

# HOW'D WE GET HERE FROM THERE? AMERICAN INDIANS AND ABORIGINAL PEOPLES OF CANADA HEALTH POLICY

Angela Mashford-Pringle

## ABSTRACT

American Indians and Aboriginal peoples in Canada have struggled through similar historical experiences, which were formulated to assimilate or eradicate them from the “new world.” Socio-political events have had far-reaching effects on Indigenous physical and mental health. This paper provides a review of Indigenous history of health in the United States and Canada. The future of Indigenous health is dependent on understanding the past.

**Keywords:** American Indians/Alaska Natives; Aboriginal peoples; health services research; governance; historical research; health policy.

## FROM TIME IMMEMORIAL IN NORTH AMERICA

American Indians and Aboriginal peoples in Canada have struggled through similar historical experiences, which were formulated to assimilate or eradicate them from the “new world.” Many scholars (Bell, 2004; DeJong, 2008; Eschiti, 2004; Jones, 2006; Kramer and Weller, 1989; US Congress, 1986; Waldram et al., 2006; Weaver, 1981) provide descriptions of extermination, residential schools, assimilation, colonization, and other tactics utilized by the North American federal governments to rid themselves of the “Indian problem.” These events had far-reaching effects on indigenous physical and mental health as well as on the policies and legislation created after the Europeans began to settle and create nations; continental expansion drove the policy and legislation toward assimilation or extermination. Although the United States dealt with American Indian and Alaskan Native issues through legislation, court decisions, and Congress appropriations funding, Canada dealt with Aboriginal peoples through some legislation, but mostly through a large number of disjointed policies (Weaver, 1981; Jones, 2006). The two countries went different routes, but the outcomes on indigenous health are remarkably similar with notable exceptions (subsidized health care and medicines, and access to health professionals).

Waldram et al. (2006) provide estimates of the number of indigenous people that were in North America upon the arrival of Europeans. This number fluctuates between two million to seventeen million indigenous people. The number of indigenous people in North America before contact is highly significant because with low numbers, the impact of Europeans, their diseases, and the genocide after settlement would not be as harsh. However, if the indigenous population was closer to seventeen million, then the impact of European arrival and settlement was extremely detrimental as the diseases and policies reduced the number of indigenous people to approximately two million across North America. The significance determines the health before European diseases came to North America and created pandemics. Jones (2006) and Roubideaux (2002) acknowledge that there were illnesses and chronic diseases before the arrival of Europeans, but they were managed through traditional use of plants and herbs. Jones (2006), Gone (2007), and Rhoades (2000) argue that indigenous North Americans used the physical landscape, nature including plants and animals, and knowledge passed down through generations to heal the illnesses that indigenous people contracted. Experiential learning, consisting of watching

a master traditional healer, was the most effective method of transferring knowledge about where to find plants, how to create mixtures, and when and how to administer these to ill people. After watching for a number of years, apprentices or those who were given the gift of healing began to work with the traditional healer or medicine man to do some of the work (Gone, 2007). This type of education occurred for many generations and was a highly effective way to pass knowledge about health from one generation to the next and in some cases to other tribes (Kunitz, 2000).

Gone (2007) explored how indigenous people used physical landscapes to heal. For example, it is far more relaxing to watch the water tumble over the edge of Niagara Falls than to watch hundreds of cars move across a highway. Indigenous people used different physical landscapes for different illnesses and different landscapes held different plants and animals that were used in the healing process (Gone, 2007). To protect the landscapes, the plants, and the animals that indigenous people used for healing, individual tribes and some tribal nations created their own laws and rules for usage, which had serious consequences if not followed (Gone, 2007). North American landscapes are predominant factors in traditional healing and early indigenous health laws.

### 1490–1760: IN THE BEGINNING... GOOD INTENTIONS?

With the arrival of Europeans in North America, health and a traditional way of life changed dramatically. New diseases entered tribes and quickly spread amongst indigenous people as they interacted across North America (Jones, 2006; US Congress, 1986). From early contact in the 1490s through to the 1700s, European explorers who stayed in North America created alliances with indigenous people (Perdue and Green, 2007). The Europeans had not endured harsh climates and large carnivorous animals that were common in North America, and there were also enemy indigenous tribes who wanted to defend their lands and retrieve European treasures of pots, steel tools, and other trinkets (Perdue and Green, 2007). The alliances provided Europeans with protection and guidance from their indigenous allies and assisted the Europeans in their discovery of the new world. DeJong (2008) states that there was a mutual benefit to these early alliances, but after Europeans had greater numbers they no longer needed the alliances. However, indigenous tribes were provided pots, steel tools, and trinkets that made their day-to-day lives easier (Perdue and Green, 2007).

The Cherokee Nation has been well documented by both English and Cherokee scholars noting that treaties between the Cherokee Nation and

European settlers began as early as 1684, with nine large treaties signed between 1721–1777 (Perdue and Green, 2007). Other east coast indigenous people like the Pequot and Seminole tribes also entered into treaties with the Europeans (Perdue and Green, 2007). The literature shows that the relationship was still amicable and reciprocal until the 1760s (Perdue and Green, 2007; US Congress, 1986).

### 1763–1790: THE RELATIONSHIP CHANGES AND THE UNITED STATES IS BORN

The Royal Proclamation of 1763 was introduced by the King of England, George III, and applied across North America with a specific claim that indigenous people were a sovereign people (Weaver, 1981) and their lands and rights were to be protected (US Congress, 1986). This declaration was the beginning of legislation and policy that has dominated indigenous life in North America up to the present day. With the signing of the Royal Proclamation of 1763, indigenous people may have been recognized as sovereign nations, but within thirteen years, the United States of America was declaring independence from Britain (Perdue and Green, 2007). With the Declaration of Independence in 1776, the United States of America were created. Some politicians and influential people wanted to maintain a mutually beneficial relationship, while others were convinced that changes were needed for the economic and social growth of the new country (Perdue and Green, 2007; Jones, 2006; Rhoades, 2000).

After the Revolutionary War in 1783, the United States government began to see indigenous people as a “problem” requiring a solution; indigenous people needed help to become more European-like and civilized (US Congress, 1986). When the Treaty of Paris was signed with the British later in 1783, indigenous people were not present and this prevented them from speaking about their claim to the land that was being given to the United States (Perdue and Green, 2007). Indigenous people inhabited and “owned” the eastern seaboard of the United States, using land well into the Ohio River Valley for food, ceremony, and healing (Perdue and Green, 2007; Gone, 2007). However, the United States government both supported extermination as a policy to capture more land, and developed assimilation policies for indigenous people who could “blend” into American society (US Congress, 1986; Gone, 2007). With the creation of states and the relegation of power to them for the land and all within their boundaries, state governments could do as they saw fit with indigenous people (US Congress, 1986; Jones, 2006).

Legislation also changed the relationship with indigenous people by making them wards of the government state (Jones, 2006; Rhoades, 2000). The *Northwest Ordinance* and the *Indian Trade and Intercourse Act* of 1790 were intended to protect American Indians from non-Indians while trying to maintain an amicable relationship (US Congress, 1986; Perdue and Green, 2007). However, politicians and other high profile individuals spoke of the hunting societies of the indigenous people, but clearly did not understand or distinguish other aspects of indigenous life like governing structures or indigenous women's contribution to tribe life (Perdue and Green, 2007). This lack of knowledge about indigenous life further fed the belief that Indians were in need of help; this took the form of assimilation through religion, education, and lifestyle (Perdue and Green, 2007; Jones, 2006).

Indigenous people became outnumbered by the settlers because of epidemics of smallpox, influenza, and tuberculosis that had entered North America since the 1400s (US Congress, 1986; Jones, 2006). Many settlers remained concerned about the health of the Indians living near their settlements and the army bases. The concern was that sick Indians would "give back" the illnesses and decimate the white population (Perdue and Green, 2007; US Congress, 1986; Jones, 2006). In response to these health concerns, the United States government provided some medical assistance to ensure that non-Indians did not get sick because of the illnesses that the Indians had (DeJong, 2008; US Congress, 1986). Indigenous people who could not be treated with relative ease and cost were forced to move away from "white" settlers without adequate compensation for the land or relocation (US Congress, 1986; Perdue and Green, 2007). Indigenous people were seen as more susceptible to tuberculosis, which further proved to settlers that indigenous people were inferior and in need of assistance (Jones, 2006; Perdue & Green, 2007).

## TO BELONG OR NOT TO BELONG

### 1790–1887: MANIFEST DESTINY AND THE AMERICAN POLICIES

The War of 1812 between the British and Americans was a crucial turning point for Indians throughout North America. Tecumseh, a Shawnee Indian from Ohio, formed an alliance amongst many different tribes throughout North America in a bid to secure the Ohio River Valley as an Indian Territory (We Shall Remain, aired April 20, 2009). Tecumseh believed that

the Indian's best hope for an Indian Territory, where their culture, traditions, and knowledge would live on, resided in being allies with the British army as they continued to promise that at the end of the war, Indians could have the Ohio River Valley (We Shall Remain, 2009). The war was waged and Indians did defend the Ohio River Valley from the Americans, but in the end lost the war and their ally, General Brock, died (We Shall Remain, 2009). With the end of the war, the death of Tecumseh and General Brock, a pan-Indian Alliance and Territory died (We Shall Remain, 2009). This war affected how Indians are perceived by the US and Canadian governments from the end of the war to the present day.

By 1819, the *Civilization Act* was introduced in the United States and it states "for the purposes of providing against the further decline and final extinction of the Indian tribes," the federal government was to provide funds to educate and keep minimal health of American Indians, especially where the Indians were close to white settlement. By this time, Indians were dying from exposure to smallpox and tuberculosis, and many were going blind from trachoma (DeJong, 2008). Indian agents, army personnel, and doctors in areas where there were many Indians began to highlight the health conditions of Indians in letters to the government, but to no avail (Perdue and Green, 2007; DeJong, 2008).

Manifest destiny was a belief held by early settlers to the United States, who believed it was their inherent right to expand and settle across the continent of North America (US Congress, 1986). To further manifest destiny and expansion to the west and south, Indians needed to be removed from the lands that white settlers wanted, so in 1838 thousands of Indians were forced to relocate from North and South Carolina to the Dakotas and Oklahoma (DeJong, 2008; Perdue and Green, 2007). The Trail of Tears, as it has become known, saw more than 4000 Indians die from exposure, malnutrition, pneumonia, and acute infections as the American government forced more than 20,000 Indians from their homes and homeland with little more than the clothing on their backs (Perdue and Green, 2007). Some American Indian tribes, like the Seminole and Algonquin, had already entered into treaties to cede land for goods, services, and future benefits (Perdue and Green, 2007). The forced relocation not only changed the physical landscape that American Indians were accustomed to and had been given by the Creator (as told in creation stories from many different nations), but it reduced the types of food that could be obtained, the type of

housing that could be created or lived in, and the traditional medicines that were available for traditional healing (Gone, 2007; Perdue and Green, 2007).

As the land mass was overtaken by European settlers, American Indians were forced into smaller and smaller areas to hunt, fish, and farm, which changed their diets dramatically over a short period of time (US Congress, 1986; DeJong, 2008; Perdue and Green, 2007). These dietary changes affected health in a number of ways, including malnutrition which leads to susceptibility to illness, and lack of money for the “market foods” available in the towns around them. The new Americans were willing to do anything to expand and grow across the United States from the borders of Canada to Mexico. This led to the *Indian Removal Act* of 1830, and the creation of more treaties with many different Indian tribes, an entrenched belief in extermination policy, and the creation of the Indian Affairs Bureau in the Department of the Interior in 1849 (US Congress, 1986; Prucha, 2000).

With the creation of the Indian Affairs Bureau in 1849, discussions began for a way to separate the “uncivilized” Indians from the rest of civilized society and by 1853 there were reservations set aside for American Indians to remain in tribes and keep their culture, while keeping them out of the way of the American people and industry (Prucha, 2000). While American Indians were trying to adjust to all the changes that were occurring, religious missionaries were also in their communities attempting to “civilize” them through education, hygiene practices, and living conditions. American Indians moved from tents, tepees, and portable housing to permanent structures like the Europeans, changing how often they moved around, where they foraged for food, the cleanliness of the interior conditions, and the number of people that could reside together (DeJong, 2006). This huge change in living conditions created new problems as many American Indians had moved with the season or food supply, but the more permanent structures forced them to stay in one place (DeJong, 2006). Without prior experience of living in such “homes,” there was a need for hygiene and cleaning practices suited to these permanent structures which created a new place to breed germs and spread illness (DeJong, 2006).

The Senate Committee concluded in 1867 that Indians were rapidly decreasing because of poor health and would not be a threat or stand in the way of expansion for much longer (DeJong, 2006). Politicians in the United States believed that if the “Indian problem” was given time, there would not be enough Indians left to be concerned with (DeJong, 2006). Therefore, it was time to move forward by ending the treaty-making period in the United

States in 1871 (US Congress, 1986). After 1871, the United States government dealt with Indians through legislation and statutes exclusively for all aspects of indigenous life (US Congress, 1986; Perdue and Green, 2007).

The *Dawes Act* of 1887 (24 Stats. 388) allotted 160 acres of land to each adult American Indian and all other land specified for American Indians was then sold to settlers (US Congress, 1986; DeLong, 2008). “Indian lands were to be held in trust, as were the proceeds from the sale of ‘excess lands’ for a limited number of years” (US Congress, 1986, p. 8). This affected hunting, fishing, and agriculture as the American Indians were forced to live in smaller and smaller tracts of unusable land (Perdue and Green, 2007). The monies from these sales never reached American Indian tribes (Perdue and Green, 2007). “While most treaties provided stipulated limits on services, typically not to exceed twenty years, the United States adopted a policy of continuing such services under general appropriations” (DeLong, 2008: p. 6), although the government often did not fulfill its obligations or promises (DeLong, 2008).

### 1790–1867: CREATING CANADA BY FOLLOWING THE AMERICANS

In Upper and Lower Canada, the European settlers were looking at the land owned by Indians and determining what could be done to take the land either by civilizing, assimilating, or relocating the indigenous people (Anderson et al., 2006; Stonechild, 2006). The French and English dealt with indigenous people in different ways based on the needs of their settlements (Stonechild, 2006). A concern for all European settlers was diseases amongst indigenous people as interactions with indigenous people occurred routinely (Stonechild, 2006; Waldram et al., 2006).

Any indigenous peoples with medical concerns in Upper and Lower Canada were brought to the Hudson’s Bay Company physicians, who treated the medical issues using a bio-medicine unlike the traditional medicine that Indians were accustomed to (Anderson et al., 2006). Throughout the 1800s, the Hudson’s Bay Company physicians, military and police personnel, as well as missionaries and some fur traders provided medical aid to Indians and Inuit people depending on need and interaction with Europeans (Anderson et al., 2006). Prior to the *British North America Act* in 1867, the policy was one of assimilation as many British North Americans believed that in time Indians would become “civilized” and blend into their society (Bostrom, 1984; Royal Commission on Aboriginal People [RCAP], 1996).

In 1867, the *British North America Act* (BNA) created the new coun-



try of Canada and assigned responsibility for Indians to the new government (Anderson et al., 2006). The new federal government had ultimate control over all peoples within its boundaries, including the Indians and Inuit people (Waldram et al., 2006; RCAP, 1996). With the formation of the country, missionaries were given funding to take control of Indian education, which had significant impacts on holistic health as Indians were forced to attend schools and learn in classrooms (Waldram et al., 2006).

Education is an important aspect of indigenous health and well-being. Therefore the impact of residential schools is also important to the overall health of indigenous people for generations (Castellano et al., 2008). The residential schools, which had already begun in the United States, provided a limited English education (Castellano et al., 2008). Aboriginal students learned rudimentary reading, writing, and math skills in combination with basic labour skills like housekeeping for girls and farming or forestry for boys (Castellano et al., 2008; RCAP, 1996). If Aboriginal children tried to speak their own language or use a cultural ceremony, they were beaten or denied food (Castellano et al., 2008; RCAP, 1996). Indigenous children had their hair cut and forced to wear European-style clothing (Castellano et al., 2008; RCAP, 1996). These children, removed from their families and communities for years, sometimes never returned home due to death, adoption, or not feeling that they would belong again (Castellano et al., 2008; RCAP, 1996). The residential schools were spiritually, emotionally, physically, and mentally detrimental to many of the indigenous children that attended; residential schools were the assimilation policy intended to finally end the “Indian problem” (Castellano et al., 2008).

### 1867–1911: WARDS OF THE CANADIAN STATE

To continue to deal with the indigenous people and attain more land, the Canadian government began to sign treaties with Indian “nations” in 1871 and continued the practice until long after the turn of the century. Treaties have traditionally been drafted as agreements between nations, which suggests that the Canadian government saw First Nations as governments like themselves that needed to be addressed in a nation-to-nation way (Waldram et al., 2006). There are 11 numbered treaties in Canada as well as adhesions and other treaties signed between Indian tribes and the federal government (Waldram et al., 2006). The most important treaty for indigenous health in Canada is the 1876 Treaty 6 with central Saskatchewan and Alberta tribes. Treaty 6 is important for the clause calling for a medicine chest to be placed

in every Indian agent's home and that Indians would not be required to pay for medical assistance (Waldram et al., 2006; Weaver, 1981; Kramer and Weller, 1989).

In the same year that Treaty 6 was signed, the *Indian Act* was enacted, defining who is "status" or "treaty and, therefore, a responsibility of the Canadian federal government (Weaver, 1981; Kramer and Weller, 1989; Waldram et al., 2006). This legislation made Indians wards of the state. They lost their freedom to perform cultural and spiritual ceremonies as well as being forced to send their children to residential schools based on western pedagogies of learning (Kramer and Weller, 1989; Anderson et al., 2006). The *Indian Act* displaced traditional government and created the constructs of Chief and council (Lavoie, 2003) as well as establishing who was eligible to be protected as a First Nations person or "status" or "treaty" Indian (Lavoie et al., 2008).

To deal with the fiduciary and moral responsibilities set forth in the BNA and to manage the new *Indian Act* and lists of "status" Indians, the Canadian government created the Department of Indian Affairs in 1880, but this new entity had no provisions for health care (Anderson et al., 2006). In 1880, residential schools began in the western part of Canada (Waldram et al., 2006). The residential schools were established by various Christian missionaries across the country with the federal government paying the bill in return for Indians becoming "civilized" and assimilated to Euro-Canadian culture (Waldram et al., 2006).

Cultural ceremonies, like the potlatch and sun dance, were banned by the end of the 1880s (Waldram et al., 2006). The banning of these ceremonies affected all Aboriginal people. Even if they did not partake in the ceremonies, this could be seen as another way of "civilizing" and colonizing Aboriginal people, which had an effect on their mental health, spirituality, and connection to community. Communities traditionally performed cultural ceremonies together; with children removed from families and communities to attend residential schools, ceremonies were lost and this was another blow to their spirituality, culture, and community networks (Waldram et al., 2006).

In both Canada and the United States, indigenous people lost more and more of their freedoms to the underlying policy of assimilation. Both governments began to legislate what indigenous people could do, where it could be done, and how they interacted with Europeans. The residential school experience was very traumatizing for most students; even those in-

digenous people who did not attend the schools had loved ones who experienced the traumas or were hidden from government agents to avoid being put into the schools (personal knowledge). The American government created many pieces of legislation to deal with the “Indian problem,” whereas the Canadian government created a few key pieces of legislation, but held fast to the “assimilation or extermination” policy that many politicians and citizens believed in.

## LOST IN BUREAUCRACY

### 1911–1960: EXPANSION, RELOCATION AND INDIAN HEALTH SERVICES

As both North American countries grew, the number of policies and legislation governing indigenous life also grew. The United States entered into 450 treaties and agreements with tribal nations between 1778–1911 (DeJong, 2008). These treaties and agreements created moral and legal obligations of the American government to American Indians, but even with reports from government agents and bureaucrats about the poor health amongst American Indians, health care was not improved or provided free (DeJong, 2008).

At the beginning of the 1900s, the “Indian problem” was seen as a domestic issue not requiring military action (DeJong, 2008). Americans wishing to expand their economy, considered the Indians to be in the way, and passed legislation that required American Indians (those who were considered to have status) to move on to reservations set aside by the government (DeJong, 2008). Moving American Indians away from their traditional homelands, sometimes by thousands of miles, diminished their health and resulted in a number of displaced American Indians dying while in transit (DeJong, 2008; Perdue and Green, 2007).

Concern for the health of Americans produced an investigation into American Indian health, launched in 1897 and concluded in 1901, which reported that tuberculosis and trachoma were devastating American Indian communities (DeJong, 2008). It was recommended that the American government provide separate hospitals and an increase in the number of physicians assigned to look after American Indians (DeJong, 2008). In 1908 a dedicated Indian Health Service was established in the Bureau of Indian Affairs and remained there intermittently until 1955 when Congress moved the health service to the Public Health Service permanently (DeJong, 2008).

The intent of Indian Health Service and Congressional appropriations funding was to decrease the number of ill American Indians, which would then prevent the spread of illnesses to other Americans (DeJong, 2008), by placing American Indians “at a distance from the mainstream of American society” (Snipp, 2000, p. 45).

“By the 1920s, the status of Indian health was at least two generations behind the national average” (DeJong, 2008, p. 45), which concerned the American government only because it was costing money, time, and effort to “civilize” and “assimilate” American Indians into American society (DeJong, 2008). In hopes of improving American Indian health and education, the federal government enacted the *Indian Citizenship Act* in 1924, which made all American Indians who were not already American citizens into citizens of the country (DeJong, 2008). This limited the sovereignty of American Indians and was imposed without consultation or negotiation (Churchill, 1994). The *Indian Citizenship Act* forced American Indians to become American citizens and meant that all civil and criminal laws, state and federal, applied to them (Churchill, 1994).

The *Indian Reorganization Act* of 1934 restored tribal governance by putting tribal councils similar to boards in businesses and corporations, and ended allotments and extended trust (Churchill, 1994; Snipp, 2000; US Congress, 1986). The *Indian Reorganization Act* affected American Indian health by giving tribes a voice on policies about health and health care (DeJong, 2008). The *Johnson-O'Malley Act* was also passed in 1934, expanding health services for all Americans and giving the states increased responsibility for health care (DeJong, 2008). These acts were seen as ways to improve American Indian health, and by 1940 Indian nurses were graduating from colleges and returning to American Indian communities to work (DeJong, 2008).

In the early 1940s, the United States purchased Alaska from Russia and the federal government extended the agreements created by Russia with Alaskan Natives to include the same medical care as was provided to American Indians (DeJong, 2008). With the expansion, two commissioners of the Indian Health Service resigned in close succession, which caused President Truman and Congress to assume control of American Indian health. They wanted to have national conformity in health meaning that American Indians and Alaskan Natives received no more or less than any other American citizen in terms of health care (DeJong, 2008).

In the early 1950s, tribal health boards were created and the Indian Health Service agreed to endorse traditional healers and traditional healing methods for use in American Indian health centres (DeJong, 2008). The endorsement of traditional healers, traditional medicine, and healing was embraced by Indian Health physicians as it closed the cultural gap and American Indian health improved where traditional methods were available (DeJong, 2008). The American government received the Herbert Hoover Commission Report in 1948 and decided by 1951 that if states or local health facilities had health care that American Indian and Alaskan Natives could utilize, no appropriations would be provided for those services or areas (DeJong, 2008). By 1953, the House Concurrent Resolution 108 terminated federal supervision and abolished all government facilities for Indians; in 1954 the *Indian Health Transfer Act* was approved by Congress and came into effect in 1955 (DeJong, 2008). This act transferred health services to Indian governments and ended federal responsibility for American Indian health services.

The new Secretary of Health, Education, and Welfare, Marion Folsom, instituted regulations on who was eligible for Indian services (DeJong, 2008). The limitations placed on who qualified as an American Indian or Alaskan Native was established as:

evidence of Indianness included tribal membership or enrollment, living on tax-exempt land, ownership of restricted property, active participation in tribal affairs or 'other relevant factors' that the Indian Service recognized as constituting membership. (DeJong, 2008, p.137)

After World War II until the 1960s, American Indians began to organize a pan-Indian movement that culminated in the creation of the American Indian Movement (AIM) that advocated for better education, health services, housing, and acknowledgement of heritage and culture (Bee, 1982). AIM advocated for monies agreed to in treaties, as well as permission for tribal governments to create new economic prospects on reservations, and improve life for American Indians. Unfortunately, many of the tribal leaders and some AIM advocates were too close to the politicians in Washington and personally reaped the benefits meant for their tribes, without providing the wealth to their communities (Bee, 1982). This nepotism and "creative networking" helped some American Indians and Alaskan Natives to live substantially better lives than their communities (Bee, 1982).

In this era, American Indians and Alaskan Natives received the funding for health services beyond their reservations through Medicaid and Medicare

depending on their status as an Indian (Roubideaux, 2002). However, proving status was difficult, thus forcing some American Indians to deal with a lot of paperwork to get healthcare (DeJong, 2008). Many American Indians and Alaskan Natives were relocated to urban areas in the 1930s–1950s, creating problems in finding adequate health care that was affordable or paid for through Medicaid and Medicare (Roubideaux, 2002). When American Indians could access health services, there was a lot of paperwork to be completed before services were rendered and in some cases this exacerbated the illness or caused further health and social conditions (Roubideaux, 2002).

## 1960–1990: WE HAVE A VOICE! CIVIL RIGHTS, TRIBAL SOVEREIGNTY, AND REDEMPTION

From the 1970s–1990s, AIM and other American Indian organizations created tribal colleges and universities as well as increasing the number of American Indian and Alaskan Native health professionals in hopes of improving the health of Indian communities (Rhoades, 2000). The Indian Health Service has been chronically underfunded and has provided disease-specific programs that do not look at American Indians in a holistic way (Kunitz, 2008). Not surprisingly, the Canadian government followed a similar path to the United States.

## 1904–1960: DEVELOPMENT OF CANADIAN INDIAN HEALTH AFFAIRS

In 1904, the Canadian government created the first federal official responsible for Indian health (Anderson et al., 2006). To further improve Indian health in Canada, nurse-visitors were instituted in 1922 as a mobile solution to provide medical aid and treatment to Indians living in remote areas of the country (Anderson et al., 2006). The Canadian government, aware of the illnesses that were being spread through Indian communities, hoped that a dedicated official and increased access to medical services would improve the health of Indians across Canada (Kramer and Weller, 1989).

The Medical Branch of the Department of Indian Affairs was created in 1927 (Anderson et al., 2006). This new branch was to “control” the tuberculosis epidemic that was causing an increasing concern to non-Aboriginal people. It was also necessary to have a Medical Branch to be in charge of the Treaty 6 Medicine Chest clause (Anderson et al., 2006).

There were few changes in healthcare and Indian affairs in Canada between 1927 and the early 1940s. In the early 1940s, the Medical Branch

moved from the Department of Indian Affairs and became the Indian and Northern Health Services branch of National Health and Welfare (Anderson et al., 2006). In the 1940s, the federal government was also developing and creating health care for Canada. Universal healthcare benefited all Aboriginal people in Canada as a person was not required to be “status” or “treaty” to receive health services (Waldram et al., 2006). Health care services were not systematically provided to everyone including Aboriginal people until after 1945 (Adelson, 2005).

### 1960–1990: WHO IS RESPONSIBLE? OUT OF SIGHT ABORIGINAL PEOPLE IN CANADA

Similar to the experience of American Indians, Aboriginal people in Canada were becoming frustrated with their relationship with the federal government. In 1960, the National Health and Welfare Department created the Medical Services Branch to look after Indian health (Adelson, 2005). It was assumed that creating a branch of the department dedicated to Indian health would improve health care and health services (Adelson, 2005).

The Alberta Indian Association was created in the 1960s to advocate for health, education, and other social services (Weaver, 1981), because the federal government, starting in 1963, was operating under a devolution policy (Weaver, 1981). The Hawthorn Report, in 1966, contained recommendations about providing health care to Aboriginal people as there was need to decrease mortality (Anderson et al., 2006). It spoke about the conditions at Indian residential schools including the physical and sexual abuse that was occurring, but the federal government did not immediately respond (Weaver, 1981). The report also outlined that “Indians were dying of disease that were preventable, and their poor housing conditions only made the link between poverty and disease more visible” (Weaver, 1981, p. 49).

The Canadian government attempted to be progressive by providing equality for all Canadians in the 1960s and early 1970s. In 1960, Aboriginal people were given the right to vote, but this was controversial because it was in direct contradiction to the growing movement for self-governance and the inherent right to indigenous sovereignty (Weaver, 1981; Castellano, 1980). In 1969, the government repealed the liquor sections of the *Indian Act*, allowing Indians to purchase and consume alcohol on or off the reserve (Weaver, 1981). Also in 1969, there was a Supreme Court of Canada challenge to allow Indian women to keep their Indian status when they married non-Indian men, but the court denied the challenge in 1973.

The most important instigator to change for Aboriginal people in Canada came in the form of the 1969 White Paper developed by the Trudeau government (Weaver, 1981). While consultations were being held with Aboriginal people across the country to determine what changes to the *Indian Act* were needed and how to improve living conditions for Aboriginal people, especially those living on reserves, the federal government determined that Aboriginal people simply had to become Canadians (Weaver, 1981). Aboriginal people were outraged with the White Paper as it would take their treaty rights away and remove reserves (Weaver, 1981).

The response from the new National Indian Brotherhood was the 1970 Red Paper (Weaver, 1981). The Red Paper declared that Aboriginal people were not willing to let go of their treaty rights and that the federal government must live up to the documentation that stated what Aboriginal people were entitled to (Weaver, 1981). By 1972, the National Indian Brotherhood had also written a well-received position paper on Aboriginal education, which outlined the need for more culturally sensitive education that would lead to Aboriginal people attaining higher education, which in turn would increase their employability and improve their health (Weaver, 1981; Adelson, 2005). The National Indian Brotherhood became more vocal and advocated more publicly after 1973.

The Lalonde Report released in 1974 was influential and focused on four main areas including the organization of health care (Pederson et al., 1988). Similar to the Hawthorn Report, it argued that the federal-provincial jurisdictional fragmentation of Aboriginal health care is “a public health concern and creates barriers to access health services” (Lavoie and Forget, 2008, p. 108). The Canadian government created the Health Promotion Directorate in 1978, which was the first in the world, aimed at individual behaviours, and responsible for health policy development (Pederson et al., 1988).

The Canadian government released the “New Federal Government-Indian Relationship” in 1976, to continue the special status of Indians and allow Indian culture to be distinct within Canadian society without separating or assimilating (Weaver, 1981). In 1979, the Minister of Health, David Crombie, introduced the new Indian Health Policy. The two page health policy was read into the House of Commons and consisted of three pillars; community development, advocacy for Indian people, and Canadian health systems that were integrated and comprehensive (Crombie, 1979). The policy stated that culture and traditions were to be prominent in Indian



health and health care, and Indian people could generate and maintain their own health systems (Crombie, 1979).

The repatriation of the Canadian constitution in 1982 was very important for Aboriginal people in Canada. Indigenous peoples are recognized by the Constitution Act of 1982 and are those who are registered as First Nations or are identified by the federal government as Inuit through Indian and Northern Affairs Canada (previously known as Department of Indian and Northern Development); recently, Métis peoples have also been recognized. The Canadian government determined who could be registered as a “status” Indian through the *Indian Act*, and all others are considered Métis, or mixed Aboriginal ancestry, which makes them ineligible for registration or the benefits that registration provides (Adelson, 2005).

To further improve Aboriginal involvement in health care and health services, the Health Transfer Policy was introduced in 1987 (Lavoie et al., 2005). This allowed the Canadian government to transfer health care funds to Aboriginal communities or tribal health associations to provide health care and health services that the community determined were necessary like diabetes, cancer, mental health, obesity and early childhood development (Lavoie et al., 2005; Adelson, 2005).

Canada and the US approached indigenous health in different ways: Canada used policy and the US used legislation. Despite many changes from 1900–1990, indigenous health advocates and scholars (DeJong, 2008; Jones, 2008; Kunitz, 2008; Pederson et al., 1988; Lavoie et al., 2005) acknowledge the federal governments have attempted to improve indigenous health.

## 1990–2010: ALL TALK, NO ACTION

### UNITED STATES: FINDING A WAY AS AMERICAN INDIANS

From 1990–2008, policy directions and political influence have shifted to recognize the special needs of indigenous people in Canada and the US. Elders have advocated for the “new buffalo,” which Stonechild (2006) explains as western education that will allow indigenous people to fully participate in all aspects of North American life. These Elders have worked with national indigenous organizations to improve indigenous health through holistic approaches similar to the population health approach used by Health Canada since 1998. Indigenous North Americans have continued to work for improved health conditions in both countries (Adelson, 2005).

The United States has passed numerous laws and acts that directly or indirectly affect American Indians and Alaskan Natives. Throughout this

paper, it becomes apparent that the United States is heading toward full self-governance, which would also stop any fiscal responsibilities. Scholars (Bell, 2004; Jones, 2006; Kunitz, 2008) point out that the funding for American Indian health care is far short of the need. To reduce chronic illnesses and improve health status requires a holistic approach to health that the World Health Organization has also advocated for indigenous people. There has been a continuous shift “from substance to money, and from problems of political power to disputes over dividing up the cash” (Barsh, 1994, p. 56) with American Indians and Alaskan Natives fighting harder and harder to get enough funding to provide the essential health care that their communities require (Barsh, 1994).

Bell (2004) argues that although culture is often overlooked as a contributor to health and health care, it influences “lifestyle behaviours, attitudes toward health, living arrangements, and receipt of healthcare” (p. 354). Many tribes are incorporating traditional healing practices, traditional medicines, cultural ceremonies and traditional healers into their health care services (Jones, 2006). Cultural practices like sun dance, smudging, and sweat lodge provide American Indians with traditional ways of healing spiritually, emotionally, and physically, which may be ignored in biomedical models of health care (Gone, 2007). The re-emergence of cultural healing knowledge and practice can improve the number of American Indians and Alaskan Natives who access health care services as it will be more in keeping with indigenous models of living (Gone, 2007).

#### CANADA: THE SILENCE HAS ENDED

The Royal Commission on Aboriginal Peoples (RCAP) provided an extensive and in-depth look at issues for Aboriginal peoples in Canada. Using research, the RCAP reports had over 300 recommendations to improve the health and well-being of Aboriginal peoples in Canada (RCAP, 1996). As part of the recommendations, the Aboriginal Healing Foundation was created in 1998 to begin to understand what occurred in residential schools and to make the information public (Brant-Castellano et al., 2008). Residential schools have had a great impact on the health and well-being of not only those that attended the schools, but their extended families and across generations (Brant-Castellano et al., 2008).

In 2000, the Medical Services Branch was renamed the First Nations and Inuit Health Branch (FNIHB) within Health Canada in 2000. While FNIHB has the mandate to provide health care services to First Nations and Inuit

peoples in Canada, more than 50% of Aboriginal people live beyond the jurisdictions of reserves or Inuit territories (Anderson et al., 2006). FNIHB has worked closely with First Nations communities to transfer responsibility and funding from the federal government to improve health care services based on community needs (Adelson, 2005).

On June 11, 2008, Prime Minister Stephen Harper stood in the House of Commons and delivered an apology to Aboriginal people in Canada for the government's part in the residential schools. The Truth and Reconciliation Commission was established in 2008 to begin resolving the residential school survivors' claims. Both the apology and the Truth Commission are historic and meant to begin the healing process for Aboriginal people. Scholars (Gone, 2007; Barsh, 1994; Adelson, 2005) have argued that current health problems like violence, alcoholism, and diabetes stem from historic trauma imposed on Aboriginal people by policies such as residential schools, forced relocation, and loss of traditional hunting and fishing rights.

Through the Assembly of First Nations and the American Indian Movement, indigenous North Americans have been fighting for what they believe is necessary for their health and their communities. The World Health Organization has created the Indigenous Peoples Health Framework, but neither Canada nor the United States has signed it. For the past twenty years, both federal governments have transferred responsibilities and funding to indigenous governments, but much more policy and legislative work is required to improve health and living conditions for indigenous peoples.

### SO HOW DID WE GET HERE FROM THERE?

The United States enacted many different pieces of legislation throughout the past two hundred years, but there has always been an underlying policy of assimilation. To improve American Indian and Alaskan Native health, there must be recognition of the past, how it affected indigenous people, and what policies and legislation can help to improve health and health care into the future. Canada has not provided as much legislation, but similar to the United States, there is a need to recognize and understand the past and its effects on Aboriginal health and health care.

Despite underlying governmental policies (assimilation, extermination, forced relocation, forced western education, jurisdictional wrangling, hollow apologies, and inadequate conditions) American Indians and Aboriginal peoples of Canada have begun to advocate for more control over many aspects of their lives. The current conditions, based on government docu-

ments, show that health status and mortality rates are improved, but unemployment, education, quality of life, chronic illnesses, and mental health concerns are far below the average Canadian or American citizen.

Indigenous peoples in North America have similar histories, but their respective federal governments have chosen different means to establish how health care and health services are provided to them (policy versus legislation). The underlying policy in both countries has been one of assimilation, which has not been completely successful, yet many indigenous people have had to understand both indigenous and mainstream cultures to survive. Walking with one moccasin and one loafer has allowed indigenous people to understand Eurocentric policy and legislation, and to use that framework to benefit their people. From education to advocacy, indigenous people have begun to utilize their understanding of the two cultures (indigenous and mainstream) to improve their communities and their lives.

Elders teach indigenous people that they must examine their surroundings to live within the confines of what the Creator has provided. With this concept in mind, it is apparent that indigenous North Americans have adapted, despite injustice, to the ever-changing realities of their situation within two nations. American Indians and Alaskan Natives may have knowledge or experience that could benefit Aboriginal people in Canada or vice versa. The future of indigenous health is dependent on understanding the past.

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**Angela Mashford-Pringle** is an urban Algonquin woman from Temiskaming First Nation in Quebec. She is currently completing her PhD in Aboriginal health at the Dalla Lana School of Public Health, University of Toronto. Her primary research interests are in Aboriginal education, health, health policy and early childhood issues.

[angela.mashford.pringle@utoronto.ca](mailto:angela.mashford.pringle@utoronto.ca)