War, Canadians developed a growing tolerance for cultural pluralism. Despite this change, however, the federal objective of Indian assimilation remained in fact in Canada throughout this period (Gibbins in Ponting, 1986: 167). As Native groups were small, widely dispersed, poorly organized and largely divided with regard to the objectives they sought, Indian affairs remained largely unimportant for most Canadians until the end of the 1960s.

Then, in 1969, after consultation with Indian groups across the country, the federal Liberal government of Pierre Trudeau tabled a white paper on Indian policy which proposed radical legislative change to its relations with First Nations. Among the changes proposed in the white paper were the abolition of the Indian Act and most special rights for Native peoples, such as treaty rights and aboriginal land claims, the elimination of the Department of Indian Affairs and Northern Development (DIAND) and the transfer of legislative and administrative authority for Indian lands to

the Indians (Statement of the Government of Canada on Indian Policy, 1969:12, *passim*).

Ponting has suggested that the motivation for this radical piece of legislation was due, in large part, to the strong liberal ideology of Trudeau's newly elected liberal government. Ponting points out that philosophically, the Liberals supported the protection of individual rights and were, in principle, opposed to the discriminatory special collective rights of the Indian peoples (1986:31, 40-41). In short, specificity had taken precedence over equality.

The federal government argued that the effective result of the Indian Act and other government policies with respect to Status Indians had been to isolate these people and place them in a perpetual state of dependency (*Ibid.*). While many agreed that the current situation for Aboriginal peoples in Canada was in general very poor, groups representing the Status Indians of Canada strongly opposed the proposed abolishment of the Indian Act. Publications such as Cardinal's *The Unjust Society* and the Indian Chiefs of Alberta's *Citizen Plus* (the so-called "Red Paper") argued persuasively that implementation of the 1969 white paper proposals would result in the eventual assimilation of all Aboriginal peoples by the dominant society (Cardinal, 1969:16; Indian Chiefs of Alberta, 1970:preface, *passim*). In the wake of strong opposition from the Native peoples, the media and the public, the Canadian government withdrew the

the 1969 white paper in March 1971 (Ponting, 1986: 34; Weaver, 1980).

Despite the common hardships that Canada's Native peoples have had to endure since before confederation, the Native lobby in Canada has traditionally been divided, disorganized and correspondingly weak. Differences in local priorities, language, culture, geographic location, legal status and resources between and within the numerous Native groups largely precluded the development of a national Native consciousness prior to 1969. Suddenly, however, in the wake of the white paper debate, Canada's Native peoples found themselves emerging from their solitude with a powerful collective voice (Ponting, 1986: 38).

With much needed funding from the federal government, a "nationalization" of Indian politics began to develop. At the same time, officially at least, the Trudeau government began to pursue a new direction in Indian affairs, one that sought increasingly to replace paternalism and assimilation with acceptance and accommodation (ibid.: 405).

In 1972, Canadian Indians began the difficult task of taking control of Indian education and, with federal support, they established their own schools and their own curriculum including such topics as Indian languages, art, history, culture and philosophy. Accordingly, the school system, which for years had been used by non-Indian officials to

facilitate the process of assimilation, has since become one of the principal mechanisms by which the Indians now promote self-reliance and autonomy (ibid.:404).

Two years after the federal government's retreat from its 1969 white paper on Indian policy, Native groups across Canada won a second victory. In the 1973 Supreme Court of Canada ruling in the case of *Calder v. The Attorney General of British Columbia* (the so-called Nishga Land Claims Dispute) six of the seven judges acknowledged implicitly the existence of Aboriginal title. This the first time that the court had ruled in favour of Aboriginal title, thereby supporting some Native peoples' claim that they own the land they occupy (Berger, 1981,:247). Although three of the six judges maintained that, in many instances, the Aboriginal title had never been legally ceded to the government of Canada by the Native peoples, the High Court's ruling was a turning point in Canadian Indian affairs (ibid.:ch. 8; Gibbins in Ponting, 1986: 305; Little Bear in Ponting, 1986: 254; IFRCOP, 1985: 12; DIAND, 1981b:10, 1986a: 11-14).

In August, in response to the *Calder* decision, the federal government announced its intention to resolve all outstanding land claims in cases where Aboriginal rights of traditional use and occupancy had neither been extinguished or superseded by law. These subsequently became known as "comprehensive" claims and included such issues as land use rights, financial compensations, hunting and

fishing rights, and assurances of increased Native political, legal and economic freedom (DIAND, 1981b:11-15).

At the same time, the government declared that it would continue to settle "specific" claims with Aboriginal groups, arising from unfulfilled federal legal obligations that dated, for the most part, back to the Indian Treaties (IFRCCP, 1985: 12-13). A decade and a half later, most of the outstanding business regarding both specific and comprehensive claims continues (IFRCCP, 1985).

Constitutional Conferences

Indian affairs in Canada took on a new meaning in the early 1980s as the federal government, in cooperation with the provinces, prepared to bring Canada's constitution "home" and to entrench in it a charter of rights and freedoms.

In June 1978, the federal government tabled a paper, *A Time for Action*. It could have been more appropriately been entitled, "A Time for Talk" as it simply suggested that the different Aboriginal groups might be permitted to express their views with respect to their constitutional rights at the forthcoming Constitutional Conferences. During the Constitutional Conferences from December 1979 to early 1982, representatives of the National Indian Brotherhood (NIB, reformed in 1980 as the Assembly of First Nations), the Inuit Committee on National Issues (ICNI speaking on behalf of the Inuit Tapirskat of Canada General Meeting), the Métis Non-

Status Constitutional Review Commission (MNSCR) and the Native Council of Canada (NCC) presented a wide variety of Aboriginal interests (McInnes, 1981:58).

Although the constitutional negotiations between the federal government, the provincial governments and the Native groups were complex and at times highly strained, as a group, Canada's Aboriginal peoples were ultimately successful in achieving a significant degree of constitutional recognition. Accordingly, three sections of the Constitution Act, 1982 recognize and reaffirm the existing Aboriginal and treaty rights of Canada's "Aboriginal peoples": the Indian (as defined in the Indian Act), the Inuit and the Metis.

The extent to which the entrenchment of Aboriginal rights in the constitution will give Aboriginal peoples more power to influence relevant government policy will be discussed briefly in chapter VI. It is sufficient to note here that the constitutional recognition of Aboriginal rights by the federal and 9 provincial governments in 1982 is an unprecedented achievement on the part of Canada's Native peoples.

In the wake of constitutional reform, the various Native groups found it difficult once again to reach a consensus with respect to their respective views on federal Aboriginal policy (*Ibid.*: 405). However, some significant progress is slowly being made, despite the renewed factionalism. In 1984, The Special Parliamentary Committee

on Indian Self Government (also known as the "Penner Committee") published a comprehensive report which, among other things, called for the abolition of the Indian Act and concrete measures to increase Indian control over their own lives (Penner, 1981: 35, 47). Although the recommendations made in the report were not new, the Committee was well represented and its findings were widely considered.

In the federal government's official response to the Penner Committee the following year, the government acknowledged, in principle at least, the Aboriginal peoples' right to greater political autonomy and expressed its commitment to "changes that would have the effect of facilitating the transition to self government, rather than reinforcing existing dependency" (Response of the Government, 1984: 7). The government was not prepared at this time, however, to make any specific or concrete changes on the grounds that the resolution of Indian self government would require further research and further discussions with Native groups (Ibid.:1, 7). Moreover, it is worth noting that in 1982 the Priorities and Planning Committee of Cabinet rejected the draft of the Penner Committee's report and gave firm instructions that any Indian government powers were to be limited and delegated by parliament (Boldt, 1985: 33).

Summary of Chapter II

The purpose of this introductory chapter has been to put

into perspective the social, political and legal background in which Canada's Indian peoples have lived for well over three centuries. This overview reveals important aspects of Native-non-Native relations in Canada that are necessary to understand if one is to appreciate fully both the need for change and the obstacles to it.

One important area that requires change in contemporary Indian society is that of health care. The health of a people is indicative of that people's overall quality of life. In the case of Canada's Indian people, their health is very poor; a potent legacy from the isolation, tutelage and economic dependence that Native Canadians have endured for generations. The subsequent chapters in this thesis deal with the issue of Native health, both in terms of its evolution and in terms of what may be done to improve it.

The discussion begins in the following chapter with a review of the development of the Indian health care services from confederation. The review will illustrate the extent to which federal Native health care policy has failed to meet what should be its principal objective: the improved health of Canadian Indian peoples.

CHAPTER III: THE HISTORY OF INDIAN HEALTH CARE FROM CONFEDERATION

There is little point in presenting the current health problems of Canada's Aboriginal peoples and the proposed directions for change without first attempting to understand the historical development of federal Native health policy. An analysis of the social, political and legal context of federal health policy with regard to Native Canadians is essential to the pursuit of a practical strategy for future policy changes.

According to the government of Canada, there is no specific federal legislation requiring the provision of health care services to Canada's Native peoples. These have been provided traditionally on the basis of custom and federal policy (Nielsen, 1985: 115).

Nonetheless, since section 91 (24) of the Constitution Act, 1867 provides that the federal government is responsible for "Indians and lands reserved for Indians," the federal government is required to assume some responsibility for the social and economic well-being of the registered Indian and Inuit population (ibid.: 119). The legal extent of this responsibility remains ambiguous, however, as according to the Constitution, health care and social services are predominately provincial concerns (Young, 1984: 257).

Originally, there was little perceived need for the federal government to provide medical services for registered

Indian and Inuit peoples. In the first place, as was mentioned in the previous chapter, the original inhabitants of Canada had their own system of medicine and health care which served them relatively well.

Secondly, until the First International Health Congress (Paris, 1851), which marked major advances in the aetiology of disease, European medicine was not much more sophisticated than the medicine of the original Canadians. In reality, the Europeans had little to offer the Indians in terms of medical support (Trigger, 1985:400).

Thirdly, as far as the Indians were concerned, the purpose of the reserves was to allow them to live according to their indigenous ways, with a minimum of interference from the white man (Nielsen, 1985: 119-121). Thus, it is not surprising that the Indians neglected to include specific provisions with regard to federally-assisted health services in their early negotiations with the government of Canada. In fact, such provisions were not made for other Canadians until years later (Isaacs, 1987:123-4).

In the numerous treaties signed between the Government of Canada and the various Indian groups, only one, contracted between the Cree of central Alberta and Saskatchewan, contained specific provisions for health care. According to the famous "medicine chest" clause of Treaty Number 6, the federal government and the Indians agreed that,

[Should the Indians be] overtaken by any pestilence,

or by a general famine, the Queen . . . will grant to the Indians assistance . . . sufficient to relieve (them) from the calamity that shall have befallen them. A medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of such Agent (Zollin in Morse, 1985: 401).

While no further mention of health services in any form was made in the final texts of any of the subsequent treaties, it is generally accepted that the subject was dealt with in the discussions that preceded the signing of treaties Number 8 through 11. It is quite possible that the contracting Indians were led to believe that health services would be provided as required, even though this was not explicitly agreed to in the treaties (Young, 1984: 258; Ponting, 1980:24).

In 1925, the Indians made some legislative progress in their battle to force the government to assume full legal responsibility for the provision of Indian health care services. In the trial of *Dreaver v. R.*, 1925, the trial judge ruled that the use of the vague term "medicine chest" in Treaty Number 6 suggested that the Crown had committed itself to ensuring that "all medicines, drugs or medical supplies which might be required by the Indians be supplied to them free of charge." (Zollin in Morse, 1985:401, McInnes, 1981:56).

In the case of *R. v. Johnston*, 1966, the Saskatchewan Court of Appeals reinforced the *Dreaver* decision in ruling that the term "medicine chest" in Treaty Number 6 should be

interpreted so as to include all Registered Indians. However, the same court also ruled that "medicine chest" did not include the whole range of medical services up to and including hospital care. Thus, the Crown's legal obligations with regard to providing health care services to the Indians remained unclear (Young, 1984:258; Cummins, 1972:129-30; *ibid.*:403; see also Indian Chiefs of Alberta, 1970:31-32).

Despite subsequent legislative confusion and the apparent lack of any statutory obligations requiring the federal government to provide health services to the Indians or Inuit, the federal government in fact assumed this responsibility. Whether the government's initial interest in providing some degree of health services for Native Canadians was motivated by humanitarian concerns, as the government contends, or by a fear that the diseased Indians might ultimately infect members of the dominant society (as the Manitoba Indian Brotherhood has suggested) remains in doubt (see for example, MIB, 1971: 59 and Nielsen, 1985: 119). The point is that, over time, the federal government assumed this responsibility and is today, therefore, largely accountable for the health and health needs of Canada's Aboriginal peoples.

In the early years of the Dominion, health care services to Canada's Registered Indian population were provided locally and privately, on an ad hoc basis and with little government assistance. Of the first to offer medical

services to the Indians were missionaries who wished to convert the Indians to Christianity and employees of the trading companies who feared the loss of Indians to disease might jeopardize the accumulation of fur- (Graham-Cumming, 1967: 120). The few medical services that were provided by the federal government were sporadic, uncoordinated and generally inadequate. As mentioned, the main aim of such services was to slow the spread of disease (ibid.: 122).

From 1867 to 1873, Indian affairs were directed through the Office of the Secretary of State under John A. Macdonald, Canada's first Prime Minister. In 1873, this responsibility was transferred to the Department of the Interior and remained there until the formation of the Department of Indian Affairs in 1888. In 1904, Dr. F.H. Bryce was appointed as the Department of Indian Affairs's first General Medical Superintendent. Bryce's research soon revealed that the Indian population was suffering from a wide variety of serious health problems, including widespread tuberculosis. However, in his subsequent attempts to help the Indians, Bryce became increasingly unpopular in the Department. Due to a variety of factors, including the relatively small but widely dispersed Indian population and a chronic shortage of available funds, Indian health services received relatively little attention at the time. According to Graham-Cumming,

Bryce's authority was steadily reduced and, from 1915 to 1927, the Department of Indian Affairs effectively did without a Medical Superintendent (1967,:124).

In 1917, Colonel L. Stone was appointed Medical Superintendent in an attempt to improve the relationship between the Department of Indian Affairs and those working in the field. Graham-Cumming suggests that it is from the appointment of Stone that organized health services to the Indian and later the Inuit peoples really began to develop (*Ibid*,:125). Nonetheless, as many people at that time regarded "health care" as a consumption-related rather than a productive activity, funds for Indian health services continued to be in short supply throughout the first half of the century and advances in Native health status occurred slowly.

The Department of Indian Affairs was abolished in 1936 and the federal Department of Mines and Resources assumed responsibilities for Indian affairs, including Indian health services (*Ibid*, 529). Relatively little occurred during the war years.

In 1945, the Indian Health Service of the Department of Mines and Resources was transferred to the newly formed National Department of Health and Welfare, while the Department of Mines and Resources remained responsible for such health-related matters as housing, sanitation, education, employment and the overall administration of the

Indian Act. This separation of Indian "health services" and other Indian "affairs" remains to this day.

Indian affairs, exclusive of health services, fell under the jurisdiction of the Department of Citizenship and Immigration from 1950 to 1966. And finally, in 1966, the Department of Indian Affairs and Northern Development (DIAND) assumed responsibility for the affairs of the Registered Indian population and for the Inuit.

In 1954, the government created the Northern Health Services in order to serve those people living north of 60 degrees latitude, the majority of whom are Inuit. Since 1962, both Indian and Northern Health Services have come under the jurisdiction of the Medical Services Branch of the Department of National Health and Welfare Canada. Today this aspect of the federal Indian affairs program is called the Indian and Inuit Health Program (Nicolson, 1985:134-36).

In the years following the Second World War, the annual expenditures on medical services for Canadian Indian and Inuit peoples grew dramatically. From 1940 to 1970, they increased from \$4 million to 198 million, some 700 percent in relative terms. On the other hand, however, government expenditures on health care for Canadians in general increased even more dramatically over the same period (Soderstrom, 1978).

Health care expenditures continued to grow throughout the nineteen fifties, sixties and seventies. By 1980, Ottawa was spending relatively more on Natives than on non-Natives with respect to health care services. For example, it has been estimated that Health and Welfare Canada was spending over \$1,000.00 per capita in Indian and Inuit communities in 1980, while the national average hovered just over \$600.00 per capita (Health Services Policy Analysis, 1983). As will be discussed later in this paper, however, the increased relative cost of Native health care likely has more to do with the relative expense of delivering conventional medical services to isolated populations than to any change in government policy regarding the urgency of Native health.

As the number of people suffering from tuberculosis declined in the 1960s, the Canadian government began to reduce the number of active treatment hospitals for Aboriginal peoples. At the same time, it increased the

number of available nursing stations, from 37 in 1960 to 100 in 1976 (DNHW, Review of Health Services in Canada, 1976:10-11). Moreover, as legislation leading to the establishment of universal medicare insurance in Canada was introduced across Canada in the 1960s, many of the financial barriers to medical care were effectively eliminated (Young 1984: 162). Despite the increasing availability of "free" provincial health programs throughout the 1960s, however, Native groups remained insistent that the federal government retain the responsibility of controlling Native health care services.

During this period 1950-1970, large segments of the dominant society in Canada believed that the health of the country's Native peoples was improving. At the same time, however, Native leaders and their supporters argued that, in fact, the health of the vast majority of Native peoples was very poor. In 1968, Professor H. B. Hawthorn, who headed a study team commissioned to review Indian conditions in Canada, released the second volume of his comprehensive work, *Survey of the Contemporary Indians of Canada*.

Hawthorn's study revealed that Canada's Registered Indian population, representing but a fraction of all Native peoples, were suffering from a wide range of health-related problems, including a very high infant mortality rate, malnutrition, chronic low-grade infections, tooth decay and widespread poverty (Hawthorn, 1968:29).

to make matters worse, in December 1969, the Medical Services Branch (MSB) of Health and Welfare Canada admitted that there had been a very disturbing increase in the death of young Indian adults. A MSB memorandum, written by Dr. George Graham-Lumming, stated that the increased death rate in the 25-29 year old age group appeared to be "associated with increasing numbers of fatal accidents, suicides and violence, all suggesting serious social dissatisfaction". (As cited in the Toronto Globe and Mail, 5 Dec. 1969:1).

The Canadian government responded to the Hawthorn Report and to criticisms of the existing Native health services by promising to consider increasing its expenditures on health care services for Indians and Inuit. The government continued, however, to insist that it was still under no legal obligation to provide health care services for Native peoples (Berger, 1980).

Indian spokesmen, such as Harold Cardinal, countered that the government's past practice of supporting Native health care services meant, in fact, that the government now had a moral if not a wholly legal obligation responsibility for ensuring the health of the country's Native peoples. In his book, The Unjust Society, Cardinal accused the government of misleading the Indians and cheating them out of their rightful claim to full and free social services. With respect to the disputed "medicine chest" clause of Treaty Number 6, for example, Cardinal asserted:

The [government representative] admits on record the Indians were assured of medicine and medical treatment. The Indians expected this to be in the treaty. . .

They were not told it was not there. Legally, the commitment is not there in the treaty. Legally, the white man clearly won that round. Ethically, it is damned comforting to be Indian (Cardinal, 1969:18).

To some extent, Cardinal's extreme position was supported by Hawthorn's findings. While acknowledging that the neither statute nor the constitution required Ottawa to provide comprehensive health services to the Indians, he stated that the government had a clear moral obligation to help the Indians. Hawthorn added that, in his opinion, the government had in fact assumed a far greater responsibility for the welfare of the Indians than its legal commitments required (1969:60).

Hawthorn concluded his survey by suggesting that the Indian peoples be regarded as "Citizens Plus": citizens like other Canadians, but with special cultural, political and social needs which they have a right to preserve (Hawthorn, 1969:62-4). The implication was that the government should recognize the Indians as equal to other Canadians while at the same time, provide for the fact that they are also different from other Canadians. The equality/specificity theme has continued to pose serious philosophical and practical problems for Ottawa with respect to Indian affairs.

In 1969, the Department of National Health and Welfare

released the Boor, Allen and Hamilton Report on Health Services for Native Canadians. The report acknowledged that the general health of Canada's Indian peoples was poor and recommended, among other things, that Medical Services Branch work more closely with the Department of Indian Affairs and Northern Development, that it take a multi-sectoral, community-based approach to health care for Native Canadians with emphasis on Public Health and preventive services and, further, that the federal government gradually divest itself of its assumed responsibility for Native health care in favour of provincial and private services (Young, 1984:162).

1969 to 1980: The Period of Native Mobilization

As a result of several important political and legal developments in the 1970s, Canada's Native peoples became increasingly adept at identifying and articulating their collective and individual concerns. Among these numerous concerns, the issue of improved Native health was key.

The Hawthorn and Boor Allen studies provided the Indians with and convincing statistical evidence of their social and economic plight. As a result of these studies in particular, the federal government found itself pressured politically to address Native concerns more completely than had been done in the past. Moreover, in focusing largely on health issues, the reports provided the relatively weak and divided Native lobby with common ground on which to challenge general

federal policy toward Canadian Native peoples.

In their rebuttal to the government's 1969 white paper, (discussed in chapter 2) for example, the Indian Chiefs of Alberta stated emphatically that Registered Indians, at least, had an undeniable "right to receive, without payment, all health care services without exception" (Indian Chiefs of Alberta, 1970:8).

This issue was explored more broadly the following year by the Manitoba Indian Brotherhood (MIB) in its publication Wahbung-Our Tomorrows. Wahbung included a comprehensive review of health services for Indians from an Indian point of view. According to the authors, poor Indian health is the result of a wide range of social and economic problems on the Indian reserves including inadequate housing, poor sanitation, low levels of education, insufficient employment, the high cost of living on the reserves, the curtailment of hunting and fishing rights, the lack of adequate medical facilities and professional staff on the reserves, a medical bias that favours curative health care to preventive health care, and the lack of Native participation in the planning and delivery of health care (MIB, 1971:ch 1).

All of these factors, the MIB maintained, have contributed to increased malnutrition, a high infant mortality, widespread alcohol and drug abuse and increased incidents of violence, accidents and suicides among the Native population ([ibid.:57-67). Significantly, this broader

approach to health came at a time when the New Democratic Party government of Manitoba was reviewing its health care policies in a somewhat "holistic" view, following international trends (Gaalilis, 1982b:127).

The Manitoba Indian Brotherhood recommended that the federal government retain its responsibility for the delivery of free health care services to Indians. In addition, it recommended that the government increase these services, and extend them to all Registered Indians across Canada. The proposals included, among other things, more health education on the reserves, greater Indian participation in Public Health and on the Boards of Health, better transportation, better coordination between the relevant government departments, the medical profession and Indian groups, increased initiatives toward the economic development of the reserves, and finally, an increased use of para-professional health care workers (MIB, 1971:79).

The health care aspect of the MIB report was insightful in so far as it recognized the need to deal with the health problems of Native Canadians through a multi-sectoral approach comprising such elements as medical care, education, housing, sanitation, environmental health, nutrition, gainful employment and increased local participation. It was, moreover, in line with proposed reforms in health and social services for Canadians as a whole and anticipated, in many

respects, similar campaigns on the international scene which led to the World Health Organization's new Primary Health Care Approach (1974) and the Alma Ata Declaration (1978). These international trends will be discussed later.

Although the MIB report failed to propose a concrete strategy by which the federal government might go about implementing the suggested changes, at the time it was published, Wahbung was instrumental in increasing public and government awareness of the plight of Native Canadians. Following Wahbung, other reports on Native Health were commissioned by both Native groups and by the federal and provincial governments, although, as will be discussed in Chapter V, the governments have sought relatively little substantive change to the current health care system for Native Canadians.

In 1974, the Department of National Health and Welfare introduced a new Indian health policy in which it once again denied any legal responsibility for providing health services to Indians, but declared that it was willing, nonetheless, to increase these to a limited extent. In its new health policy, Ottawa stated that it would supplement provincial health care programs where necessary and provide financial assistance for indigent Indians seeking health services who were not fully covered by provincial or private health insurance plans (DNHW, 1974:12).

Various Indian groups objected to to any provincial

control of health services for Indians on the grounds that it threatened their special status and Aboriginal rights and might eventually lead to the assimilation of the Indian people by the dominant society. However, throughout the 1970s, provincial involvement in the provision of health services to many Indian peoples did increase - a trend that continues to the present day. In an attempt to minimize opposition to this development, the federal government agreed to reimburse all Registered Indians and Inuit for a wide range of benefits that are not covered under the provincial health insurance programs (Boldt, 1988:8-10; Young, 1984:262).

In 1976, the National Indian Brotherhood published a paper on Indian health services in which they demanded the right to control their own health services through the establishment of their own health boards and committees. Government response to the report, however, was poor and chose instead to side-step the issue for another five years.

In 1978, the National Indian Brotherhood set up a National Commission Inquiry on Indian Health. In 1980, the Commission released a Statement of Principle in which it recommended that the federal government give immediate priority to preventive health programs in the Indian health care system. The Commission also recommended strongly that the federal government transfer control of the Indian health

services to the Indians themselves (HSC, Annual Review, 1978:82:16).

By the late 1970's, however, the government was primarily concerned with the unsettling fact that while expenditures on health care rose throughout the 1970s, there did not seem to be a significant improvement in the health status of Aboriginal Canadians (DIAND, Indian Conditions, 1980:5). In late 1978, under the Liberal government, the Medical Services Branch announced plans to substantially reduce its expenditures on non-insured benefits for Registered Indians and Inuit, in light of what it perceived as a wide spread abuse of the service by the recipients (Gilmore, 1979:89).

Native groups strongly opposed the proposed policy (ibid.:89-94). They argued that, contrary to abusing the system, Indians were victims of neglect and colonization (Berger, 1980:364-66; Spert, 1987:passim). In response to Indian outrage and negative media, the federal Liberal Minister of Health at the time, Monique Bégin, was obliged to place a 6 month moratorium on the proposed changes. Bégin maintained that the government's proposed policy was sound. However, in the ensuing months the Liberal government was defeated and the controversial guidelines were never reintroduced (Young, 1984:265).

The Years of Change

In response to popular opposition to the 1969 white paper on federal Indian policy, to the Supreme Court's divided ruling on the Nishga land claims settlement in 1971, and to the increasingly articulate and unified opposition of Native groups, the federal government gradually began to accept the right of Canada's aboriginal peoples to fundamental, legal, political and social change. Given the overall poor health status of the Aboriginal peoples, politicians and Native peoples alike, identified health care as one of the most significant areas for change.

In September 1979, the Conservative government of Joe Clark released a statement on a new Indian Health Policy. The new policy left it up to the medical profession to decide what Indians and Inuit require or do not require uninsured benefits. The policy also recognized the "intolerable conditions of poverty and community decline which affect many Indians" and sought "a framework in which Indian communities can remedy these conditions" (CMHR, Statement on Indian Health Policy, 1979:2).

In a break from the past, the federal government acknowledged, for the first time, its legal as well as a traditional responsibilities to the Indians for the first time. In its new health policy, Ottawa proposed a three-tiered approach to improving the overall health of Native peoples. This approach included: (a) a multi-sectoral approach to complete social, economic and spiritual community

development; (b) the preservation of the "traditional" relationship between the federal government and the Indian people; and, (c) continued participation by the federal government in the health care system as it pertains to Indians but with a greater role for the Indians themselves (Ibid.:1-3).

That same year, Medical Services Branch undertook an internal study in order to assess its shortcomings and become more effective in addressing the health needs of Canada's Indian population. In its Indian Health Discussion paper, MSB admitted that the government's efforts to improve the health of the Indian people were no longer effective:

While the death rates for Indians have always been high, there is now an alarming new phenomenon: Indian people are experiencing a rapid increase in deaths from accidents, poisonings and violence . . . the number of suicidal deaths has doubled since 1975.

Our standard medical tools do not seem to address . . . (the) accelerating crisis of health and social breakdown . . . (this) situation is incompatible with both the aspirations of the Indian people and the tenants of self-determination and human rights. It has contributed to the passivity vis a vis the health services which has almost destroyed the interest of the Indian people in providing for their own health needs. (MSB, DNHW, 1979:6, 7)

Medical Services Branch stated that it would seek increasingly the active participation of Native peoples in the development, administration and delivery of their health care-related services. Moreover, the federal body

concluded that its own function with regard to health services for Native peoples would gradually change from "one of directing, controlling and delivery to one of assisting, consulting, teaching, advising and responding" (Ibid.:69).

This policy decision was extremely important in the light of certain international events of the period, which will be discussed in detail in Chapter IV. The point to be emphasized here is that, by the end of the 1970s, the federal government had clearly come to accept, in principle at least, the fact that the serious health problems of Canada's Native peoples could only be eliminated through the efforts of the Native peoples themselves and through the application of unconventional medical practices.

Once again, the federal government faced the equality-specificity dilemma; at once attempting to reconcile the political imperative of ensuring the Indians' continued distinctiveness, as provided in the Indian Act, and the practical difficulty in providing them with a level of health that would be equal to that of other non-Native Canadians. This dilemma, which continues to the present day, was compounded by the fact that, while the Indian Act could at once be construed as a contributing factor to the Indians' poor health status, it is also the sole piece of legislation that identifies them as Indians. Thus, one may argue that by nature of remaining distinct, the Indians have remained

unhealthy.

One of the principal most challenges the government faced with respect to the development and implementation of a new Indian health strategy was the need to learn exactly what the various Indian groups felt they needed and how they thought the changes should be carried out. In December 1977, the federal government commissioned Mr. Justice Thomas Berger to investigate how the government should go about getting meaningful input from Indian and Inuit peoples in its pursuit of an improved health policy. Berger's Report of Advisory Commission on Indian and Inuit Health Consultation was published the following year.

In the Report, Berger referred to and cited graphic examples of the very poor state of Native health (Berger, 1980:1, 2-5). He then recommended that the government allocate substantial funds on an annual basis for the express purpose of permitting regular and meaningful consultation between the federal government and various Native groups (Berger, 1980:7). The money has been allocated annually since and the consultations have been taking place. However, some members of the current Conservative government have argued that the allocation of separate funds for Native health consultation is a waste of money and it is possible that the funds will be discontinued in the near future (Nielsen, 1985: 343, 346).

The purpose of the regular government-Native peoples

health consultation is to gradually devolve federal responsibility for the planning, administration and delivery of health care services to Native peoples. This objective is consistent with the government's stated intention in the 1974 Indian Health Policy (Berger, 1980:5). As will be pointed out below, however, the consultation process does not seem to have been as successful as Berger had anticipated when he made his recommendations.

Initiatives in the 1980s: Commitment Without Change

Motivated by political and legal headway made in the 1970s, Canada's Native groups approached the 1980s determined to gain further economic, legal and political concessions from the federal government, without sacrificing their entitlements to specific rights and privileges as Canadian Aboriginal peoples. The changes that occurred, however, as significant as they have been, have not yet led to improved the quality of life of most Native Canadians.

In 1980, the Department of Indian Affairs and Northern Development released a comprehensive study on the social, economic and political condition of Canada's Indian peoples during the previous 20 years. The study entitled, Indian Conditions: A Survey, once again emphasized the unacceptable social, economic and political hardships suffered by the Canadian Indian peoples.

The report noted that Canada's Indian population had been growing faster than the national average since the 1950s. From 1961 to 1985 it was estimated that the Indian population would double from 180 thousand to about 350 thousand (Indian Conditions: 3). Therefore, the need for social services such as health care services which had been rising, would continue to rise well into the 1980s. Furthermore, while some advances had been made with respect to certain aspects of Indian health over the previous 20 years, Indian Conditions noted that the average life expectancy for Indians was still about 10 years below the national average in 1980. Once again, violent and accidental deaths, the primary cause of premature death among the Native population, were reported to be more than three times the national average, while suicides in the 15-24 age group was six times greater for Indians than for other Canadians (Ibid.:4). Other statistics were cited regarding the high incidence of alcohol and drug abuse, suicide and crime among Indians.

What is most significant is that the Survey acknowledged that the causes of ill health among the Native population were multi-sectoral and related to a wide variety of factors that had been created by the lack of an independent economic base in Indian communities and the rising dependence of the vast majority of Indian peoples on the federal government. The government also acknowledged in this report that curative

care had reached the limits of its effectiveness in Indian communities (ibid.:8). Rather than spending more resources on curative care, therefore, the Report recommended that the government concentrate on such matters as community development, environmental health and overall problem of Indian social deterioration (ibid.:passim). The holistic, preventive approach to health and health care espoused in Indian Conditions did not arise in isolation but relate to general international changes with regard to conventional views of health that will be discussed in the following chapter.

In the 1980s, Medical Services Branch expanded its initiatives in the area of health care services for Native Canadians. Evidence available at this time continues to suggest that these initiatives have been relatively ineffective in reducing the incidence of poor Native health. In order to propose possible change to the existing health services, it is necessary to first examine the structure and the overall operation of the current Indian and Northern Health program. Such an examination may reveal flaws in the nature of the present Native health program and suggest ways in which the program might be made more effective.

The Current Indian and Northern Health Service Program

Most health services for Native peoples are provided by community health nurses, treatment nurses, and community health representatives. Other staff include a wide variety of administrators, physicians (usually working under federal contracts), health educators, nutritionists, janitors and interpreters (Nielsen, 1985:125). In order to coordinate the efforts of the many people working in the six major areas of MSB's Indian and Northern Health Program, Medical Services Branch, in conjunction with DIAND and a wide range of other public and private services, operates or supports a network of 9 regional offices (one for the Atlantic region and one for each of the 6 remaining provinces, the Yukon and the Northwest Territories), 17 zone offices and approximately 500 local facilities at five different levels of care.

At the primary, or first, level of care, the federal government has established 67 health offices which are actually little more than space set aside in Native communities, for use by visiting doctors and nurses who are holding clinics or conducting health education programs. The secondary level of care is provided by approximately 100 health stations which are located in isolated communities and administered by community health representatives (see below). The health stations may accommodate emergency cases and provide basic facilities for more comprehensive care by visiting nurses or doctors. They also operate as a base from

which health information can be disseminated.

At the tertiary level of care there are 127 health centers and 96 nursing stations which are generally located in isolated communities. Both are staffed by nursing personnel, but while the former carry out public health and preventive care measures, the nursing stations have between 3 and 12 beds in order to provide both inpatient and outpatient care and they are responsible for one or more satellite health stations.

At the fourth and most advanced level of care, the Atlantic region, each of the other 6 provinces, the Yukon and the Northwest Territories each have one general hospital which provides continuous primary and secondary care. In addition, the Yukon and the Northwest Territories, respectively, have 3 and 2 smaller, less sophisticated "cottage" hospitals, bringing the total number of hospital facilities to 14. According to the Medical Services Branch Annual Review, 1982-83, the last year it was published, MSB delivers only 15 percent of all "treatment services" delivered to Native people. The hospitals have been greatly assisted in recent years through contractual arrangements between the various hospitals and Canadian universities and through work-sharing arrangements with other levels of government (MSB, 1984:10; see also, Bain, 1979). (The number of health facilities has been estimated from MSB Annual Review 1981-

82:5 and Nielsen, 1985:118).

The Program: The Medical Services Branch's Indian and Northern Health program consists of six major components. These are (a) Administration, (b) Hospital Services, (c) Dental Services, (d) Environmental Health and Surveillance, and (e) Community Health. While aspects of these various components are in some ways related, MSB considers them separately and accordingly, finances them separately (Nielsen, 1985:121-24). These are described below.

(a) Administration: This component covers mainly expenditures for Indian and Northern Health that occur at the regional and zone levels and covers a wide range of administrative functions. In 1985-86 it was estimated that MSB would spend \$4,190,000 or a little less than 1 percent of its total expenditures on Native health care on administration (Nielsen, 1985:118).

(b) Hospital Services: The Medical Services Branch operates its hospitals in relatively remote areas where hospital services would not otherwise be included. The hospitals are located in Moose Factory and Sioux Lookout, Ontario, at Norway House and on the P'equis Reserve in Manitoba, at Fort Qu'Appelle in Saskatchewan, and on the Blood Reserve in Alberta. In addition, Northern Health Services operates one general hospital in each of the Yukon and the Northwest Territories (MSB, 1984:15-16). There is great variation among the hospitals in terms of size,

complexity and the range of services offered (Nielsen, 1985: 127). In 1985-86 this component of the program was expected to cost \$44,460,00 or about 17 percent of MSB's total expenditures on Native health services.

(c) Dental Health: This program is designed to provide a wide range of on-going preventive and curative dental care to Native Canadians. In addition to basic dental care and the instruction of school-age children by a combination of visiting MSB staff and private practitioners using portable on-site clinics, the program offers opportunities and funding for Native peoples to train as dental auxiliaries at the National School of Dental Therapy in Prince Albert, Saskatchewan.

(d) Environmental Health and Surveillance Program: Another recent initiative of the Medical Services Branch is the Environmental Health and Surveillance program. It was set up in 1983 to monitor environmental conditions in Indian and Inuit communities and establish environmental controls and strategies. The program is involved in conducting environmental inspections of communities, including the sampling of water and air, in the collection of relevant data, and in the education of Native people with respect to environmental conditions (MSB, 1984:14). The effort seems to be worthwhile, however, it is unclear what resources the program has. Furthermore, even if the identification of

environmental problems and the education of Native peoples about them is successful, it is uncertain what exactly, if anything, the program can do to assist Native peoples in their attempts to eliminate any environmental hazards they may identify.

(e) The National Native Alcohol and Drug Abuse Program: The National Native Alcohol and Drug Abuse Program (NNADAP) provides another example of the federal government's recent attempts to increase Native people's participation in the health care system. NNADAP began in 1987, in an effort to support Metis and non status Indians as well as Indian and Inuit communities' efforts in reducing the widespread abuse of intoxicants by many Native people. The NNADAP is designed so as to be culturally and spiritually sensitive to its participants' needs, offering support and guidance in addition to rehabilitation (MSB, 1985).

According to Nielsen, while the NNADAP is currently being run by the federal government in cooperation with Native communities, it is hoped that the pilot program will ultimately be replaced by similar on-going local programs at the community level (Nielsen, 1985:125). MSB has concluded that the NNADAP, which is scheduled to operate until 1988, is working well (ibid.:361). To the extent that the program is successful, it not only helps those Native people who are suffering from drug, alcohol and solvent abuse, but may also provide a working model for more extensive health care

projects in Native communities.

(f) Community Health: The issue of community health development for Native communities will be discussed in greater detail in the next chapter. What is important to note is that community health development involves ten essential elements: (a) the use of local community personnel in the delivery of health services and, (b) local community control of the planning, and administration of the community health program.

Nielsen estimated that MSB would spend \$180,785,000, or 58 percent of its total expenditures for Indian and Northern Health, on "community health" in 1985-86. Nonetheless, it remains a neglected aspect of the program as a whole. The two significant developments that have been made in recent years are MSB's attempts to increase Native people's participation in the delivery of both professional and para professional health services, and secondly, the establishment of thirty-three Health Demonstration Projects in Native communities. While some progress has been made in this respect, it appears to have had little impact on health. These initiatives will be discussed in greater detail in chapter V.

(g) Devolution of Responsibility: The latest facet of Ottawa's strategy to improve health services for Canada's Indian peoples has involved the gradual devolution of responsibility for the administration of local health care

services from Medical Services Branch to the Indian bands themselves. Accordingly DNIW established a Program Transfer and Policy Development Section of MSB to pursue negotiations with Indian bands regarding the establishment of a process and a timetable for increasing Indian participation and control of the Indian health service. Critics fear that this process of program devolution, which involves sectors other than health, is being undertaken by the government primarily as a means of saving money and thus will be pursued recklessly with disastrous results (Koldt, 1988:Introduction; Nicholson in Fonting 1980:62).

Dyle suggests that Canada's Indian peoples are in fact being given greater responsibility for health and health care but still lack the power to effect changes in the entrenched structures and relationships which ultimately determine the quality of their lives (Dyle 1986: 41-3; Speck 1987:195).

Given the high cost and relative ineffectiveness of the federal government's health care initiatives for Native Canadians, an alternative approach to improving health in this area must be considered. Experience has demonstrated the enormous costs and limited value of extending the existing Canadian health care system into Indian communities. It is logical to assume that unless significant changes to the status quo are made, these health initiatives will continue to be largely ineffective.

Accordingly, meaningful long term improvements in Indian

health require a fundamental restructuring of the Indian health care system. It is argued in this paper that such a restructuring should be implemented along the lines set out in the primary health care strategy as defined in the Canadian-endorsed International Declaration on Primary Health Care, 1978. In the following chapter the primary health care strategy is discussed and its applicability to Canadian Indian communities is demonstrated.

CHAPTER IV: PRIMARY HEALTH CARE

In this chapter the concept of primary health care (PHC) is described and its recent rise to preeminence as a health care strategy is reviewed. Then, based on the experiences of other countries, the potential of PHC as an effective health care strategy for Canada's Native peoples is considered from both a practical and a philosophical point of view. The assumptions made about PHC in this chapter are further analysed in chapters V and VI.

PHC is an ancient and varied concept. There are a variety of interpretations with respect to what PHC actually is and how it works. In general, however, the primary health approach to health care delivery is based on two fundamental premises: (a) that the major causes of poor health today are due more to socio-economic factors than to pathological factors; and (b) that poor health is, in the vast majority of instances, most effectively resolved through organizational changes to existing health care services that seek to remove the major causes of illness and disease, rather than through medical innovation to treat the sick (WHO, 1978:passim). In short, a health care strategy based on PHC entails a complete reorientation of conventional health care priorities in the community.

PHC constitutes a multi-sectoral and technologically appropriate, holistic approach to providing essential or "first contact" health care services, whereby priority is

given to the public health, preventive care and individual self-help aspects of existing conventional health services. The objective of the PHC approach is to eliminate the essential causes of poor health, such as isolation, poverty, lack of education, pollution, despair, and unsafe working conditions, rather than simply treating its symptoms. Accordingly, the specific nature of a given PHC approach will vary depending on the context in which it is applied.

PHC is widely perceived as a subsystem of the larger network of health services in a community; it is neither location- nor population-specific. PHC may be found, for example, in hospitals in chronic care wards and in outpatient wards, as well as outside the hospital in urban, suburban and rural areas.

Three key elements to an effective PHC strategy are commonly identified. First, because it is tightly knit to the daily life of the community, PHC must be applied or adopted in such a manner that it conforms to the specific health-related needs of the community in which it is situated. Thus, the planners and operators of the PHC initiatives should be well aware of these needs as they arise and as they change (WHO, 1973:1; Livits in White & Bullock, 1980:94). This is particularly important where the cultural make-up of the PHC community is substantially different from that of the mainstream society, as PHC seeks to address its

clients' perceived needs in addition to their actual needs (de Smeester and Parlor in White and Bullock, 1980:79).

Second, it is necessary that the community "link" its PHC initiatives with the broader, conventional health care services. Because PHC is relatively elemental, patients requiring full medical attention need to have access to secondary and ultimately tertiary care facilities. The PHC approach is not intended to replace conventional care facilities where these exist, but rather, it is intended to serve in the health-related areas that are not addressed by conventional care institutions. Linkages between the primary level of care and subsequent levels of care are, therefore, vital to the overall integrity of the community's health services sector (WHO, 1978:1; Bennett, 1975:51). Planning for such linkages can present difficulties, particularly as there are commonly strong philosophical and cultural differences between the way the macro (ie. national) and the micro (ie. local) health services operate (Chaves in White and Bullock, 1980:74-5).

Third, all effective PHC requires extensive community participation. As a multi-sectoral, labour-intensive, cooperative effort, PHC cannot succeed without the active support of the community in which it operates (WHO 1978; WHO, 1981:41-42; IBRD, 1980:2; Chaves in White and Bullock, 1980:73-74). The collective involvement of the members of the community in the planning and delivery of total health

care services is, more than any other factor, key to the success of any PHC initiative.

While the primary or "first contact" approach to health care involving such things as community involvement and prevention have been practised to some extent in many societies for centuries, interest in the concept of primary health care (PHC) has grown significantly over the past decade as its potential as an effective health care strategy in less developed countries (LDCs) is recognized. It is helpful to review the emergence of PHC as a development strategy in the Third World in order to understand how a similar strategy might be applied to Canada's Native communities.

The PHC Background

Up until the late 1960s, the need for some holistic form of health strategy in LDCs was largely ignored by development planners. Institutionalized health care was widely regarded as a predominately consumption-oriented activity which, because of its high cost, should be confined to urban areas and expand nationally at later stages of industrialization led economic development (Bryant, 1969:95, 98-100; Fodaro, 1995:195-22). Moreover, in the immediate postwar period, there was concern in some academic circles that improved health in LDCs would accelerate a preexisting, high population growth in those countries and thereby undermine

the positive impact of economic growth.

Thus, throughout the 1950s and 1960s, the development of national health care programs in many LDCs was largely deemphasized in favour of an increased role for the World Health Organization (WHO) to deal with selective health risks and to gradually develop a national health infrastructure. According to the International Bank for Reconstruction and Development (IBRD or World Bank), life expectancy in the LDCs as a group, increased approximately 70 per cent from 1940 to 1970. This rapid improvement appears to have been due primarily to the initiatives of WHO in reducing the incidence of communicable and vector diseases and, to a lesser extent, to the development of formal health care services in most LDCs.

By the early 1970s, however, the health situation in most LDCs had begun to deteriorate. One problem has been that WHO's disease control programs have proven unable to keep pace with the growth and evolution of the diseases they were meant to destroy (IBRD 1980:170). A second problem lies in the nature of most developing countries' health care services which are based on technologically advanced, western, curative type medicine (Iry, 1976:309; Gish, 1975:115).

The present structure of health services in most LDCs has arisen as a direct result of the development strategies that these countries pursued in the 1950s and 1960s. For

many years, traditional economic policy held that underdeveloped countries could best "develop" by attempting to emulate the economic development experiences of the Western industrialized countries (Todaro, 1985:79-80). Accordingly, the governments of many LDCs pursued a policy of rapid economic growth through selective urban industrialization. The fruits of economic growth in industrialized countries was thought to subsequently "trickle down" and become well distributed throughout the society for all to enjoy (*Ibid.*:84).

This form of rapid industrialization, however, followed a "dual economic" model in many LDCs whereby the modern, capital-intensive, urban-based sector flourished at the expense of the traditional, predominately agricultural sector from which cheap labour was obtained by industry. Thus, as the highly productive, city-based, industrial sector grew, many workers migrated from the rural to the urban areas in expectation of earning a higher wage there. In fact, the "urban pull" is so great in many instances that workers have continued to migrate to the cities even in the face of widespread open unemployment (*Ibid.*:258-64). As a result of these and other factors, the industrialization-based development strategy of many LDCs has led simultaneously to growing rural and urban poverty (*Ibid.*:Chapter 1, 264).

The emergence of dual economies in LDCs has led to the

development of dual health care systems in these countries: one for the better-off urban populations and another, vastly inferior, for the urban and rural poor, the vast majority. By and large, the health care facilities that do exist in LDCs are urban based. These in turn tend to be expensive, capital-intensive facilities that use advanced, curative technology appropriate only to the needs of the wealthy and are, therefore, wholly inaccessible to the countries' growing urban and rural poor majorities.

By the early 1970s, health care services in most LDCs were proving largely ineffective in addressing the growing health needs of LDC populations. In addition, the cost of these conventional urban health care services, dependent as they are on capital imports and highly trained professionals (many of whom, once educated, leave their homes for wealthier countries), is rising rapidly and prospects for extending them are bleak (WHO, 1978:ch. 1).

In the wake of two major increases in the cost of world petroleum in the 1970s, rising protectionism in the affluent countries against third world imports, deteriorating terms of trade in many LDCs, devaluing LDC currencies, the growing third world debt, rising interest rates, high unemployment, rapid inflation, expanding LDC populations, significant reductions in foreign aid transfers and a deteriorating level of health in most less developed countries, by the late 1970s many political leaders in the third world sought to

rationalize their expenditures on health care programs to make them more cost efficient and effective.

These circumstances contributed to the organization of a joint WHO-UNICEF (United Nations Children's Fund) conference at Alma Ata in the USSR in September 1978. At the conference, delegates from 154 states, including Canada (HOW, 1988:4-5, 15), and 67 international organizations unanimously endorsed a declaration of a "Global Strategy of Health for All by the Year 2000" (WHO-UNICEF, 1978a:1). The focus of the declaration (summarized in Appendix A) is primary health care. As a result, it has become widely known as the Alma Ata Declaration on Primary Health Care.

The Alma Ata Declaration states that good health should be recognized not as a privilege, but as a universal human right. The Declaration also acknowledges that the good health of a population is a necessary prerequisite to a country's full economic, social and political development. Moreover, the Declaration requires the supporting government to proceed with national health strategies that will reach underserved populations through the implementation and support of primary health care initiatives (Appendix A).

In essence, the Alma Ata Declaration presents PHC as a rational, low-cost, labor-intensive, technologically simple, culturally-sensitive, multi-sectoral and effective synergistic process through which existing resources can be used to

provide essential health care services for all populations currently under-served by conventional health care.

The approach is synergistic, as all systematic health care must be, in that it operates in conjunction with numerous non-medical activities that directly affect people's health. Such activities include personal and environmental hygiene, education, nutrition, improved food fortification, storage and distribution, clean water and transportation and communication facilities. In addition, the effectiveness of PHC depends directly on such factors as adequate financing, employment, full community participation, community-based administrative autonomy and leadership responsiveness (WHO, 1981:ch.6).

Key to the "community participation" aspect of PHC is the "primary health worker" (also known as the "village worker," the "community health worker," and so forth). The primary health worker (PHW), often a female in LDCs, is a member of a given community who is selected (or appointed) and trained as a health auxiliary personnel. Once trained, the PHW is usually assigned to work in her own community among her own people where, ideally, she speaks the language, practices the local religion, respects the customs, looks the same as everyone else, understands local problems and concerns and is generally well respected. The PHW is more likely to be on hand than a doctor as there are generally a lot more of them in any given community, and they

are far less expensive to train and to remunerate than are physicians (Taylor, 1976:220-22; WHO, 1981:39).

The PHW typically works out of a local dispensary or small medical clinic and travels to clients in their homes, usually by foot, just as the so-called "barefoot doctors" of China do (Sidel, 1980:86). The PHW is generally familiar with common causes of illness and disease and is trained to recognize these and, if possible, to treat her patients with simple remedies or medication, either in the home or at the dispensary. When the PHW is unable to do anything for the patient, she makes arrangements to ensure that the patient is delivered to the secondary or tertiary health facility, as required. Thus, the establishment and maintenance of multi-level health care is fundamental to the success of any PHU.

A sizable aspect of the PHW job involves educating the members of her community with regard to such topics as personal and environmental hygiene, planned parenting, maternal-infant care, nutrition, immunization, and occupational health and safety. In addition, PHW are generally expected to compile vital statistics for use by health planners, monitor sewage and water conditions and replenish their primary medical supplies regularly.

Thus, the PHW must have a sound background in the principles of primary diagnosis and treatment. She should also have good intercommunication skills, judgement skills

and leadership skills. She should be compassionate, tolerant and well organized.

Proponents of the PHC approach usually echo the critics of "medical industrialism" who argue that conventional health care methods based on modern, sophisticated, hospital-centered techniques requiring expensive "state-of-the-art technology" and highly trained professionals have a predominately curative bias (Gish, 1975:15). Accordingly, much of conventional, western style medical care tends to be fragmented and reactive, responding more readily to the symptoms rather than to the causes of poor health (Weller, 1980:408-9, 415). Furthermore, this high technology care absorbs a greatly disproportionate share of most national health care budgets. It follows, according to this line of argument, that the governments of large, unhealthy populations should implement the all-encompassing, preventive, technologically simple and relatively inexpensive forms of health care delivery espoused in the PHC strategy (Fendall, 1971:299-300; Weller, 1980:408-9; Navarro, 1974:16).

As mentioned earlier, many countries have already implemented various forms of PHC strategies in an attempt to address the health needs of a greater number of people more effectively and at reduced cost. However, the available empirical evidence regarding the effectiveness of PHC in comparison with more conventional health care techniques

remains inconclusive. Many researchers have argued that the experiences with PHC in such countries as China (Sidel and Sidel, 1982), India (Taylor, 1976; Benyouseff, 1977), and Tanzania (Chagula et al. in Newell, 1975; van Litton, 1976; Gish, 1975) have demonstrated the relative merits of the PHC approach.

Nevertheless, the aforementioned studies, along with similar others, fail to demonstrate convincingly the inherent superiority of PHC. In addition to a lack of meaningful and quantifiable health indicators which may or may not illustrate the relative success of a given PHC initiative, one must consider the enormous diversity of the social, political, economic, demographic and geographic conditions under which various PHC programs may operate. Thus, if one country has apparent success with its peculiar form of PHC, there is no reason to assume, a priori, that the same PHC strategy will be equally as effective in another country in which the political, geographic, economic, demographic, social and/or cultural characteristics are significantly distinct (Fondahl, 1977:297).

Furthermore, there are important arguments against the widespread implementation of PHC. Some writers, such as Newell, have noted that the acclaimed success of PHC is still largely confined to demonstrations from experimental projects, many of which remain experiments (Newell, 1975:191-

202). Roemer argues that, in wealthy countries such as the United States (and perhaps Canada, by implication) the use of "physician substitutes" or PHWs constitutes an inexpensive "band-aid" to a serious problem: the shortage of primary care physicians (Roemer, 1977:4). Isalidis' suggests that Roemer's concerns about creating "second rate" care through the use of auxiliaries is invalid. There will never be enough doctors to satisfy everyone's needs and, at the moment, many doctors are performing simple tasks that can be performed just as well, if not better, by the less costly, community-based health auxiliary (Isalidis, 1980: 100-1).

Other critics of the paradigm see PHC as idealistically simplistic or, at best, difficult to manage. It is pointed out that an effective PHC strategy requires many factors which are lacking in most less developing countries (LDCs). Foremost among these are the lack of a political commitment to PHC on the part of the central and regional governments, the lack of financial resources to sustain long term development goals and the absence of sufficient bureaucracy or administrative organization at the local level.

Even with adequate government political and financial support, PHC administrators face an enormous task in terms of securing community support, establishing and prioritizing health goals, procuring the resources they need, ensuring reasonable transportation and communication linkages with the secondary and tertiary health services, avoiding wastage and

corruption and, finally, soliciting, training, supervising, supporting, evaluating and retraining PHWs in the communities.

Finally, it should be noted that the idealism associated with PHC largely ignores the reality of political timetables which favour short-term change at the expense of long term gain. The importance and breadth of these and other impediments to the development of effective PHC will be discussed in detail with regard to the Canadian situation, in chapters V and, in particular, VII.

PHC does not constitute the panacea of the health care needs of the world's under-served populations. Nonetheless, there is growing recognition of the urgent need for radical reforms to most health care systems (WHO, 1981:1, 21-22). This is particularly felt in areas where most of the causes of ill-health are preventable by appropriate technology and current global health expenditures, where large populations are excluded from the formal health care system and where widespread illness has contributed directly to such social ills as poverty, demoralization, the unnecessary consumption of scarce resources, lack of productivity and wasted human capital (Blakeslee, 1985: 47, 50).

Given the present health status of Canada's Indian peoples, and in the absence of any empirical evidence to suggest that the PHC strategy is ineffective, it may be

argued that the Canadian government, which has endorsed the Declaration of Alma Ata (HWC, 1988: 4-5, 1; personal conversations with staff at MSB and at the UN), should adopt a widespread PHC strategy for its Indian peoples (Koedde, 1979:1343-46). While some progress with regard to improvements in some aspects of Native health has been made over the past two decades, as discussed, infant mortality rates for Canadian Indians remain two to three times higher for Natives than for non-Natives. Native Canadians also suffer from abnormally high rates of morbidity and mortality due to acts of violence, accidents and suicide (Grescoe, in Coburn et al., 1981; Siggner, 1984).

There is growing evidence that many of the causes of poor health in Indian communities stem from the Indian peoples' feelings of destitution and demoralization which has been brought about, in part, by the lack of gainful employment opportunities on or off reserve and by the loss of much of their sense of traditional ways of life, their languages, customs, folklore and religions (Spect, 1987:191, *passim*; Little Bear, 1980; Ponting, 1986:359). Poverty, geographical and social isolation vis-a-vis the dominant society, the deterioration of the traditional family unit, congested, unsafe, unhealthy housing, inadequate education, pervasive government paternalism and widespread drug and alcohol abuse also contribute to some extent to the tragedy of Indian health. And, of course, the problems are cyclical:

poor health leads to lower productivity which leads to unemployment which leads to more poverty which may lead to malnutrition, inadequate housing, crowding, poor sanitation, depression, alcohol abuse, violence and many other related health problems (Statistics Canada, 1984; DIAND, 1980; HWC, 1979).

Despite the nature of the health problems of the vast majority of Canada's Indian people, the Canadian government has made little effort to break away from a conventional, technologically advanced, curative health care system to serve Indian communities. Regardless of whether or not one believes that PHC represents a viable solution to the health needs of under-served populations in less developed countries, it is conceivable that the strategy holds great promise in Canada with regard to this country's Native peoples.

Canada is a wealthy nation both in material and human resources. Given her wealth and vast size, Canada's population of 25 million persons is relatively small by international comparisons. Thus Canada has relatively more resources to spend on health care than do most other countries; the Canadian governments have traditionally spent about 8% of the country's GNP on health care related goods and services. Moreover, the main target population for the PHC strategy discussed in this chapter represents perhaps no

more than 1.5 million persons (including Metis and non-status Indians) or 2% of Canada's population.

Furthermore, as the Canadian government has often stated its intention to provide adequate health care services for the Indian population, the government cannot realistically afford to continue to ignore the potential strengths of PHC as a fundamental step toward realizing its legal, political, social and moral commitment to the Native people of Canada.

As an official of the Department of National Health and Welfare so succinctly put it:

. . . we are firmly committed to the view that real improvements, dramatic improvements, in in the health of many native communities, have to come about as a result of a multiplicity of things: as a result of the employment situation, improvement in the economic situation, improvement in the housing situation, improvement in the community infrastructure. We do not think we can improve those very tragic statistics solely by the application of contemporary medicine. The renewal has to come from within (MSR, 1981).

Whether the health official was speaking of PHC per se, or only of the need to incorporate traditional, or indigenous medical techniques into current health care strategies for Native Canadians is not really important. What is significant is that the above quote, like so many recent others clearly expresses the profound frustration that has arisen, in government and elsewhere, from the failures of conventional health care strategies to significantly improve the health status of Canada's Native peoples.

The many logistical, political, legal, economic and as of yet undetermined reasons to suspect that the implementation of PHC initiatives in Indian communities will be difficult to achieve will be addressed more fully in the following chapters.

The Philosophical Argument for PHC

The appropriateness of the PHC strategy to Canada's Native communities is not restricted to arguments that the the Indian communities represent this country's own "third world" and should, therefore, be dealt with accordingly. Canada is not a developing nation in the current sense of the word and the the Indian health problems are predominately political and philosophical in origin, not economic or geographical.

The philosophical nature of the PHC approach to health care delivery is, as I will demonstrate, far better suited to the indigenous social and ideological orientation of the Native peoples. Accordingly, PHC is more likely to be accepted by the Indian communities than it has been or is likely to be elsewhere in the country.

There exists in Canada today two fundamental conceptions of social order. One, sometimes referred to as the "homocentric" worldview, is the predominant social philosophy of the Canadian majority. The other, commonly referred to as the "cosmocentric", or "holistic" worldview, is that of the

Native Canadian population.

As its name would suggest, the homocentric worldview is founded on the moral priority of the individual. Its origins are to be found in the writings of Western political philosophers such as Hobbes, Locke and Rousseau. The homocentric perception of the world is based on the primacy of the individual who is governed in society by his adherence to a social contract.

The Canadian Indian's "holistic" worldview, on the other hand, is based on the premise that the "whole," the cosmospiritual order, not the individual, is paramount. The "whole" consists of all objects in the community, both animate and inanimate, each of which is possessed with a soul, and is interrelated. The social imperative of such community-oriented society is to ensure that harmony is maintained between all things (Goldt and Long, 1985:166). In traditional Indian societies, this "natural law", with its community focus, affected everything an Indian did. Moreover, much of this philosophy remains alive in the minds of Canada's Indian peoples today (Ibid.:507-508).

It is possible to draw a close parallel between the philosophical basis of PHC and the Native peoples' indigenous beliefs. Just as the Native peoples have traditionally respected the interrelationship of all things, PHC is founded on the multi-sectoral aspects of health. In the mind of the Indian, illness and disease arise as a result of a

disturbance in the world's "natural balance"; in order to remedy the sick, one must restore the balance. Similarly, PHC seeks to reduce or eliminate the typical imbalances that exist within a community between available resources and health needs. In sum, the Canadian Indian's holistic worldview is far more in keeping with the multi-dimensional, community-oriented, self-help PHC approach to the causes of illness and disease than with the individualistic, curative orientation of modern medicine.

A further aspect with regard to the "appropriateness" of PHC to Native Canadian communities is the fact that one's health is to a significant extent determined by one's cultural perceptions. The causes of disease relate directly to one's perceived, "role" in the universe and to one's perceived relationship with animate and inanimate objects. Similarly, the cures to disease and illness may vary in many cases depending on the symbolic and conceptual conditions under which they are administered (Sogah) in (Loburn et al., 1981). As PHC is community-based and culturally sensitive, it is clearly likely to be more effective psychologically for Native Canadians than is conventional medicine.

Given that the Canadian government's conventional, reactive and predominately curative approach to Native health, is not working, that the government has officially endorsed the Alma Ata Declaration on Primary Health Care,

that PHC is compatible with indigenous Native beliefs, and, most importantly, that PHC appears to work, it is time that the government pursued the adoption of PHC-type initiatives in Native communities in earnest. In the next chapter, the federal government's record with respect to PHC in Canada will be reviewed. Then, in chapter VI, consideration will be given to an alternative strategy for the implementation of PHC in Canada's Native communities.

CHAPTER V: PHC APPLICATION IN CANADA

The purpose of this chapter is to review federal "community-based" initiatives in Native communities in the area of health to determine the extent to which these are consistent with the PHC approach. Ottawa's endorsement of the Alma Ata Declaration in 1978, coupled with its subsequent heralding of the virtues of PHC-type initiatives, seemed to suggest that the federal government was prepared to support more PHC in Canada in the 1980s. Moreover, the revealing conclusions of Indian Conditions, and subsequent studies, demonstrated the extent to which PHC-type initiatives are needed in Native communities (MSR Annual Review, 1987-88:4-6; Nielsen, 1985:; HWC, 1988). In this chapter, it is revealed that, in fact, the federal government has not succeeded in promoting the adoption of PHC in Canada and the reasons for this apparent contradiction are discussed.

PHC For Ottawa

In its attempt to extend health services to all Canadians over the past 40 years, the federal government has established an expansive and expensive network of hospitals, clinics, nursing stations and health centres/stations across the country. In 1983, there were approximately 450 such establishments in Canada designed specifically to serve the needs of Canada's Native populations (MSR, 1985:19). Yet in spite of these services, and in spite of relatively high

federal per capita expenditures on Indian and Northern Health Services (CHS, 1984:11) the health of the Indians remains, in general, well below the national average (Harris, McCullough, MSR, 1988:41).

As was mentioned in chapter 3, many recent studies, such as Indian Conditions, noted that Indians tend to have a shorter life expectancy than do non-Natives. Violent deaths among Indians is reported to be three times the national average. Suicides, particularly among the young, occur around six times more often in Indian communities than in non-Native communities. An estimated 50 to 60 per cent of Indian deaths and illnesses have some relation to alcohol/drug/intoxicant abuse (DIAND, 1980: 15; cf. Murdoch, 1980:32-45).

In response to the continuing problems of Indian health and the developing international sensitivity to the socio-economic determinants of health, the federal government has sought increasingly, over the past fifteen years, to introduce health care initiatives for Canada's Aboriginal peoples which, one might argue, correspond closely with the PHC approach as defined at Alma Ata. Since the early 1970s, Ottawa has repeatedly identified such factors as greater "community participation" in health care delivery for Aboriginal peoples, including the training of Aboriginal peoples in health-related professions, a growing acceptance

of indigenous medical techniques, increased acceptance of local control of essential health services, and a greater recognition of the relationship between poverty, community underdevelopment and poor health as integral to the realization of good health for Aboriginal peoples in Canada (MSB Annual Reports, 1981-84). In keeping with this stated priority, the Nielsen Task Force estimated that nearly 60 per cent of MSB's total expenditures on Indian and Northern health would be spent on "community health" in the fiscal year 1985-86 (Nielsen, 1985).

Nonetheless, as the following examination of these initiatives reveals, the federal government's attempts to introduce PHC-type strategies to Native communities through the Indian and Northern Health program, fall far short of a meaningful and consistent federal commitment to PHC.

Current Federal Initiatives in Indian-PHC: The Record

Federally-created and financed programs that seek to encourage a greater degree of community participation in and (ostensibly) community control of government controlled Native health care services have constituted the essence of Ottawa's attempts to increase the role of PHC in Native communities. The Canadian government's attempt to develop a community-based health focus among Native peoples has centred around two principal objectives: an increase in the delivery of health services to Native peoples by Native peoples; and

the devolution of responsibility for health from the federal government to the Native peoples themselves.

In accordance with the first objective, Ottawa has sought to train and employ a number of Aboriginal peoples as para professional workers in their own communities. Foremost among the federal government's initiatives in this area is the Community Health Representative (CHR) program.

Implemented in the 1960s, it was originally designed to reduce serious cultural and communications gaps that often separate non-Native health professionals and their clients (Weller, 1981:6). Local Indians and Inuit are selected and trained in the basic principles of community development and preventive medicine in the hope that they will be able to contribute in an unsophisticated, but important way to the improvement of essential health care in their respective communities (*ibid.*:76).

Ottawa's efforts to increase the use of para professionals has been frustrated by several factors, including inadequate financing, poor support from the broader health care system, poor communication, stressful working conditions and a wide variety of organizational and jurisdictional problems. The Nielsen Task Force on Program Delivery concluded that the principal difficulty with the federal Community Health Representatives stems from the CHRs' lack of territorial, provincial and professional recognition. In general, the Nielsen Report states that, despite federal

intentions to the contrary, the Native para-professionals face "dead-end" careers which have no aspect of transferability outside Aboriginal communities (Nielsen, 1985: 344).

When one considers the conventional care bias of Canada's dominant health philosophy, discussed later in this chapter, however, it is not at all clear that the question of the transferability of CHC health skills from Aboriginal communities to mainstream society is particularly relevant. It is perhaps more accurate to conclude that the relatively poor success of the CHC program is due to a general lack of government support for the program. Despite Ottawa's rhetoric which recognizes the potential merit of using para-professionals to improve Native health care at a reduced cost, their numbers will continue to grow slowly (Nielsen, 1985: 344).

The second objective of the federal approach to IHC for Native peoples, the devolution of Native health care responsibilities, revolves around three basic initiatives: increased Native staff representation at MSB; the Native Health Careers program; and program devolution. In 1984, MSB reported that it had increased Native representation on its staff to 22 per cent, including two "executives". Given that it is the Native peoples themselves who are best able to determine the health needs of their respective communities,

the improvement of Native representation at the federal planning level represents a potentially important development. Despite the increase in MSB Native staff, however, the essential, centralized structure of the Indian and Northern Health program has remained intact. One must question, therefore, who these native "representatives" are, what their degree of responsibility really is and what sort of effect, if any, they can have on the federal health care policy for Native Canadians.

In 1984, \$7.8 million in federal funds was earmarked for a three year Native Health Career - (NHC) program, designed to increase the number of Native Canadian health professionals. The intent of the program is to reduce the non-Native dominance of the health care professions and allow a greater number of Native Canadians to receive sophisticated medical care from one of their own people as opposed to from a non-Native. Furthermore, by assisting Natives to become health professionals, the federal government is apparently preparing Native peoples to assume greater responsibility for their health needs.

Although this program has not yet been evaluated, there are indications that its focus is far too narrow to meet its objectives of increasing Indian control of Indian health. The Nielsen Task Force on Program Delivery noted that there appear to be jurisdictional difficulties inherent in the NHC program as, DIAND, the federal government department

responsible for the program, has no authority with regard to post-secondary education and must, therefore, purchase it from provincial universities, colleges, and medical teaching institutions (Nielsen, 1985: 17).

Moreover, when one considers that, at present, few Native Canadians finish secondary school, let alone university, and that a very small percentage of university students are accepted to medicine in any given year, the federal government's attempt to increase the number of Native graduates from Canadian medical schools represents a questionable priority.

Finally, Jean Goodall, in her recent study of Native nurses points out that professional training alone does not produce effective Native health professionals. Goodall's study reveals that Native professionals working in the health field in Native communities frequently suffer from discrimination, a poor work environment, alienation and conflict between band, regional, provincial and federal policies (Goodall, 1984). As the discussion in the following chapter will illustrate, Canada's Native peoples require more than conventionally-trained Native doctors and nurses if they are to take control of their health care services.

Program devolution represents the third aspect of Canadian government's strategy of devolving its

responsibilities for Native health the Natives themselves. The best example of this initiative on a large scale is provided by the so-called Community Health Demonstration Projects program.

In 1982, the Liberal government of Pierre Trudeau established "Health Demonstration Pilot Projects" in 25 Native communities across the country (Hensard, 18-11-1982:6:10). The purpose of the demonstration projects, which were designed to last two years, was to allow Indian and Inuit communities to gain experience in running community-administered health programs. It was planned that the participants would gain meaningful exposure to and an understanding of the timing, costs and benefits of community-based and -run programs (MSB, 1984:6).

In 1985, the year the program was scheduled to end, Ottawa decided to fund the projects for another two years, despite the Nielsen Task Force's recommendation that they be discontinued on the grounds that they were not meeting their objective (Nielsen, 1985:340-41). By the end of 1987, all of the projects had been "completed". Interestingly, the evaluation of the program has not been made public; MSB officials refer to it as an "internal document." Despite the fact that some of the projects have continued on band or regional funding (Garro et al., 1986:281), the absence of a report on the program, coupled with personal conversations with HWC officials suggest that the effort "fizzled out."

The evidence reveals that, despite rhetoric to the contrary, the Canadian government continues to give the development of a much-needed community-based, PHC-type health care system for Native Canadians low priority (cf. MSB, 1985). The Indian and Northern Health program remains highly centralized and conventionally-oriented along the medical model of health care delivery. Isahtis and Manga state that this is a further example of how the dominant society is unprepared to reallocate its resources to PHC type initiatives, because of fiscal constraints and immediate vested interests, even though they are likely to be less costly to the dominant society in the long run (Isahtis and Manga 1987:2-3). It is to this problem we now turn.

Shortcomings in Federal PHC Initiatives

The principal problem with the current federal health care policy for Canada's Aboriginal peoples is the federal government's lack of political commitment to the PHC strategy. As a result of the lack of government commitment, the three essential requirements for effective PHC identified in Chapter IV, remain unsatisfied. These are: (1) knowledge of community health needs; (2) the establishment of good linkages between the primary, secondary and tertiary levels of health care as well as linkages between various sectors of activity in the community that have a direct impact on health; and (3) full community participation in the delivery

of primary health care services (See for example: WHO, 1978; Chaves in White and Bullock, 1980:71-78; Bennett, 1979:505-514).

These shortcomings in the current federal health policy for Aboriginal Canadians will be discussed in order to show the extent to which the lack of federal political commitment is a contributing factor in the perpetuation of poor health in Canadian Indian communities. Then, the principal reasons for the federal government's relatively poor political commitment to PHC will be identified and discussed before presenting an alternative approach to the development of PHC initiatives in Canadian Indian communities.

(1) Knowledge of Community Health Needs: The federal government appears to have a generally poor understanding of the specific health needs of individual Indian communities. Created in Ottawa and imposed on the Aboriginal peoples by outsiders, the Indian and Northern Health program applies more or less uniformly throughout the country and it is not well suited to address the peculiarities of local conditions (Starblanket, 1979:17). Health-related research in Aboriginal communities tends to be done sporadically and largely at the whim of local practitioners or universities, rather than in direct response to community expressed concerns. Federal funding for the regular compilation of accurate health statistics is inadequate with the result that

there is perpetual uncertainty as to what the precise health status of Canada's Aboriginal peoples is (Harris and McCullough, 1988: Conclusion and Appendix A).

The lack of sufficient statistics also makes it difficult for the health planner to determine what the specific causes of poor health in any given Aboriginal community might be (*ibid*). And finally, Canada's Aboriginal peoples have traditionally lacked the necessary ability and resources to assess their individual and collective health needs properly and to then present them effectively to the federal government (Blalock, 1985:15).

Insufficient health-related research in Indian communities, the general paucity of accurate health statistics and the years of federal disinterest with regard to Native health issues have made it extremely difficult for health planners in the federal government to determine exactly what the health needs of specific Aboriginal communities in Canada are. Without such an understanding, the federal government cannot succeed in developing meaningful primary health care initiatives for or with Canada's Aboriginal peoples (*ibid*:16).

(2) Linkages: Given the present absence of good PHC initiatives in most Indian communities, current concerns with regard to the establishment of linkages between primary care and other levels of care may seem premature. One must keep in mind, however, that these linkages constitute a

fundamental aspect of the PHC strategy. They must be developed in conjunction with all PHC initiatives and not postponed until the PHC initiatives are already in place. Appropriate linkages include such factors as communication and transportation infrastructures and organizational relationships between health care institutions and health care workers, as well as between the various levels of government, the health care sector and other sectors. The linkages must be improved if PHC measures for Native peoples are to be effective.

The relative geographic, cultural and linguistic isolation of most Aboriginal Canadians makes the establishment and the maintenance of good linkages between broad local PHC initiatives and more narrow secondary and tertiary levels of health care difficult to achieve. The outline of the structure of the Northern and Indian Health program provided in chapter III indicates that efforts have been made by the federal government to organize health services for Aboriginal Canadians along the lines of progressive levels of care. However, sparse populations, limited roads, poor federal/provincial cooperation with respect to Indian health care have undermined, removed, or prevented the establishment of linkages between all levels of health care for Canada's Aboriginal peoples (Boldt, 1988:10; Nielsen, 1985:169).

(3) Community-Based Participation: At present, Ottawa is seeking to impose a greater degree of PHC on Native communities. These initiatives have failed to attract widespread support the Native Client groups principally because they have been imposed and poorly supported. Despite its rhetoric to the contrary, Ottawa remains faithful to its age-old Indian health policy of "health by the government for the people," rather than "Health By The People" as Alma Ata had intended.

Second, because PHC incorporates a multi-sectoral approach to health and health care development, improved participation by the Indian peoples will depend, in part, upon the provision of better opportunities in the area of employment, housing, sanitation, recreation and education, than are currently available (HWC, 1988). If they are to be expected to participate fully in the PHC efforts, then the Indians must believe that their participation will lead to concrete results.

Having established that the Canadian government's unwillingness to support PHC in Native communities has precluded the creation of the necessary conditions for effective PHC, it is now necessary to consider why it is that the government remains uncommitted to PHC, despite the overwhelming evidence that suggests that PHC is exactly what the Native peoples need.

The Lack of Federal Political Commitment to PHC

The lack of federal commitment to the expansion of PHC initiatives in Canadian Indian communities has been identified as the principle cause of the poor progress of PHC in Indian communities. This is not due to the fact that the federal government has something better in mind for the Indian people. The government has stated on various occasions, its support, in principal, for the concept of PHC in underdeveloped communities (MSB Annual Report, 1983:62). Rather, the federal government's reluctance to give whole hearted support to the primary health care strategy is due to a combination of four principal factors.

First, Canadian Indians as a group have traditionally represented a relatively weak minority political lobby group in Canada and their interests are therefore not a priority with the federal government. Second, on-going tensions in federal-provincial relations has seriously impeded the development of well-coordinated health policies in Canada. Third, the nature of Canada's technologically-biased, curative-medical approach to health care precludes the widespread use of primary care initiatives in Canada. And fourth, the PHC approach is largely incompatible with the broader general interests of the capitalist state in Canada. Each of these four factors will be discussed in detail below.

Indian Political Weakness: It cannot be said that the

development of PHC strategies per se in Canadian Indian communities represents a universal objective among Canada's Indian leaders as no Indian document deals with this specifically. However, the ideals encompassed in the PHC approach are consistent with the Indians' common objectives of greater self-reliance, preservation of indigenous cultural, linguistic and religious practices and "total community development." (Penner Report, 1985: 3). In fact, the writings of many Indian leaders suggest that they support the autonomous, community-based PHC approach to health care delivery (MIB, 1971:74; NIR, 1977:307,309, Starblanket, 1979).

It is suggested here that the Canadian government's reluctance to commit itself to the adoption of a primary health care approach in Aboriginal communities is due, in part, to the fact that, until very recently, Canada's Aboriginal peoples have carried very little political weight. Until 1956, it was illegal for a Registered Indian to organize politically. Even after 1960, when Canadian Indians were granted the right to vote in federal elections, and throughout much of the 1970s, the Aboriginal peoples constituted a highly dispersed, rather poorly organized and poorly represented minority "group" living in relative isolation on the fringes of the dominant Canadian society (Fonting, 1984:284).

This problem has been rectified somewhat over the past

decade as national Native organizations, in response to recent legal and constitutional developments concerning such issues as "comprehensive claims" and Native "rights," have become better organized, more unified in their respective objectives, and better able to articulate their concerns to all levels of government (ibid.).

Nonetheless, while their concerns affect all Canadians, the relative social, cultural, economic and physical isolation of the Aboriginal peoples from the rest of Canadians continues to render the immediate concerns of Canadian Indians relatively unimportant to most non-Native Canadians (Ponting, 1985; Globe and Mail, 3/2/87:12). Moreover, recent visibility has tended to focus almost exclusively on constitutional issues and on media events staged by Indians (logging petitions at the Queen Charlotte Islands, 1985; on-reserve gambling, 1986; Mohawk blockade of the Champlain Bridge in Montreal, 1988). This, in turn, has led to widespread ignorance with regard to Native issues in Canada and to a popular perception among many Canadians that the Indians, Inuit and Metis are all attempting to secure more rights and more land than they are legally or ethically entitled to. As a result of the traditionally weak and misunderstood Indian lobby, the federal government has been largely able to ignore the problem of poor health and underdevelopment in Indian communities.

Canada's Federal-Provincial Conflict: Following the Second World War, public enthusiasm for increased social services rose dramatically in Canada. However, while responsibility for social services per se, including the provision of health care services (with the exception of certain health care provisions under MSB) lay with the provinces, the federal government has traditionally held the lion's share of the public purse, having assumed the provinces' right to direct taxation during the Second World War (Tsalikis, 1982b:124-25). Thus the introduction and development of social services in Canada have traditionally been dominated by questions of fiscal responsibility and divided jurisdiction between Ottawa and the provinces (Stevenson, 1982:171; Mango and Weller, 1983:273).

As a result, health care policy in Canada has evolved in a largely haphazard, fragmented way in response to opportunistic politics rather than in accordance to a national plan (Tsalikis, 1985a:154-55). The provinces maintain that because MSB is legally responsible for the health and welfare of Native Canadians, Native health should remain a federal responsibility (Nolsen, 1985:2.6). Boldt, on the other hand, suggests that the federal government is seeking to devolve itself of its responsibility for Indian social welfare programs in favour of provincial alternatives. Through policy and program neglect, Boldt argues, Ottawa is

forcing the provinces to react and take greater responsibility for Native health (1988:71).

The Canadian government's ad hoc and reactive approach to Native health in general has rendered the federal Native health care program largely ineffective and precluded the development of effective Native-FHC by impeding the establishment of good linkages to the provincial health care services (Nelson, 1985:155).

Anne Crichton has suggested that federal-provincial antagonisms with regard to health care policy in Canada could be substantially reduced through the provision of block grants from the federal government to the provinces. Meanwhile, the federal government, through the Department of National Health and Welfare, could retain "restricted functions of research and expert consultancy to the provinces." (1976:65). Thus, Crichton argues, would allow the provinces to develop better holistic health care systems, linking primary, secondary and tertiary levels of care, because they would have full control over the planning and financing of health care.

However, as was mentioned in chapter 2, the majority of Canada's Indians have, in the past, opposed any attempt by the federal government to give the provinces responsibility for Indian health care services. They argue that any attempt by the federal government to devolve itself of its

responsibilities for Indian affairs in favour of the provincial governments might ultimately encourage assimilation (Spork, 1987:156). Furthermore, Ottawa, with its national perspective, is not prepared to relinquish its current fiscal regulatory powers over provincial health care programs. Thus the Canadian health care system, inclusive of the Native health programs remain, to a significant extent, the products of federal-provincial bargaining (Evans, 1982:15-6; Manga and Weller, 1983:231, 241).

Canadian Conventional-Medical Culture: The majority of Canadians have traditionally expressed a profound ambiquity toward modern, expensive, individually-oriented health care services which, because of their capital-intensive and technologically-sophisticated nature, tend to be based in physician-dominated hospitals (Evans, 1982:3-4). While on the one hand the sophisticated medical services provided by this "closed" health system are of comfort to many, it is widely recognized that it is extremely costly to maintain financially and ineffective in preventing the principal causes of poor health. Alternatively, open health care systems, such as those encompassing extensive PHC, offer a more comprehensive degree of preventive as well as curative care. Yet, Canadians have in general favoured the enrichment of the "closed" health system. In reviewing the development

of the conventional-medical culture in Canada. It is possible to establish the degree to which this culture precluded the widespread adoption of PHC.

The advent of modern medical technology in the late 19th and early 20th centuries led to a steadily increased use of hospital-based, curative health care techniques throughout the industrialized western world (Weller, 1980:408).

Hospital construction in Canada was stimulated in the late 1940s with the introduction of the Appropriations Act No. 4, by the federal Liberal government of Mackenzie King, which authorized federal grants for hospital construction in the provinces (Isabitts, 1982a:176). Subsequently, in response to the rapidly increasing cost of medical technology in the 1950s, St. Laurent's Liberal government introduced the federal Hospital Insurance and Diagnostic Services Act in 1957. The Act provided for financial assistance to provincial hospitals and set out conditions contributing to universal access to hospital services for the Canadian public (Manga and Weller, 1981: 219).

In 1961, a Royal Commission on Health Services was established, under Justice G. Hall, by the Conservative government of John Diefenbaker. The proposals of the Commission, published in 1964, were largely embraced by the Liberal government of Lester B. Pearson and led to the formulation of the Medical Care Act, passed in December 1966.

The Act provided for federal payments to the provinces that introduced health plans based on the four principles of universal coverage, comprehensive benefits, portability of coverage and government non-profit administration (*Ibid.*: 270-51).

By 1970, all the provinces had entered the scheme. In addition, the Hall Commission recommended that Canada step up its efforts to educate more medical doctors and to encourage in-migration of qualified foreign medical professionals in anticipation of rapid population growth in Canada throughout the 1960s and 1970s (Isaiah, 1982a: 140). As the population "boom" failed to materialize, Canada has subsequently restricted in-migration of foreign doctors, however, Canada's medical schools have resisted government efforts to restrict their growth and the M.D. to population ratio continued to rise throughout the 1970s and early 1980s (Evans, 1983: 12).

Progressive government support of hospital expansion and the introduction of various types of medical insurance in the provinces rapidly led to a situation whereby hospitals, with their acute care bias, have become the "temples" of health care in Canada today (Isaiah, 1982b: 11; Soderstrom, 1978; Weller, 1980: 408). At the same time, health insurance schemes in Canada universally adhere to the principle of reimbursing doctors in private practice on a "fee for-

service" basis. According to Evans, this method of payment has a built in bias in favour of licensed medical practitioners and, in particular, specialists who can command higher fees, and indirectly discourages the use of physician substitutes. This has contributed to widespread overuse of medical doctors, and in particular specialists, in instances where someone with less training could deliver the same degree of care at a substantially lower cost (Isaiah, 1982a: 141; Evans, 1983:18).

As the cost of health care services soared to over 7 percent of the gross domestic product in the late 1960s, all levels of government in Canada found that it was impractical and fiscally undesirable to sustain the rapid expansion of hospital-based conventional health care in Canada. The Canadian health care system was also plagued with gross inefficiencies which contributed to an excessive and all too frequent abuse of hospital emergency wards in the absence of suitable health care alternatives to the hospital in most Canadian communities (Isaiah, 1982b:14; Evans, 1983:20).

Accordingly, in 1969 the Pearson government released the three volume, Lalor-Lorice Report on the Cost of Health Care. The report suggested that the existing health care services in Canada should be extended to include a greater number of Canadians at a lower per capita cost through the development of alternative methods of health care organization based on

"community health centers," rather than on hospitals (Lealistic, 1982b:138). Whereas hospitals tend to be geared toward providing relatively expensive, curative care, the report suggested that the community health centers would embrace a more "holistic" view of health and health care whereby "health" is not a strictly medical concept, but rather incorporates other aspects of the individual's social and economic well being (ibid.).

Community health care initiatives in Canada have sought to link the physical and non physical components of illness and disease and thus place an emphasis on prevention, as opposed to symptomatic treatment, to be achieved largely through the linking of health and social services (Lealistic, 1982b:144-47). The enthusiasm for "community-based" health services led to the establishment of community health centers (CHCs) in numerous provinces and in particular in Manitoba and Quebec. This represented Canada's foremost attempt to incorporate the primary health care approach in the conventional Canadian health care system.

The strategy behind the provincially-run CHCs was to increase community participation in the delivery of health care, to increase the use of outpatient services in the hospitals and to reduce overall expenditures on health care, without reducing the level of health care provided. In fact, proponents of the CHC program were confident that the centres would result in a net increase in health care delivery, both in terms of quantity and in terms of quality of service (Hastings, 1972; O'richlon, 1976:64).

In 1972, under the direction of Dr. J.E.F. Hastings, the federal Liberal government established a Community Health Care Project to examine the long term prospects for community health centres in Canada. The Hastings Committee failed, however, to clarify the CHC concept or to make concrete recommendations for its consistent implementation across Canada (Fsalitis, 1982b:153). Six years later, in 1978, Hastings reviewed the impact that his 1972 report had had on the development of CHCs in Canada. His conclusion, "Neither sweet, nor sour," underlined the overriding ambiguity of Canadians toward the CHC concept and foreshadowed their ultimate resistance to it (ibid:153).

The limited and largely unsuccessful experience of CHC in Canada, and in particular in Quebec where it showed the most promise initially, has served to underline the severe obstacles to the linking of health and social services in

Canada, in an effort to increase holistic, preventive health care for Canadians. According to Tsaltiris, no comprehensive evaluation of the CHC initiatives has yet been attempted in any province. However, the limited studies that have been carried out in Saskatchewan, Ontario and Quebec identify three major problems with the past and existing approaches to CHCs.

First, the absence of well thought out federal or provincial guidelines for CHCs has led to widespread confusion over terminology. This confusion has hindered the development, coordination and responsiveness of CHC initiatives everywhere, led to poor linkages between CHCs and conventional care institutions and encouraged the persistence of conventional approaches to health care delivery in the CHCs, without contributing to an overall reduction in the cost of health care services in Canada (Tsaltiris, 1987b:153-4).

Second, CHCs have failed to attract significant popular support from the public. This appears to be due to a number of factors, including: (a) the persistence of continued government support for conventional care institutions; (b) the fact that, because CHCs focus on the delivery of technologically simple, preventive health care measures to the poor, they are commonly associated with "second rate" care (in an era of universal "free" health services, many

people prefer hospital emergency wards to the CHCs); and, (d) CHCs faced severe and persistent organizational and financial problems in linking health and social services between relevant provincial departments (Ibid.:151-153; Crichton, 1975 and 1976:64).

Third, the CHC concept drew opposition from the medical profession and, in particular, from the many medical practitioners who associate CHCs with low pay, relative social and professional isolation, a lack of professional independence (as CHC staff work in a team environment), and a holistic approach to medicine with which many doctors are apparently uncomfortable (Isalitis, 1982b:151, Crichton, 1975:10).

Canada's experience with community health care centres serves to underline the tremendous resistance that exists in this country with regard to preventive care initiatives, despite official government rhetoric to the contrary. Any political commitment to the preventive approach to health and health care delivery that may exist within the minds of federal and provincial policy-makers has been seriously undermined by other forces. The pervasiveness of the conventional medical culture in Canada, which precludes a serious government commitment to the PHC recommendations of Alma Ata, has been widely attributed to two essential factors: (a) The overwhelming political

influence of the medical profession and related industries; and (b) to a popular technological bias among Canadians in general.

The Medical Lobby: With respect to the power of the medical lobby, Evans (1987), Crichton (1976), Ehrenreich (1978), Isalitis (1980:102) and Illich (1974:41) contend that the conventional curative orientation of modern health care systems such as Canada's is due to the overwhelming ability of the medical profession and health-related industries to influence government decisions concerning health and health care delivery to suit their own specific interests. Isalitis has appropriately termed this phenomenon the "medical industrial complex" (1980: 102).

In Canada, medical training, professional examinations, work environments, medical equipment and advances in medical technology are all biased toward conventional, western-style medical care which emphasizes curative rather than preventive health care. Collectively, the medical profession represents a cohesive, highly educated, well-informed, resourceful and socially-revered group upon which the general public feels a sense of dependence (Ehrenreich, 1978: 14). As a result, the medical profession has traditionally constituted an extremely powerful political lobby group in Canada.

What is more, the medical profession's fundamentally curative-focus is widely shared by other important lobby

groups in Canada such as multinational drug companies, hospital associations and manufacturers of medical equipment. There is much evidence to support the view that these powerful interest groups are instrumental in encouraging all levels of government in Canada to support hospital-based curative care, which lines their respective pockets, rather than long-term, community-oriented preventive care which is potentially far less lucrative.

As mentioned in Chapter IV, effective preventive care strategies require an on-going, long term political commitment that lasts much longer than most democratically elected governments do. In fact, attempts to expand preventive care strategies at the expense of curative care growth risk drawing severe opposition from the medical profession, unions, and industrialists. Clearly, in a technologically advanced, capitalistic and "democratic" society as Canada, it is generally politically asinine, if otherwise questionable, for the government of the day to seek short-term political gains through the far less controversial support of acute care institutions and research.

The Technological Bias: The argument favouring technological bias is supported by authors such as: Weller (1980:409, 415-15), Tsaiilis (1980:97, 102), Ehrenreich (1978:12), Mechanic (1975:62) and Illich (1974:3). Each of these authors support the view that modern western health

systems such as the one that exists in Canada today, reflect a general western preference for technological innovation and advancement. Canadians are, so to speak, fascinated with new technology. As members of a wealthy, technologically advanced nation, Canadians strive to assert their individual right to the "best" health care available which, in their eyes, generally means the latest and most expensive available (Evans, 1982:138; Weller, 1980:414-15).

Canadians lend their support to the curative "ideology" of the medical profession in financing new and expensive technological advances in diagnosis, treatment and research in the apparent belief that new advances in medical technology necessarily lead to "better health". Apart from the fallacy of equating good health with physical well-being, this emphasis on technology ignores the harm that modern medicine is causing in its insatiable consumption of resources and in the distortions it creates in the health care delivery system. More medical technology means more medical specialists, technicians, laboratories, equipment and the like. Thus fewer resources, including general practitioners and money, are available for alternative methods of health care delivery (Flhrenreich, 1978:12).

Ulrich expands on this theme radically by asserting that, in fact, modern medicine has long passed beyond any useful function and may in fact be destructive (1974: 51,56).

Illich's argument is that modern, curative style medicine creates all sorts of artificial dependencies, illusions and even stress without actually improving the individual's health. Moreover, Illich contends, modern medical care is often used as a form of social control by the dominant members of society (*ibid.*: 41; cf. Navarro, 1978:183-84, 194-95).

Finally, conventional medical wisdom is rooted in what Renaud has called "the specific etiology of disease." According to Renaud, modern medicine has adopted an "engineering" approach to health and health care whereby each disease or illness is deemed to have a specific direct cause that can be isolated and rectified, given the appropriate medical technology (in Ehrenreich, 1978:108). Thus, rather than dealing with the whole person in his given socio-economic environment, modern medicine seeks technological solutions to problems with specific parts of the individual, in isolation from the individual's environment. Adherence to the rule, "if it's broken, fix it," has led the public, politicians and health professionals in Canada to pay progressively less attention to the relevant socio-economic determinants of poor health (Navarro, 1978).

Developments in Canada since the 1940s have demonstrated the extent to which all levels of government in the country prefer to give their support to advancing medical

technology rather than to preventing instances of ill health. Perhaps Canadians are unduly influenced in this regard by the United States, where a similar technological bias prevails (Evans, 1982). Perhaps, here again, it is the influence of powerful lobbies who have a direct financial interest in the continued development and use of medical technology that have prevailed. In any case, the technological bias inherent in Canadian medical care continues to impede the expansion of PHC in the country.

The Nature of the Capitalist State in Canada

Recently, several authors have suggested that impediments to comprehensive change in Canada's health care policies from an acute care to a preventive care emphasis are not fundamentally due to such problems as the relative power of the medical lobby, the political efficacy of supporting modern technology, or the problems of provincial-federal fiscal relations. Rather, these authors argue from a Marxist standpoint that the principal problem with Canada's curative care orientation lies in the capitalist priorities of the state in such industrialized societies as Canada (Navarro, 1976b:443-44; 1978; Chronreich, 1978). The argument is an interesting one and merits examination. However, because of its highly critical and defeatist line of reasoning, it adds little in the way of practical alternatives to the status quo. For this reason, it is presented here only as a matter

of interest and to demonstrate that the author is aware of structuralist alternatives to the functionalist approach taken in this paper.

A good example of the marxist-structuralist view is provided by Navarro who criticizes the Alma Ata Declaration for adopting a philosophic view that is compatible with the capitalistic view held by the "hegemonic development establishments of the Western world" (1984: 467). Navarro argues that the Declaration was adopted by representatives of the same social class who have it in their interest to develop policy by determining (a) what is presented; (b) what is not presented; and (c) how it is presented (ibid.:470). It is Navarro's contention that virtually all International Declarations such as the Alma Ata Declaration represent nothing more than empirical and functionalist positions which are couched in technical terms so as to appear "apolitical" and factual. At the same time, alternate positions are repressed or even excluded as being non-technical and wholly political (ibid.:470).

Navarro's concern is that the formula for implementing PHC proposed in the Alma Ata Declaration will not work because it is based on what he terms "a theoretical pragmatism" or "empiricism": An analysis of variables without reference to their structural relationships. Thus to list areas of change that need to be addressed in order to

improve a community's health such as sanitation, transportation, education and administration, completely avoids the main issue which is the need to redefine power relations within the structure of society (p.47.). Health is a profoundly political issue and the Alma Ata is a political document designed to serve the interests of the dominant classes.

The marxists continue, arguing that evidence that structural problems with regard to health care organization in capitalistic societies such as Canada lie far beyond the realm of "tinkering with the system" is provided by the relative ineffectiveness of what appear to be straightforward federal and regional initiatives to alter the status quo in favour of primary health care strategies (Isalitis, 1982a:155). Federal and provincial governments in Canada in recent years have repeatedly acknowledged the serious organizational shortcomings of their current health care delivery systems and yet they have been unable to do anything about it.

In 1964, for example, the federal government's "enlightened view" of health care in Canada was outlined by the Royal Commission on Health Services which defined "comprehensive care" as the provision of "all health services, preventive, diagnostic, curative and rehabilitative." In fact, however, the resultant Health Care

Services Act limited itself to medically required services and constituted little more than a fiscal measure ensuring federal payments to support the inherently curative-bias of existing provincial health care programs (Fisahlis, 1982b: 154).

A second example is provided by the federal government's release in 1974 of its controversial health policy, A New Perspective on the Health of Canadians, often referred to as the Lalonde Report after the then Liberal Minister of Health. The report attracted much attention in Canada in underlining the significant flaws to be found in Canada's current system of health care delivery. The report suggested that further substantial improvements in health care for Canadians would not be brought about through the development of new medical technology. In fact, Lalonde concluded, the overall health of Canadians could best be improved through modifications in social organization and in personal conduct (Lalonde, 1974:126, *passim*).

Among the proposed interventions in social organization that Lalonde suggested might be beneficial with respect to health were stricter controls on environmental pollution, action to reduce occupational hazards, and attempts to improve traffic safety. However, having identified the need for substantive social reorganization in the interest of better health, Lalonde then admitted that, given the

extremely high levels of expenditures on conventional medical care to which the federal government was firmly committed, the prospects for serious government intervention into those new areas would severely limited (Lalonde: 1974).

Instead, the report encouraged Canadians to adopt new "healthy lifestyles" on the dubious assumptions that, even in the wake of an exploitive market, individuals have strong control over their behavior and, that by modifying their lifestyles, Canadians can avoid or resolve the widespread problem of poor health (Isaiah, 1980:99; cf. Navarro, 1978:206). Accordingly, over the past decade, the federal government and provincial governments have tended to emphasize lifestyle modification while relatively little has been done to remove the far more serious and pervasive socio-economic causes of disease and illness in Canada's modern industrialized society, over which the individual has very little control (Isaiah, 1980: 99; Isaiah and Manga, 1987: 10).

Crichton criticized the New Perspective for its complete disregard for the recommendations made by Haslings in 1972, favouring the establishment of community health centres with its integrated team approach. By stressing the individual's responsibility for his own health, Crichton argued that Lalonde had weally adopted a policy alternative that did not challenge the vested interests of the powerful medical lobby

(Crichton in Coburn et al., 1981).

The community health care centers' attempts to expand PHC initiatives in both Native and non-Native Canadian communities serve as further examples of the Canadian state's inability to fundamentally alter the existing curative health care system. Marxist writers, in particular, have used the above examples, along with similar examples to be found in other western, industrialized societies to indicate that the health care initiatives undertaken by the state in these societies are fundamentally determined by the capitalist nature of the state (Navarro, 1978).

Because the Canadian state is capitalistic, all activities within the state will ultimately contribute to the long term process of capital accumulation by the state (Renaud in Ehrenreich, 1978:101-102). The health care system in Canada has a curative basis precisely because, the marxists argue, such a health care system contributes directly to the long term process of capital accumulation (*ibid.*:102). As modern medical care is extremely sophisticated, it requires extremely skilled professionals, large medical staffs, buildings, new technology and extensive inputs of capital equipment, all of which leads to a further accumulation and concentration of capital. The expansion of less sophisticated primary health care initiatives, on the other hand, is less likely to add to capital accumulation and

is therefore neglected.

In addition, Renaud has argued that by reducing health care to the engineering paradigm, discussed above, modern medicine has succeeded in "commodifying" the health needs of the individual. Thus, the individual is led to seek relief from disease and illness by purchasing it from his physician, drug companies and other health-related industries. This too contributes directly to the process of capital accumulation (Renaud in Ehrenreich, 1978:108-9).

Finally, the curative health care system serves a "legitimizing" function in the capitalist state. Navarro is particularly adamant about this function of the curative health care system. He argues that it is the nature of the class struggle between the bourgeoisie (of which the medical profession is a part) and the proletariat that has led to the development of medicine's curative orientation in modern capitalist societies. Because the conditions that create disease and illness in capitalist, industrialized societies, are inseparable from the processes that lead to capital accumulation (industrialization through the exploitation of labor) curative medicine does not seek to "solve or cure" these problems. Rather, Navarro asserts, it seeks simply to "ameliorate and take care of" the problems as they occur and only to the extent that is absolutely necessary to appease the masses (Navarro, 1978:195-97).

This chapter has reviewed the contradiction that exists between the needs of Canada's Indian peoples, the federal government's explicit recognition of the value of "community based", holistic health care in Indian communities, and the virtual failure of the government to turn official policy into reality. In the second third of the chapter, other federally supported primary health type initiatives were examined in an attempt to demonstrate that the Canadian government is effectively unable to incorporate a comprehensive primary health care aspect in the existing health system (Newell in Fry, 1980:217).

In the final part of this chapter, it was argued that the Canadian government lacks a strong political commitment to primary health care in this country and four reasons for this lack of commitment were discussed: (a) the relative weakness of the Indian political lobby; (b) the slow development of national/Native health care policies; (c) the Canadian historico-medical society; and, perhaps, (d) the nature of the capitalist state.

Poor government support of PHC in Canada, in general, has severely undermined all PHC-type initiatives in Indian communities. Without federal support there has been little improved interministerial coordination and cooperation, weak linkages between the health care services of the Indian peoples and provincial health care systems, inadequate

financing and very little community participation in the development and control of PHC.

In the following chapter, an alternative method of expanding PHC in Canada's Indian communities will be examined.

CHAPTER VI: THE IMPLEMENTATION OF INDIAN-LED PHC

If PHC would be good for Canada's Indian peoples, and the government is unable to implement it properly, then the Indians should be given the opportunity to pursue PHC themselves.

It is argued in this chapter that Canada's Native peoples are far more likely than non-Natives to succeed in establishing working PHC in Indian communities. It is argued further that because Native-led PHC has a good chance of success, it should be supported by the federal government. The chapter concludes with the assertion that even with government support, Native-led PHC can only be effective to the extent that governments are prepared to permit greater Native autonomy.

In Chapter V, the lack of political commitment on the part of the federal government in support of PHC initiatives in Indian communities was identified as the root cause for the virtual failure of these initiatives. Whether this poor commitment is due to internal problems such as the relative weakness of the Indian political lobby, the ad hoc development of federal-provincial health care planning, and the curative bias of Canadians, or to systemic factors, such as the nature of the capitalist state in Canada which favours conventional medical practices, the devolution of responsibility for PHC initiatives from the state to the

Indian people in Canada promises to provide a solution to each of these problems. Furthermore, in overcoming the problem of poor government support of PHC, Indian-led PHC initiatives hold good promise for ensuring the three key prerequisites for successful PHC are fulfilled: knowledge of community health needs; linkages established between health care services and other sectors; and, active community participation.

Although the Indian lobby is relatively weak, the Canadian government could gain significant political points if it were to succeed in securing effective health care in Indian communities without seriously upsetting the status quo. The government must at least be seen to be doing something to address the problem of poor Indian health, if only to satisfy the collective conscience of the members of the dominant society (Ponting, 1985).

The position taken in this thesis is that, if Ottawa were to allow the Indians to adopt and control a health care strategy based on PHC in their respective communities, it would not take a great financial or political risk. If administrative, financial and organizational change were kept minimal, much of the existing Indian health care could remain in tact as the secondary and tertiary aspects of the health care services. The onus would be placed on the Indian communities to get their people involved in developing health

care initiatives based on FHC.

Second, the fact that the federal and provincial governments continue to be at odds with regard to how the country's health care services should be organized and financed remains an on-going problem for the Indians. Ottawa would like to see the provinces assume greater responsibility for the Indians; principally because of the high cost and administrative difficulties associated with administering Indian affairs. The provinces and the Indians, however, are opposed to such a development. While the provinces would like to have legal jurisdiction over Indian lands and resources, they are wary of the possible long term fiscal and political implications of assuming additional responsibility for the Indians. The Indians, for their part are opposed to the federal government transferring its responsibility for Indians to the provinces because they fear that provincial control would lead ultimately to assimilation (Boldt, 1988:10).

The point here is that if the federal government is no longer interested in supporting the Indians and the provinces are unprepared to, then the Indians should be granted greater responsibility for themselves. In fact, this is exactly what is occurring, though at a relatively slow pace and to a very limited degree (Ibid.:10). Accordingly, the establishment of FHC initiatives has not been precluded by the historical

development of Canadian health care services, they have simply been neglected by the governments responsible. In Native communities, the federal-provincial conflict only interferes with the development of PHC to the extent to which the federal or the provincial governments, who have other priorities, are responsible for the development of these initiatives.

Third, the preference Canadians have for modern medical services that are predominately hospital based and supported by very sophisticated equipment and specialized practitioners does not preclude the development of less conventional health care services by Canadian Indians in their own communities. While far from untouched by modern Canadian society, Canada's Indian peoples remain, in many respects and to varying degrees, faithful to their indigenous, cultural and religious beliefs. As was discussed in Chapter IV, the Canadian historico-medical culture which is grounded in western liberal tradition of competition and priority of the individual is far removed from the indigenous, "holistic" medical culture of the Canadian Indian.

Thus, philosophically at least, it is reasonable to assume that, given a choice, the Canadian Indians would be far more accepting of a health care strategy based on PHC, which stresses the individual's responsibility to the good of the whole community, than would a non-Native. The

Canadian Indian is far less likely to be attracted by the draw of modern expensive medicine that more often than not requires he be removed from his community, placed in an institution, treated by a stranger who does not speak his language and treated in a way that is foreign to him. Then he would be to accept a "home-grown", community-based health care strategy that is multi sectoral, immediate, culturally and technologically appropriate and consistent with his religious practices and common sense.

It is also true, from a philosophical point of view, that PHC strategies can be successful in Indian communities, if run by the Indians, notwithstanding the capitalist nature of the Canadian state. PHC is basically a socialist health care strategy in the sense that it is dependent on community participation, cooperation, equality and simplicity rather than on competition, technological advances, exploitation and scarcity. Thus, according to the Marxist arguments discussed in the previous chapter, in a capitalist state such as Canada, the government cannot be expected to support the PHC approach at the expense of conventional health care strategies.

It would seem to follow that, as participants in the capitalist state, the Indians too are destined to pursue conventional health care strategies that contribute to the process of capitalist accumulation, whether they are

independent or not. It is in fact, however, reasonable to conclude that if the Indians were autonomous, their adoption of egalitarian "socialist" PHC might in fact be consistent with the aims of the capitalistic state. If, through the successful application of PHC, Indian communities were to become productive and self-sufficient Indians, would become producers and consumers of capital, rather than the "burden" they are at present. Increased consumption, increased innovation and linkages between the "periphery" (Native communities) and the "center" (the dominant society) will occur faster with PHC (cf. Dalesley; cf. Navarro, 1984:471).

According to this line of argument, the Canadian government as the agent of the state is unlikely to pursue PHC at the expense of capitalist accumulation through the promotion of conventional health care services, but it would logically allow an independent group to pursue initiatives that lead ultimately to the further accumulation of capital. The government would still have to support the Indian initiatives financially, but it would not have to plan from a centralized position strategies that are basically incompatible with its capitalist bias.

Finally, it should be kept in mind that not only would Indian-led PHC initiatives resolve the paralysis of the Canadian state in implementing effective PHC, but this would

be highly consistent with the principles set down in the Alma Ata Declaration. The Declaration states that:

Primary health care requires and promotes maximum community and individual self reliance and participation in the planning, organization, operation and control of primary health care. (WHO, 1978: 1).

Therefore, in supporting the development of Indian-led PHC the Government of Canada would set an exemplary international example, both in terms of its commitment to international declarations, which have no legal force, and in terms of its treatment of its country's Aboriginal peoples. This would represent a significant achievement for any Canadian government.

An argument in favour of permitting the Indians to develop, implement and control their own PHC initiatives has been made (cf. Penner, 1985:33-35; Berger, 1980:5-6, 118, 1970: passim). Fundamental to this argument, however, is the requirement that Canada's Indian people be far more autonomous. Without a far greater degree of political, administrative, economic and legal autonomy the Indians' attempts to pursue meaningful PHC will be thwarted from the start. Thus PHC necessitates the realization of a fundamental alteration to the existing political, legal and fiscal relationships between the Native peoples and government of Canada. It is necessary then to examine the recent Indian struggle for autonomy within Canada in order to

assess the degree of autonomy required to permit the realistic adoption of PHC in Native societies.

PHC and Native Autonomy

The leaders of various Native groups across Canada have argued for years that their people have an inherent right to govern themselves on the land they occupy. Their argument is founded in the facts discussed in chapter two of this paper: for thousands of years prior to the European arrival in North America Canada's Aboriginal peoples had been autonomous and self-reliant. Moreover, in all the years that the Native peoples have dealt with non-Natives relatively few have ceded those original rights. Those that have are, for the most part protected by treaties, which the Canadian government has largely failed to honour.

The Native leaders claim to their right to Aboriginal title (i.e. their right to the land they occupy) is generally recognized in Canadian common law. In fact even the Royal Proclamation of 1763 acknowledged implicitly the Native peoples' possession of Aboriginal title (Penner, 1985: 39; TRCOP, 1985: 7-8; Elliot in Morse, 1985:48-121; McInnes, 1981: 52). The Natives' claim to Aboriginal title has been reaffirmed in the Canadian courts, most notably in *Calder vs the Attorney General of British Columbia*, 1973, discussed in Chapter III. In that decision, the majority decision of the Supreme Court supported the Nishga Indian band's contention

that the Aboriginal title they held prior to British Columbia's entry into confederation had not been abrogated despite the province's unilateral declaration to the contrary (Morris, 1985: 61-2; Berger, 1981:chapter 8).

Moreover, as a direct result of the Calder decision and subsequent legal and political decisions, Ottawa's endeavour to settle comprehensive land claims with Indian groups reveals the government's explicit recognition of Aboriginal claim to Aboriginal title. This is illustrated in the texts of all three comprehensive land claims that have been concluded wherein the government required the Native groups party to the comprehensive claims agreement to "extinguish all Native claims, rights, title of all Indians and Inuit in and to the territory" (JBNV Agreement, 1976:15 - cited in TFRCOP, 1985: 39). This blanket extinguishment of all rights by the crown through a legislated clause would be unnecessary if not for the existence of Aboriginal title (TFRCOP, 1985:39; Elliot in Morse, 1985:61-70; McInnes, 1981: 56-7).

Accordingly, upon repatriation of the Canadian constitution in 1982, the Canadian government acknowledged the existence of "Aboriginal rights" based on Aboriginal title and entrenched them in the constitution (Section 35). While these rights can now be said to exist uncontested, they are as yet undefined.

In accordance with provisions made in the Canada Act,

1982, four constitutional conferences on Aboriginal rights were held from 1983 to 1987. The conferences were attended by Native leaders from the Assembly of Nations, the Inuit Committee on National Issues (speaking on behalf of the Inuit Iparisat of Canada General Meeting), the Métis, Non-Status Constitutional Review Commission (MNSCRC) and the Native Council of Canada, and by representatives from the federal government, nine provincial governments, the Yukon and the Northwest Territories. The objective at the conferences was to reach a mutually acceptable definition of Aboriginal rights. Foremost among the "rights" to be defined was the Natives' "right" to self-government.

Native leaders contend that their peoples' existing Aboriginal title implies an existing right to self-government. In owning the land, i.e. having title to it, the Indian argument follows that the Indian people have an inherent right to govern themselves (Lyon, 1984:5). They argue, therefore, that this inalienable right to self-government should be entrenched under clause 36A of the Canada Act 1982.

The Canadian government on the other hand has argued that the existence of Aboriginal title does not imply the existence of an inherent right to self-government. Ottawa's position is that Canada's Native peoples do not possess an inherent right to self-government, but rather a qualified or

conditional right that remains to be defined. Any provision the government may make to allow the Indians to govern themselves will be legislated through an act of parliament clearly defined, limited and subject to change (Canada, 1984: 1-7).

The constitutional negotiations climaxed at the constitutional conference on Aboriginal self-government in Ottawa, March 26-27, 1987 without resolving the issue of Indian self-government (Speci, 1987:155; Globe & Mail, March 28, 1987:1; Canada, 1984: passim).

Ideally, the federal government would rather not have to deal with the Native peoples as "citizens plus". Ottawa would prefer to provide the Indians with the same rights and privileges as all other Canadians, without affording them any special rights. The dilemma for Ottawa stems from the fact that Canadian law, politics, culture, history and even economics recognizes the individual and collective specificity of all Native peoples. Thus, negotiations with the Native Canadians over land rights, treaties and autonomy will proceed.

Recently negotiations between Ottawa, the provinces and a variety of Native groups have occurred on a band by band basis. To date a variety of settlements have been reached, most notably, the Sechelt Indian Band Self-Government Act, March 15, 1986. Under the Sechelt Act, the Sechelt

Indians have formally extinguished their implied aboriginal rights in exchange for new, or at least, better defined rights under Canadian law. Given the constitutional stalemate and the fact that most Indians are desperate to change the status quo, it is likely that many will go the way of the Sechells and negotiate their right to govern themselves with the governments concerned. Critics of this process suggest that it amounts to a little more than a poorly disguised "divide and conquer" tactic. According to such critics as Ponting, Ottawa's objective is to undermine Indian unity, and thereby bargaining power, by forcing each Indian band to negotiate a legislated definition of its rights individually. By proceeding cautiously and on a one to one basis with the bands, Ottawa may ultimately succeed in compelling many bands to settle for relatively limited and clearly defined "Aboriginal rights" (cf. Ponting, 1985).

In addition to the obvious political and economic ramifications this might have, the need to define and respect the Native peoples' constitutional "Aboriginal rights" constitutes a tremendous philosophical dilemma for Ottawa. Ottawa must now reconcile its legal obligation to define the Aboriginal rights of Native Canadians in the constitution with its long standing imperative of national legal parity.

This dilemma is manifested in Ottawa's tendency to attempt to finalize "forever" its legal arrangements with

Native groups, such that issues such as "special right " for Indians will ultimately be put to rest (HRCOJ, 1984:5-6). If Ottawa is able to satisfy the Native groups without sacrificing too much, then it may accept and legislate their right to be distinct to a precise degree, without future compromises to national equality. There is, however, a fundamental flaw in Ottawa's line of reasoning. As long as there are Native Canadians, Ottawa will be forced to deal with them as such regardless of whether or not their concerns have already been addressed in a previous agreement or treaty. In spite of Ottawa's efforts to minimize it, therefore, the equality-specificity dilemma with respect to Canada's Native peoples and the dominant society will continue unabated.

CHAPTER VII: IMPEDIMENTS TO INDIAN-LED PHC

This paper is based on a relatively simple argument: Canada's Indian people have poor health despite existing health care initiatives. The Canadian-endorsed, internationally acknowledged primary health care strategy is practically and philosophically suited to the needs of Canadian Indians. Evidence suggests that the Canadian government cannot implement PHC effectively in Indian communities, so it follows that the Indians should adopt it themselves. In order to create the conditions under which Indian communities can adopt PHC the Indian people must have greater autonomy. Currently, discussions are underway between the federal government, provincial governments and numerous Indian groups toward the increase of Indian autonomy.

There is however, a fundamental flaw in the assumptions made regarding the link between PHC in Indian communities and Indian autonomy. For while PHC requires Indian autonomy, Indian autonomy by no means implies an adoption of the PHC approach. As obvious as this statement is, its significance is critical to the value of the thesis' proposition that PHC is the appropriate health care strategy for Canada's Indian populations.

Canada's Native peoples exist in a legacy of colonialism that has plagued them since the arrival of Europeans in

Canada some 350 years ago. Today, despite their increased political might, the entrenchment of their yet to-be-defined rights in the constitution, large comprehensive land claims settlements, improved transportation and communications facilities and other developments ostensibly in the interest of the Native peoples, Native Canadians continue to be impoverished, malnourished, undereducated, isolated, politically divided, largely destitute and in many cases highly distrustful of the dominant society (Ponting, 1985: Introduction)..

To the extent that devolution in the area of health and related sectors does continue, there is little reason to assume, a priori, that Indian leaders will necessarily adopt PHC strategies as a means to resolving their communities' fundamental social problems. To date, PHC represents little more than a philosophical ideal that may prove extremely difficult to coordinate and relatively slow to develop. Furthermore, PHC in its proposed format is fundamentally a concept that has been developed by the dominant society (Navarro, 1984:471) which we may ask the Indian to adopt because he has little alternative.

It is too soon to tell what the nature and extent of the devolution of federal programs to Indian communities will be. Given that the devolution process is in fact proceeding, however, it is necessary to examine the prospects for moving

"autonomous" Indians adopt PHC strategies in their respective communities.

In this chapter five major impediments to the establishment of Indian led PHC initiatives are identified. Each impediment is analysed both in terms of how it may interfere with the PHC process and in terms of what the Indian people must do to overcome them. The purpose of this final chapter is not to suggest concrete solutions to as yet unresolved problems, but rather, to provide a useful discussion of some of the important issues to be considered. Finally, it should be kept in mind that while Native Canadians have many additional obstacles to realizing productive independence, the discussion here is restricted to the issue of PHC.

To suggest emancipated, or partially emancipated Indian communities will automatically adopt development policies founded on PHC, is to suggest they have no other choice. The assumption is naive and inaccurate. In fact, there are several compelling reasons for concluding that leaders of increasingly autonomous native communities will not embrace PHC.

Conventional Care Bias: Second Rate Care

Perhaps the single greatest barrier to the adoption of a comprehensive PHC strategy by autonomous Indian communities, is that many Indians will tend to view PHC as constituting

"second rate care" (cf. Fendall, 1972:109). Whereas a Canadian living in Calgary or Toronto can generally have his illness promptly attended to by highly educated specialists at a variety of state-of-the-art hospitals with relatively little difficulty, proponents of PHC suggest that the less fortunate members of society should be content to have their needs attended to by a local amateur in a local clinic with limited supplies or medical expertise. Only once this "primary" step has been taken and failed does the less fortunate patient then obtain access to "proper" medical facilities and medical personnel.

Clearly, on the face of it, this type of "second rate care" will be unacceptable to the members of any Native community, many of whom have come to measure "progress" and "success" in terms of values held by the dominant society, including "modern" health care (Speck, 1987:212). For this reason, PHC initiatives must be viewed in their entirety as a complete development strategy based on the principles of equitable distribution and resource maximization.

As Bennett points out, PHC is not an inferior type of care that is to be "tacked" on to the existing national health care services, but rather, it is "the essential of the system for improvement of health towards which other levels of care are oriented" (1979:510).

The proposition that PHC constitutes "second rate care"

suggests that an expansion of conventional "first rate care" is more desirable than the establishment of PHC initiatives. The fallacy of this line of argument has been clearly demonstrated in this paper: The expansion of conventional care, which has been occurring in Native communities for decades, offers no solution to the Natives' current social and economic plight whereas PHC does.

If PHC initiatives are to be pursued by Indian leaders in their respective communities, then they must be convinced of the fact that PHC does not seek to replace hospitals with clinics or doctors with health auxiliaries, but rather, PHC seeks to address health-related problems that are ultimately distinct from the sorts of health problems treated by physicians in large hospitals. Accordingly, the hospitals, doctors and many other aspects of the existing conventional health services remain integral to the overall health status of the community. This is why it is necessary to distinguish between primary, secondary and tertiary levels of health care both within and between communities. At present, however, the health problems of Indians that are addressed at the secondary and tertiary levels of care are all too often due directly to the absence of good PHC services at the community level.

Equally important, the success of PHC initiatives in Indian communities will depend on the effectiveness with

which Indian leaders can communicate their rationale in supporting such initiatives to the members of their respective communities and convince them that PHC is in their individual and collective best interest.

Conventional Bias: The Dominant Society

The current, popular bias favouring conventional care services over PHC initiatives in Canada highlights a second difficulty for Indian leaders who seek to pursue PHC initiatives at home.

As of yet, Indian communities have not established the bureaucratic structures necessary to properly administer all their respective affairs in the absence of the federal government. While these might be developed in Indian communities relatively quickly, Indians will continue to depend to varying degrees on the support of members of the dominant society for the resources and expertise required of any bureaucracy. With respect to the implementation of PHC initiatives, this support will involve the formidable task of convincing the members of the dominant society, who have traditionally viewed it to be in their interests to support conventional health care practices, of the value of Indian PHC initiatives. Even once the Indians have established their own bureaucratic structures sufficient to administer their PHC programs and policies, including trained health manpower, Indian communities will continue to remain

dependent on the support of the dominant society to maintain inter-sectoral linkages and financing (Bennett, 1979:510). This potentially difficult problem when Indians decide they want to do something the non-Indians don't want them to do.

However, this dilemma is by no means restricted to the field of health. Indeed, if ever Native groups do achieve a meaningful degree of autonomy, there will likely be conflicts with the dominant society regarding many issues over which jurisdiction is shared with other Canadians. This question of conflicting jurisdiction which can only be partly anticipated is, perhaps, one of the greatest obstacles to Native autonomy to be overcome.

Lack of a Model

The third major difficulty Indian leaders can expect to confront if they pursue the development of a local health care service based on PHC is the absence of a pre-existing model, or framework that might assist them. Although various PHC initiatives have been pursued in countries throughout the world for decades (Navarro, 1984:470; Chaves, 1980:74 in Bullock) each national experience has been vastly different from the other (Fendell, 1972:297). The practical, political, cultural, philosophical, legal and economic situation of Canada's Native peoples is unique. Accordingly, the PHC strategies they develop need also be

unique in order that they be suited to their respective communities' needs, resources, and objectives. Thus, while the essential principles of PHC should remain in tact, its application should not follow a predetermined pattern based on the experiences of one other country. (Ibid:297).

The absence of PHC "blueprints" is a disadvantage, but realistically, the same disadvantage exists in all countries that attempt to structure health care services founded on the principals of PHC. It should not therefore, be regarded so much as a hindrance to success as an opportunity for creative solutions.

Other Priorities

In many instances, it is highly probable that Native leaders of future Indian communities, autonomous or otherwise, will have priorities to attend to other than health. As was mentioned in chapter four, many people have traditionally regarded poor health as symptomatic of other problems in society, primarily economic, that must be addressed first. A new political leader must act quickly and effectively if he is to retain the support of his followers. Moreover, the more influential members of a society, who often do not suffer themselves from poor health, may hold a more traditional economic view of development in which economic development should proceed first as it leads ultimately to social development (Gudaro, 1987). Healthier

leaders do not need IHC, what they need is power, influence and prosperity. Even the most sincere may, therefore, send objectives that are very different from those proposed in this paper.

As modern economic theorists point out, however, the dismal development experiences of many LDCs since the 1960s, have demonstrated that the classical economic models that placed economic growth before social development generally failed to improve the overall social and economic condition of the country (Odaro, 1985:chapter 1). Just as those experiences have demonstrated the imperative of the multi sectoral approach to development, intelligent and committed Native leaders will recognize and respect the need to incorporate effective and affordable health care initiatives, such as those afforded by IHC, in their overall development plans.

Financial

Autonomous Indian communities will vary with respect to the extent of their economic viability. This will be related to a number of factors ranging from the extent to which natural resources may be available for exploitation and how adept a given community is at exploiting them, to alternative fiscal arrangements that may be made with the federal and/or provincial governments.

Political independence, or autonomy, by no means guarantees economic freedom. The extent to which an Indian community is able to pursue its policy of PHC, or any other policy, will ultimately depend on the degree to which it is assured of financial viability. This topic has been dealt with extensively elsewhere (Fonting, 1986:194-210; MacIe in Fonting, 1986:211-227; Hawkes, 1984; Blum, 1986) but with respect to PHC it involves a particular problem. The federal government is at present officially seeking to devolve itself of much of its responsibilities for Indian health services (Sperl, 1987: 12; Penner, 1987: 5; Boldt, 1988:10; personal conversation with MSB).

Accordingly, Native communities that wish to pursue PHC strategies must be given broad licence to use their resources as they see fit, including those from the federal government. If the federal government allocates a certain sum of money to a given Indian community for "health care", it is clear to see where conflict will arise if that Indian community chooses to spend the money on a road to its local dispensary, or on housing, sewage or speed bumps. Because "health" is such a nebulous and broad subject, proponents of the PHC strategy have a very different interpretation of what constitutes health expenditures than do most people in modern Canadian society. In the current climate of devolution it is not at all clear if Ottawa will be sensitive

to the multi-sectoral nature of primary health care.

In this chapter five factors have been identified as major obstacles to the development of effective PHC initiatives by Indian leaders in their respective, autonomous, communities. Foremost among these is the popular bias in Canada that favours the conventional health care services to a less sophisticated, less modern one. It is this bias that may lead the Indians themselves to view PHC as "second rate care" or that may alienate members of the dominant society and thereby doleline Indian led PHC initiatives to failure.

Second, because Indian communities have to date been severely repressed by the federal government few have developed the bureaucratic structures or experience required to design, implement and sustain any effective PHC initiatives. Third, the Indians will be forced to pursue PHC without recourse to a format or guidelines developed elsewhere: there are no examples, no shortcuts. Fourth, PHC will be neglected by those Native leaders who have other political priorities. Fifth, PHC will be extremely dependent on the good will of Ottawa to finance multi sectoral, long term initiatives according to a Native timetable.

This pessimistic summary of the impact to PHC in Indian communities ignores the three key rationales behind proposing it in the first place: (1) It holds great promise as a mean-

of improving the health status of Indians; (2) the Canadian government has endorsed Alma Ata; and, (3) PHC is philosophically compatible with indigenous Indian values and philosophy. Despite the various problems highlighted here, if the Indians want PHC, they will get it if they are autonomous.

It is important to consider what Ponting has referred to as the "social vitality" of autonomy (self-government) of the Indian. His contention is that as the status quo is unacceptable, Indians should adopt self-government and give it a try (Ponting 1983:761-2). Ponting remains confident that the overall positive effects of self-government will far outweigh the negative effects. By becoming responsible for their own affairs and thereby responsible for their own successes, self-governing may improve the Indian peoples' self esteem. As a result there may also be strengthening of the family unit, improved education, innovation and a positive identity (cf. Starblanket, 1979).

As Ponting optimistically points out, Indian prospects for successful self-government are good relative to other "decolonizing people" (Ponting, 1986:367). By the same token their subsequent adoption of PHC-based development strategies, also hold promise given their potential efficiency and compatibility with Indian mores and objectives.

CHAPTER VIII: SUMMARY AND CONCLUDING REMARKS

The absolute domination of Canada's Native peoples by Europeans in the eighteenth and nineteenth centuries changed the Indian's way of life profoundly and forever. In less than four generations, the vast majority of Canada's Native peoples were reduced from healthy, autonomous, complex societies to weak, wholly dependent, simple communities existing, but barely, on the outermost fringes of Canadian society. Concurrent with the Native peoples' changing way of life grew legislation and a bureaucracy designed to undermine all Native institutions and initiatives and expedite what was thought to be the inevitable assimilation of the Indians by the dominant society.

While the years of domination, oppression and neglect have largely persisted to the present day, over the past twenty years, non-Natives have become increasingly prepared to accept Native Canadians as legitimate, if distinct, members of their own, dominant society. In assuming greater responsibility for Native affairs, however, non-Native Canadians face the difficult task of reconciling the fact that while (legally) all Canadians are equal, some are also distinct.

Canadian federal Indian policy has been characterized by the need to reconcile the equality-specificity character of

Native-non Native relations in this country. Today, in the wake of the constitutional recognition of Aboriginal rights, the equality-specificity dilemma will become progressively more challenging to reconcile.

In this thesis, one specific aspect of Canadian Indian policy, the issue of Native health, has been examined at length. The historical review in chapters two and three served to reveal the extent to which contemporary Native health problems have been caused by the changes to the Native lifestyle by the European "invasion". Accordingly, it was argued that the principal causes of poor Native health are socio-economic in nature rather than medical.

In chapter four, an alternative, non-conventional, cost effective, community-suited approach to delivering health care in Native communities was presented along the lines of a primary health care strategy.

The argument made in chapter five was that PHC cannot be imposed on Native communities by the government, but, rather, the strategy must be "adopted" by the Native peoples themselves. The question of future Native political and economic autonomy was then discussed in Chapter VI.

Finally, the last chapter dealt with some of the practical difficulties with implementing PHC strategies in Native Canadians.

The thesis discussion has revealed that the proposed

solution: PHC for Native Canadians, is far from simple and its success far from certain. Each step in implementation of the PHC approach in Indian communities is rife with logistical, political, legal and cultural difficulties. From the development of a national, government-supported, Native policy on PHC, to the creation of the community sensitive conditions under which PHC must operate, to dedicating sufficient PHC resources, to convincing the Indian peoples that it is in their own best interest to adopt PHC, it seems the PHC approach is destined to fail.

And yet, it should not fail. PHC should be encouraged and pursued here in Canada for exactly the same reason- the Canadian government has said it should be pursued in the developing nations of the world: under-served populations can best be helped by helping themselves in a nationally-supported health program founded on the principles of PHC (WHO, 1978:1). Canada, a technologically advanced, wealthy, politically stable, international leader in questions of world peace and human rights, has far more resources at its disposal than do most countries of the Third World. Furthermore, with the proclamation of the new constitution in 1982, Canadians now have a legal as well as a moral obligation to help the Indians and all Native Canadians in a constructive and productive way.

Given this country's positive international standing,

the Government of Canada can ill afford the negative publicity that popular news media pay to the plight of the Canadian Indian (cf. Toronto Star, 03.12.85: 1).

As isolated, impoverished, underemployed, undereducated, largely destitute and wholly dependent wards of the state, Canada's Indian peoples suffer from a disease that might best be termed "social disintegration." This disease has been caused by years of colonization and domination followed by years of neglect and bureaucratic paternalism. Because Canadian Indian policy has been highly centralized, ethnocentric, haphazard and principally designed to restrict Indian initiatives and objectives, its agents, DIAND, HWL (MSB) and the Indian Act, are clearly inappropriate forums through which mutual Indian/Canadian interests should be pursued.

There is, of course, no straightforward formula for rebuilding the diverse network of Indian societies that the dominant order in Canada has tried so hard, for so long to destroy. However, the mere survival of many of these societies holds in itself great promise for a better future. The long term outlook is particularly heartening when one takes into consideration the rapid growth of the Indian population, the youth of the majority of Indians, their improving education and the political and legal progress they have made over the past two decades.

The solution to the socioeconomic disadvantage of the Indian peoples lies in their desire and ability to help themselves, to run their own lives, to plan their own futures, to make their own mistakes and to build on their own achievements (Penner, 1983: conclusion). The premise underlying the PHC approach as defined at Alma Ata in 1978 and subsequently, the world over, is "Health by the People." If applied properly, the PHC approach to development offers good promise both practically and philosophically, as a means of assisting the Indians to achieve true political and economic independence within and compatible with the context of the broader Canadian society.

Appendix A

International Conference on Primary Health Care

(Organized by WHO and UNICEF)

Alma-Ata, USSR, 6-12 September 1978

V. DECLARATION OF ALMA-ATA

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity, is a fundamental human right and that **the attainment of the highest possible level of health is a most important world-wide social goal** whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the peoples particularly between developed and developing countries **as well as within countries** is politically, socially and economically unacceptable and **is, therefore, of common concern to all countries.**

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and the developed countries. The promotion and protection of the Health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate

individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary Health Care

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in a community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common disease and injuries; and provision of essential drugs;
4. **involves, in addition to the health sector, all related sectors** and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. **requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care**, making fullest use of local national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by the people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, detente and disarmament could and should release additional resources that could well be devoted to peaceful aims in particular to the acceleration and economic development of which primary health care, as an essential part, should be allotted its proper share.

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The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding commitments to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

N.B. The highlighted phrases are particularly germane to the arguments presented in this thesis.

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