REPORT OF ADVISORY COMMISSION

ON INDIAN AND INUIT HEALTH CONSULTATION

The Honourable Mr. Justice Thomas R. Berger, Commissioner

Ottawa, Ontario

February 28, 1980

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The Honourable David Crombie,
Minister of National Health and Welfare,
House of Commons,
OTTAWA, Ontario.
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Dear Mr. Crombie:

In December 1979, at your request, I undertook a Commission of Inquiry with a view to recommending methods of consultation that would ensure substantive participation by the Indians people and the Inuit people in decisions affecting the provision of health care to them.

The Inquiry has not been an extended one, since its scope has been limited, and since I think my recommendations should be placed before the government so that consideration may be given to them in time for action to be taken early in the fiscal year 1980-1981.

I have reviewed the materials prepared by the Medical Services Branch of your Department, by the National Commission Inquiry on Indian Health established by the National Indian Brotherhood, and by the provincial and territorial Indian organizations affiliated to the Brotherhood. I have held meetings with Dr. Lyall Black, the Assistant Deputy Minister of the Medical Services Branch, and his staff in Ottawa, and with a number of Regional Directors of the Branch. I have also had discussions with Community Health Representatives, the Registered Nurses of Indian Ancestry, health professionals in the private sector, representatives of the medical schools, and the Honourable Emmett Hall, who is conducting a review of public health insurance programs for the federal government. I have met with the National Commission Inquiry on Indian Health and representatives of all the provincial and territorial Indian organizations affiliated with the NIB. In addition, members of my staff have met with representatives of Indian organizations not affiliated with the NIB, including the Conseil Attikamek-Montagnais and the Nishga Tribal Council. They have met as well with the Native Council of Canada.

I have conferred with the Inuit Tapirisat of Canada and the Committee for Original Peoples Entitlement.

Throughout, I have received the full cooperation of your Department; in particular, that of Dr. Black, Ms. Jean Goodwill and Skip Brooks have been of especial help.

The federal government has, pursuant to Cabinet Document 386-79CR(1), made $950,000 per annum available for the purpose of Indian health consultations.

Consultation about the ways in which Indian people and Indian communities are to participate in the planning, budgeting and delivery of health programs cannot be severed from participation in the actual planning, budgeting and delivery of these programs. The shape of the institutions which will be created to implement the new Indian Health Policy, will emerge from the consultations. The institutions, established for purposes of consultation, will become institutions for the delivery of health care. Hence, the extent to which the Indian people participate in the consultations will have a direct bearing on the extent to which any program for Indian participation in the management of their health care programs succeeds. I therefore recommend that the management of the consultation process and the consultation funds be in the hands of the Indian people.

The case of the Inuit is in certain respects different from that of the Indians. I am making a separate recommendation with regard to them.

These are my recommendations:

1. I recommend that $800,000 per annum should be distributed among the provincial and the territorial Indian organizations affiliated with the National Indian Brotherhood (NIB). The money would be used by them to develop the consultation process. An appropriate share of the funds should, however, be made available to Indian organizations and Indian bands which are not affiliated with the NIB.

2. I recommend that the National Commission Inquiry on Indian Health (NCI) established by the NIB be funded on a permanent basis. In my view, a sound case has been made for a national overview of Indian health by Indian people. The NCI should be funded by $150,000 per annum out of the funds appropriated for consultation.

3. I recommend that funds be made available to the Inuit for purposes of developing Inuit awareness and expertise in the field of health care, and for consultations. These tasks should be entrusted to Inuit Tapirisat of Canada (ITC) and Committee for Original Peoples Entitlement (COPE). The money for the Inuit should not come out of the funds provided by Cabinet Document 386-79CR(1), but should be the subject of a separate appropriation, to be negotiated with ITC and COPE.

4. I recommend that the federal government should hold a national conference on native health in 1981 or 1982. The conference should be attended by representatives of all of Canada's native peoples.

My recommendations are founded on the principles of the new Indian Health Policy which the federal government adopted on September 19, 1979. This is a far-reaching document which offers the means for the amelioration of the underlying causes of Indian ill health in Canada.

May I express my gratitude to you for the cooperation and support I have had from you in the course of the Inquiry.

Yours truly,

Thos R. Berger

Thomas R. Berger

TABLE OF CONTENTS

INTRODUCTION

The alarming state of ill-health among Canada's native peoples and the necessity for improving their health care has recently acquired a prominence in terms of the priorities of native organizations and in the relations between the federal government and the native peoples. When, late in 1978, the federal government established guidelines for uninsured health services, Indian organizations throughout the country objected. The whole issue of native health and native health care was thrown into relief. The protest over the establishment of the guidelines became a protest over the whole question of native health care and brought a call for an explicit acknowledgement by the federal government of its responsibility in this field.

As a result, the federal government adopted a new Indian Health Policy[1] on September 19, 1979. After referring to "the tragedy of Indian ill-health", this important document states that to remedy this intolerable condition, there must be increased participation by Indian people in the management of their health care programs.

At the same time there has been a call by the Inuit Tapirisat of Canada for a greater commitment by the federal government to the improvement of Inuit health care.

The task of this Inquiry has been to address two specific questions posed by the Order-in-Council of December 13, 1979[2]: What methods of consultation are available to ensure that there is substantive participation by Indian and Inuit people in decisions relating to their health care programs, and which of these methods ought the Minister to adopt?

THE PRESENT STATE OF INDIAN HEALTH

The new Indian Health Policy of September 19, 1979, refers to the tragedy of Indian ill-health. The dimensions of that tragedy and the origins of the present crisis should be understood.

In pre-Columbian times, there may have been as many as one million Indians living in what is now Canada. They were, by all accounts and on the basis of contemporary criteria, a healthy race. Nicholas Denys wrote in 1672:

> They were not subject to disease, and knew nothing of fevers. If any accident happened to them...they did not need a physician. They had knowledge of herbs, of which they made use and straight away grew well. They were not subject to the gout, gravel, fevers or rheumatism. The general remedy was to make themselves sweat, something which they did every month and even oftener.[3]

But the new diseases brought by the Europeans were diseases with which the Indians had had no experience, to which they had no immunity, and for which they had no effective medical treatment. Smallpox, whooping cough, measles, chicken pox, bubonic plague, typhus, malaria, diphtheria and influenza swept through the Indian populations.

By the beginning of the twentieth century, the Indians had been reduced to a state of complete destitution and dependence. The loss

of whole generations, the enfeeblement of those who remained, the fear of demographic destruction, the loss of faith in their own institutions and in their own values — all of these had resulted in demoralization and a sense of powerlessness in Indian communities throughout the country.

Alcohol was, of course, linked to demoralization and decay. But it should not be regarded as the cause. Excessive use of alcohol was, rather, a manifestation of the disintegration of Indian society. At the same time, it accelerated and compounded the process, while taking its own immense toll of life.

It has been the Medical Services Branch (MSB) of the Department of National Health and Welfare that has ministered to the medical needs of the Indian people. The diseases that ravaged Indian communities in the past have been brought under control, though not completely. Even today, tuberculosis has by no means been eradicated. But in terms of conventional diagnosis and treatment, MSB has achieved a notable measure of success.

The MSB medical care program for Indians and Inuit is extensive. Insured services — primary health care and hospital care — for Canada's 300,000 status Indians[4] and 22,500 Inuit[5] are provided through medicare programs across Canada in the same way as they are provided to non-natives; they are funded on a shared basis by Canada and the provinces. But primary medical services for native peoples are supplemented on reserves and in remote northern communities by the MSB through hospitals, nursing stations and health centres staffed and funded by the Branch. Uninsured services, that is those not covered by medicare, such as eye glasses, dentures, prescription drugs and medical transportation services, have been paid by MSB. The Branch's budget of $100 million and its complement of 4,000 staff constitute a large segment of public investment in health care in Canada.

Yet notwithstanding the dedication of MSB and its staff, and the expenditure of these sums, the grievous state of Indian health today is plain for all to see. The reason is that so many of the causes of Indian ill-health lie beyond the fact of illness itself, and the remedies lie beyond the mandate of MSB.

Indians are usually poor. Their homes are crowded. One-third, at least, of their houses are unfit for human habitation. There is a lack of clean water, and inadequate sewage and garbage disposal. The prevalence of respiratory illness among Indians is, of course, aggravated by the absence of central heating in a cold country.

Cultural changes can also contribute to ill-health. The shift among Indian mothers from breast-feeding to bottle-feeding appears to be associated with increases in infant deaths from gastro-intestinal disease. Poor diet, especially a preference for junk food and pop, has resulted in malnutrition and other forms of disease. Anyone who has been to an Indian reserve has seen the evidence of dental decay and disease in the mouth of nearly every child.

The picture is discouraging. And in recent years it has been compounded by an epidemic of violence associated with the use of alcohol in Indian communities. The "Indian Health Discussion Paper" prepared by a task force within MSB says:

> While death rates for Indians have always been high, there is now a new and alarming phenomenon: Indian people are experiencing a rapid increase in deaths from accidents, poisonings and violence. In 1978, more than one Indian in every 400 died from violent or accidental causes with an estimated 30 to 60 per cent associated with alcohol and drug abuse. In national terms, this is equivalent to 58,000 deaths in Canadians which, if it occurred, would be viewed as a national disaster. Even more alarming are the facts that nearly one in five of these deaths was due to suicide and that the numbers of suicidal deaths have doubled since 1975.[6]

The breakdown in the social fabric in Indian communities is seen to be most acute among the young: In the Pacific Region, for example, 50 per cent of all suicides in 1978 were among males under the age of 25.[7]

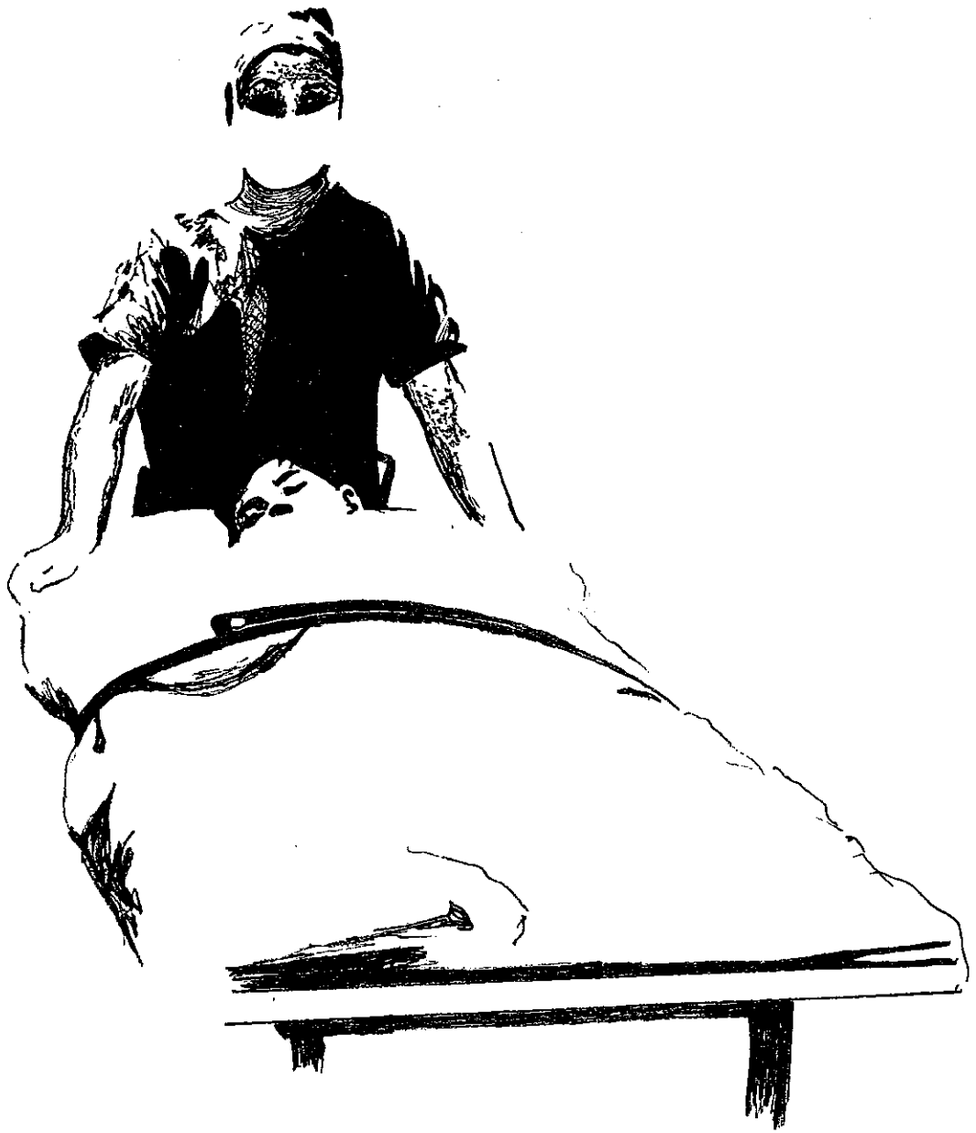
Three decades of health education and improved access to health care in Canada's general population have effected consistent and dramatic reductions in the stillbirth and newborn death rates. Yet, despite this, the stillbirth rate for Indians remains over twice that of the population as a whole, and death of live-born infants in the first 7 days is 1.8 times greater. Infants in the first twelve months have twice the death rate of those in the general population.

(These comparisons are for the Pacific Region in 1978.)[8] Any further improvement will have to come from an amelioration of the underlying causes of Indian ill health.

The problems of Indian health are the outcome of centuries of oppression, of the domination of one society by another. Noel Starblanket, President of the National Indian Brotherhood (NIB), speaking at the Opening Ceremonies of the Battlefords Indian Health Centre, on July 26, 1979, expressed the Indian point of view:

> To be forced to live a life that is totally out of one's own control is a source of constant stress, and leads to the weakness and demoralization of individuals and of entire communities. We as Indian people have been forced into coerced dependence upon paternalistic and ever-shifting federal policies and this situation has contributed to a great extent to the manifestations of social ill health now seen among us, including alcohol and drug abuse, family breakdown, suicides, accidents, and violent deaths. There is increasing scientific evidence that the stress of dependence and uncertainty leads to physical sickness and disease as well.[9]

The Indians' loss of faith in themselves cannot be restored except by their own determination to rediscover themselves and forge their own distinctive and contemporary identity. This is what is happening in Canada today. The Indian people are determined to remain a distinct



people in our midst. Their determination in this regard has given rise to the land claims movement and the call for self-determination in all aspects of their lives. Noel Starblanket, in his Battlefords speech, discussed the ramifications of self-determination in the field of health care:

> Our people are becoming increasingly vocal in expressing that the all-important first step in combatting these social pathologies is for our communities to take their destiny back into their *own* hands, and to set their own goals and priorities. The few Indian communities that have succeeded in the struggle to regain control of their own affairs have demonstrated a remarkable increase in community spirit, and a corresponding decrease in problems with social diseases and violence. Such communities serve as living proof that the main barriers to improved Indian health are both social and political, not simply medical and that the relationship between paternalistic government attitudes and the ill-health of our people is a very real phenomenon.[10]

Herein lies the only possibility for restoring the health of Indian people and Indian communities, the only way of eradicating the underlying causes of Indian ill-health. The Indian people must be offered the means of addressing these causes.

THE NEW INDIAN HEALTH POLICY

On September 19, 1979, the federal government adopted a new Indian Health Policy, by which it

> ...is committed to promoting the capacity of Indian communities to play an active, more positive role in the health system and in decisions affecting their health.[11]

Under the new policy, the special relationship between the federal government and the Indian people is to be strengthened by opening up communication and establishing greater involvement by Indian people in the planning, budgeting and delivery of health programs. The new policy recognizes the special needs of Indian health and emphasizes "increased participation of Indian bands in health care delivery...and provides for close consultation...on health programs, finances and allocation of resources".[12]

The goal of the policy is to achieve an increasingly improved level of health in Indian communities, generated and maintained by the Indian communities themselves. This is a reflection of the tendency of federal policy in Indian affairs since 1973, most recently exemplified by the statement by the Honourable Jake Epp, Minister of Indian Affairs and Northern Development, on November 20, 1979, in which he said that his Department must cease to be an administrator of services and become an adviser and facilitator of community-based development.[13]

The federal government's policy recognizes that the strengthening of social, economic, cultural and spiritual development in Indian communities is the foundation for the improvement of Indian health. In this, the federal government's policy is entirely consistent with the Declaration of Alma-Ata, which was promulgated at the International Conference on Primary Health Care, September, 1978, and which received the support of all delegates at the Conference, including those from Canada. Article VII of the Declaration of Alma-Ata says

> 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...[14]

Without necessarily subscribing to the views expressed by Ivan Illich in *Limits to Medicine*,[15] it is possible to conclude that all of us have become too dependent on the ministrations of our physicians and other medical professionals. With Indian people, given their more serious health problems, that dependence is much further advanced. Hence their call for self-reliance is one that possesses a higher profile — a more compelling dimension — in the context of their condition generally.

INDIAN GOALS IN THE FIELD OF HEALTH CARE

The Indian people wish to move from a condition of dependence to one of self-reliance so far as the whole range of their relations with the dominant society is concerned. This is what the land claims movement is all about. This is

what we should understand Indian people to be talking about when they speak of self-determination.

But this does not mean that the Indian people want to take over the MSB medical establishment. They are not now capable of running it. Furthermore, they realize that the whole question of health care is bound up with a host of other questions — questions having to do not only with housing, water supply, and sewage disposal, but also with schools, cultural renewal, economic opportunities, and the development of institutions that reflect their common interests.

So the strengthening of the whole fabric of Indian culture, Indian communities and the Indian economy is the key to improving Indian health:

- Better housing will reduce the incidence of infectious diseases and a number of serious respiratory ailments.
- A school curriculum that emphasizes dietary habits, hygiene and personal responsibility for health in a manner relevant to Indian children will contribute to the improvement of Indian health.
- A new pride in the Indian past will check the erosion of Indian cultural values. Indian mothers will no longer feel bound to give up breast feeding their children in order to conform to their perception of white middle-class norms.

More important, however, than any other step, is the need for Indian people to assume responsibility for the management of their own affairs, including their own health programs.

In his Battlefords speech, Noel Starblanket said:

> I assert that the era of exclusive federal management and control of the health systems and programs which directly affect the Indian individual, the Indian family, and the Indian community is hastening to its end. Indian people must now express their rights to self-government, and provide policy and program direction to all those organizations — whether government or private — who are committed to helping to improve their health status. The doubt and cynical attitude which pervades many of the professionals within these organizations, can only be eradicated when a community educates itself, takes pride in its self-sufficiency, and demonstrates to the providers of service how a community can become self-reliant, and therefore not entirely subject to the whims of an unfeeling and distant government.
>
> However, structures must be set up so that band representation can participate in the decision making, priority setting, and planning exercises of the health delivery, and to convert to a *community based and community designed and controlled health care system*....
>
> Also of vital importance, is the principle of an ever increasing development of, and reliance upon, local Indian people as the primary providers of skilled technicians, and health administrators....
>
> To go a step further health care is not only everyone's right, but everyone's responsibility. Informed self-care should be the main goal of a health program, given that people, provided with clear simple information can prevent and treat most common health problems in their own homes, earlier, cheaper, and most often better than can doctors. Consequently, *basic health care should not be delivered but encouraged*, and medical knowledge should not be the guarded secret of a select few — but should be freely shared by everyone.
>
> Ultimately the health system must encourage wellness, self-care, prevention, and family development. It must utilize traditional medicine mechanisms, and encourage self-reliance and dignity in the delivery of an essential community service.[16]

How, then, do the Indian people aim to achieve self-reliance in the field of health care? Through meaningful participation, with control of their own health care at all levels — community, regional and national — as the ultimate goal. The process must, of course, be founded upon participation at the community level, but at the same time, the Indian people believe that they must organize at regional and national levels: without such organization, they

believe that no coordination or consolidation of their views on health care can take place.

Increasingly, there is an identity of interest among Indian people in the need for improvement of their health care, and they are participating in many activities across Canada to this end. In the Cree community at Moose Factory, a planning committee representing status and non-status Indians has been working with government departments and outside consultants to improve water and sanitation systems. The Health Committee at Wemmindji (Paint Hills) in Quebec undertook, with the help of a nutritionist, to develop local sources of Vitamin C from the bush. The Health Committee at Sandy Lake in northern Ontario has begun a Pa-me-e'-ti-win (Homecare) project. The work of Alberta's Nechi Institute provides evidence that spiritual reawakening can lead to a reduction in alcoholism. At Big Trout Lake in Ontario the local Indian band developed, on its own initiative, a scheme for sewage and garbage disposal based on the principle of appropriate technology, as an alternative to an expensive sewer system.

The Community Health Representatives (CHRs) trained by MSB, many of whom are now employed by band councils, assist in providing primary health care in Indian communities. All of the CHRs are Indians, and almost all of them are women. In the field of health care, Indian women are contributing much, and can contribute much more. On February 13, 1980, I attended a meeting of one hundred CHRs from all over British Columbia. They insisted on meeting on their own, in a forum that would not be dominated by government officials or health

professionals. It was the first such meeting, and the frank discussion of health problems and health needs, which they had, was of immense value.

Many of these developments have been spontaneous and have emerged from Indian initiatives. (A working inventory of such initiatives is appended to this Report.) Through them, the Indian people have demonstrated not only their desire to lessen their dependence on government and the MSB, but also their ability to play an active role in achieving this.

MEANINGFUL CONSULTATION: A COMMON GOAL

No one has suggested that existing consultative machinery is adequate. The new Indian Health Policy has given rise to a real expectation that important changes will soon take place in enlarging Indian participation in the management of Indian health care programs in Canada. The question is, what method of consulation will lead to substantive participation by Indian and Inuit people in their health system? An allocation of $950,000 per year has been made to be used to develop a consultation process between the Department of National Health and Welfare and the Indian and Inuit people.[17]

When consultation has taken place it has been conducted under MSB auspices on an ad hoc basis. There have been meetings between MSB officials and chiefs and band councils, and some bands have set up health committees. Their effectiveness, however, is limited because they are purely advisory. There has been no effective

consultation at the regional[18] level. Neither has there been any effective consultation at the national level. The unsatisfactory nature of this situation was shown by the failure of the federal government to consult the Indian people about the guidelines for uninsured services established in December 1978.

The inadequacy of present arrangements has been summed up in the Indian Health Discussion Paper: Current channels of communication between the Department and the Indian people often consist of irregular and informal meetings on current problems, usually at the request of Indian leaders. Insufficient staff assistance, together with crowded agendas and a bewildering array of issues, has put Indians at a disadvantage, particularly as regards the long-term perspective required for health promotion and prevention efforts.

There is mistrust, too. Dependency breeds a sense of grievance. The longer it continues, especially when those who are dependent are seeking to achieve the means to self-reliance, the greater the tension. This tension characterizes the relations between the federal government and the Indian people today.

What then is to be done? What should be the goals of the consultation process? How should it be conducted? Who should be responsible for the expenditure of the consultation funds?

The consultation process should be designed to achieve three goals: a flow of information between Indian people and those agencies engaged in the delivery of health services to Indian people; the meaningful involvement of Indian people in decisions relating to all aspects of health care; and Indian control and management of their health care programs. Furthermore, if the consultation process is to succeed, there must be a genuine willingness by all parties involved to work together towards the common goal of improved Indian health. In the words of Dr. Lyall Black, Assistant Deputy Minister in charge of MSB, "Consultation entails being prepared to listen to our clients and being prepared to change, based on what they have to say".[19]

The consultations that MSB officials and employees have carried on in the past at the band and zone levels have been funded out of ordinary operating expenditures. It has been suggested that the money to be provided annually for consultation should be used to strengthen this mode of consultation. Funds provided through the MSB regional offices would be channelled to communities. The MSB believes the consultations should involve its staff at the regional and zone levels and Indian communities grouped together in geographical or tribal arrangements. There would also be meetings between representatives from MSB Headquarters and the NIB to review national programs and priorities and the allocation of resources between regions to reduce or eliminate disparities.

The Brotherhood and the Provincial and Territorial Indian Organizations (PTOs) propose that the funds should be administered by the National Commission Inquiry on Indian Health (NCI), which is a sub-committee of the NIB's executive council. Pursuant to the Brotherhood's proposal, the NCI would receive $150,000 per annum. The PTOs would receive core funding and additional funds based on a formula that would take into account the size of their populations. Funding would be extended to Indian bands and organizations not presently affiliated with the NIB.

The NIB says that consultation will be meaningful to Indian people only if Indian organizations have control of the process itself. If Indian people are to administer their own health services, they have to start somewhere. The sum of $950,000 represents less than 1 per cent of the MSB budget.

The Brotherhood's proposal is that the PTOs should have responsibility for the management of the consultation process. This may entail the establishment by a given PTO, in the first instance, of a health portfolio to stimulate and coordinate the formation of health councils at the band level or the tribal level. It may entail meetings of representatives of band councils to formulate policy and programs. It may also entail the establishment of a provincial health council. Some PTOs are already in a position to proceed with the development of a health council structure; others are not. I will turn to these proposals in some detail in the next section of this Report.

A third suggestion was made: instead of placing the consultative process in the hands of the MSB or the Indian organizations, it should become the responsibility of a new body consisting of representatives of MSB and

the Indian people, and perhaps of the Department of Indian Affairs and Northern Development as well. This body, with a staff of its own, would be independent of MSB on the one hand and of the Indian organizations on the other hand. The difficulty with this suggestion is that it would entail the erection of a new bureaucratic structure, not only at the national level, but also at the regional level, if it were to implement the consultation process adequately.

I have concluded that the management of the consultation process and the consultation funds should be placed in the hands of the Indian organizations, that is, the NIB and the PTOs.

I think there will have to be established, over time, health councils at the band or tribal level. But the Indian people say that so long as the government deals with them band-by-band, there can be no effective policies and programs developed by Indians themselves. Their interests will remain fragmented; there will be no unified expression of Indian interests in the field of health care. I think this position is sound. So there will have to be health councils at the regional level, as well as a national Indian health council. These health councils, at all levels, will provide the forum for consultation between the Indian people and the Department of National Health and Welfare.

Since the object of the new Indian Health Policy is to transfer to the Indian people the responsibility for their health programs, the responsibility for managing the consultation process should be given to them. There can be no doubt that whoever calls the meetings and decides who should attend will effectively control the consultation process.

It would not be wise to elaborate on the structure of health councils. This will be a matter for the Indian people. But some things can be decided now. The consultative machinery must not be merely advisory. It must have the power to determine the shape and direction of the consultation process, and in addition, may undertake in due course operational functions at the local level and coordinating and research functions at the regional and national levels.

I have referred to health committees, health councils and health boards. There are health committees now in many Indian communities. In their relations with MSB they are purely advisory. The health councils envisaged in this report would be funded and would have a mandate from band councils, the PTOs and the NIB, as well as access to the MSB. Dr. Black has said that "(in) the process of consultation, we will have to open our financial books and be prepared to discuss in great detail each and every aspect of the program, to justify utilization of resources and expenditures".[20] Health boards (for example, the Battlefords Indian health board) would evolve as health councils move from consultative to executive and operational functions. Since this report is about consultation, I have dealt chiefly with health councils.

Consultation about the ways in which Indian people and Indian communities are to participate in the planning, budgeting and delivery of health programs cannot be severed from participation in the actual planning, budgeting and delivery of these programs; the shape of the institutions that will be erected to implement the new Indian Health Policy will emerge from the consultations. These institutions, established for purposes of consultation, will become institutions for the delivery of health care. Hence, the extent to which the Indian people participate in the consultations will have a direct bearing on the extent to which any program for Indian participation in the management of their health care programs succeeds. I therefore recommend that the management of the consultation process and the consultation funds be in the hands of the Indians.

I should like to emphasize that all of the consultation money should be allocated to the PTOs and the NIB (subject to an appropriate share being made available to Indian bands and organizations which are not affiliated with the NIB and the PTOs). It has been suggested that some of the consultation funds be used for cross-cultural training of MSB staff. I do not doubt the need for such training, but the money for such a program should not come out of the consultation funds. It ought instead to come out of funds available for staff training and development. Otherwise there is a danger that the consultation funds — which must do for the status Indian population of the whole country — will be distributed so widely and for such a miscellany of purposes that they will not be spent effectively at all.

Do the NIB and PTOs have the capacity to manage the funds competently? Indian bands in Canada are managing the expenditure of a great deal of money. Today, 519 out of 573 bands are administering one or more local programs or services with a total budget of $227.2 million. In

addition, bands receive $28.8 million to cover the administrative costs of the programs.[21] In the field of health care there are already 397 contracts in effect between MSB and Indian bands and organizations, covering an expenditure of $10,175 million.[22]

If the Indian bands can be trusted to manage competently the money entrusted to them, why should not the management of such expenditures also be entrusted to Indian organizations, such as the NIB and the PTOs, which are the creatures of the Indian bands, created by them to carry out purposes that Indian bands alone cannot achieve?

On February 7, 1980, the Department itself made grants totalling $192,750 to the NIB and the PTOs, out of funds appropriated for consultation during the current fiscal year, and these grants were distributed on the basis of a formula submitted by the Brotherhood.[23] These funds were made available for the purpose of informing chiefs and band councils of the current status of the consultation process and developing plans for health education at the band level.

There is every reason to give Indian people responsibility for the management of the consultations. Only in this way will the consultations be productive. Only in this way will the consultation process constitute a preparation and the means for greater participation by Indian people in their health care programs.

The Minister of National Health and Welfare is responsible for Indian health care. The creation of Indian health councils will not alter that state of affairs, except to the extent that the Minister and the band councils agree to alter it. The timing and the extent of any transfer of responsibility will be up to them.

In some instances, the transfer of responsibilities has already begun. The Nishga Tribal Council has entered into a contract with MSB to lay the groundwork for the establishment of a local Indian health board to manage health care in the Nass Valley. In North Battleford, a cluster of bands has established a district health board to operate a hospital, a clinic and related services.

Some local bands will not wish to move beyond the consultation process for some time. Others will wish to proceed at a faster pace. In each instance, it will be a matter for the local chief and band council to determine for themselves.

Indian people have expressed an especial concern about preventive medicine and public health. It may be that some band councils will seek to assume responsibility for these

immediately. Aspects of curative medicine may come later. For instance, while the responsibility for home visit care can be transferred soon, the transfer of responsibility for hospital care and nursing care may have to wait. These are questions that band councils and local health councils will have to consider and upon which the health councils to be established by the PTOs might offer advice.

While I have outlined the differences that emerged in the course of this Inquiry, they should not be allowed to obscure the fact that there was common ground on a range of issues. An examination of the proposals made by the NIB on the one hand and the Indian Health Discussion Paper on the other hand reveals many points of convergence. I think there is a consensus for the recommendations I am making.

THE PROVINCIAL AND TERRITORIAL INDIAN ORGANIZATIONS

The PTOs are already seeking to coordinate health activities at the regional and band levels. They have begun to bring band, district and tribal representatives together to consult on Indian health. Out of their common concerns, a number of detailed health policy papers, as well as programs in health liaison, community health, and health curriculum development, have emerged at the regional level. Out of them, too, have come proposals regarding the function and configuration of consultative machinery.

The PTOs have devised well-articulated plans calling for meaningful local participation in consultation on Indian health policy and programs. In view of this and considering their particular ability to respond to regional and district differences, these Indian organizations are the bodies best suited to administer the health consultation funds in each region.

A number of PTOs, such as the Union of British Columbia Indian Chiefs, the Manitoba Indian Brotherhood, and the Federation of Saskatchewan Indians, have established health liaison programs. Many of the publications of the PTOs carry articles with advice on how to improve personal and community health. The Ontario Indian, for example, published by the Union of Ontario Indians, ran an article in January 1980 discussing the advantages of breast feeding to infant health. Indian health centres governed by Indian boards have been established at Morley, Alberta, and at North Battleford, Saskatchewan. The Federation of Saskatchewan Indians is developing a health curriculum for Indian schools in cooperation with the Saskatchewan Indian Cultural College. The Lennox Island band council of Prince Edward Island proposes to develop materials on nutrition, diabetes, prenatal care, child care, drugs and alcohol.

Although the proposals prepared by the PTOs vary considerably in scope and method, according to particular regional needs, five characteristics are common to all.

The approach to consultation advocated in all the proposals is *developmental*. The proposal by the Confederation of Indians of Quebec (CIQ), for example, provides for the first two years to be spent collecting information nationally and locally. Only in the third year would bands be encouraged to form local health committees. Similarly, in the case of the Federation of Saskatchewan Indians, a provincial Task Force on Indian health would study priority health problems and take up the concerns of district fieldworkers. Not until its fourth year of operation would it become the official Health and Social Policy Board of the Federation.

Second, all proposals call for *participatory* consultation. Public meetings, workshops, and the development of tribal and regional health councils are essential elements of many of the proposals. Treaty No. 3 has presented perhaps the most detailed plan for participation in the development of local health councils; its proposal deals at length with membership, functions and representation on a district level council.

All of the proposals are *integrated* into the overall program efforts of the PTOs. The health consultation process proposed by the Union of British Columbia Indian Chiefs, for example, is seen as one component of the Health and Social Development portfolio of the Union. With the Union of Ontario Indians, the consultation process has become an important part of the long-range planning of all of the Union's socio-economic development programs.

All the proposals call for the health consultation process to be directly *accountable* to chiefs and band councils: they meet, they discuss, they choose, they act. The PTOs facilitate these activities, but do not direct them. Again, the Treaty No. 3 proposal is the most detailed in operational terms on this point, but all of the other proposals are explicit about the principle.

Finally, the proposals indicate the *fiscal responsibility* of the PTOs. The budgets presented are clear and realistic. The objectives of each proposal are also clear, promoting useful opportunities for evaluation.

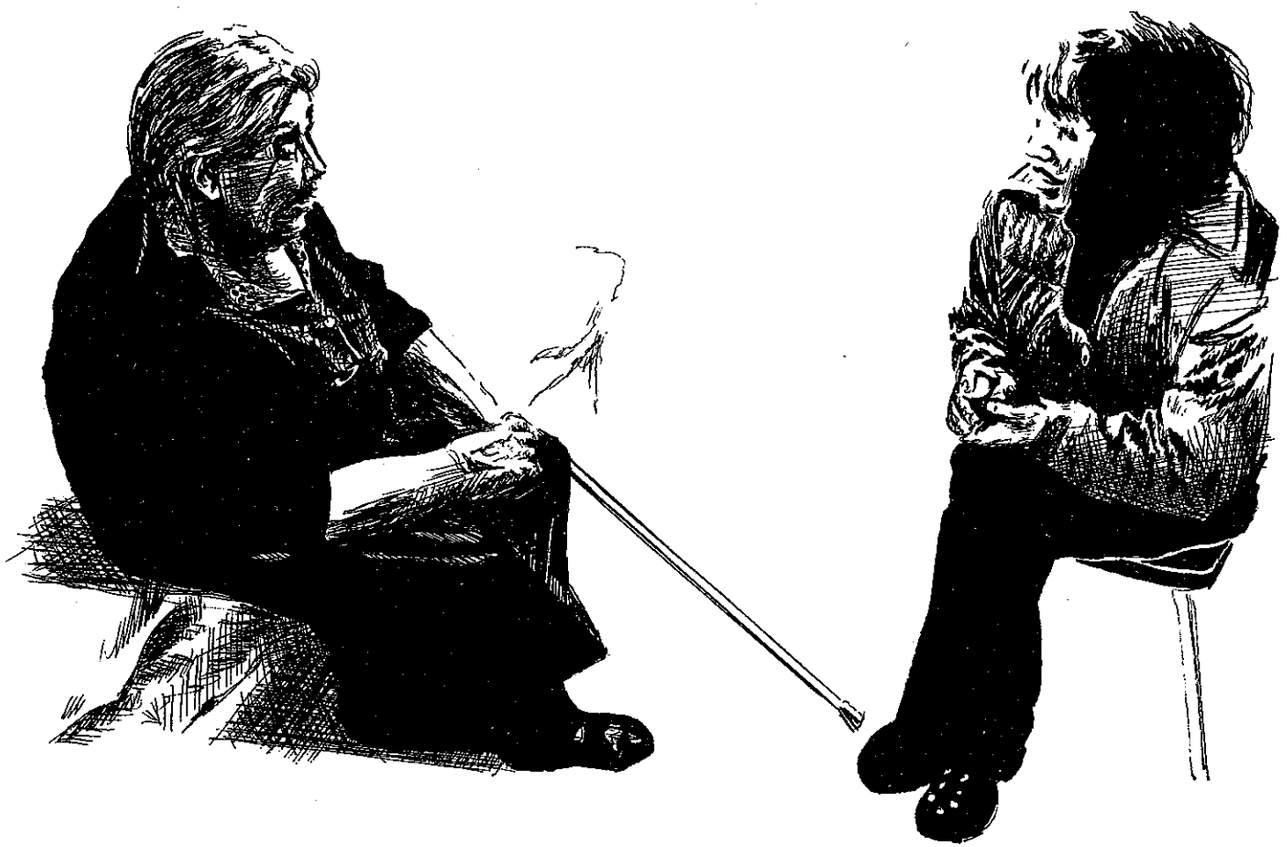
Let me examine the proposals in turn.[24]

In the Maritimes, both the Union of New Brunswick Indians and the Union of Nova Scotia Indians, whose health liaison officers were absorbed into the drug and alcohol programs several years ago, wish to re-establish health liaison programs. The chiefs would serve as the initial health council for each organization, and funds would be required to support regular meetings. The Lennox Island Band Council of Prince Edward Island has proposed a training program for local health educators to develop materials and hold workshops on nutrition, diabetes, child care, prenatal care, weight control, drugs and alcohol.

The Confederation of Indians of Quebec proposes a five-phased approach to consultation on Indian health. The first two years would involve the collection of data on Indian-controlled health services across the country, followed by a general meeting of all bands at which this information would be presented and bands would then collectively choose their course of action. In the third and fourth years, each band would either form its own health and welfare committee or join with other bands to form a regional health and welfare committee. During the fifth year, meetings would be held between designated band representatives and government representives to plan the transfer of health services to Indian people.

The Association of Iroquois and Allied Indians in Ontario plans immediately to form a health council, consisting of two members from each reserve plus a lesser number of government representatives, to enhance communication between those who use and those who provide and increase knowledge about health. Using existing resources, the health council's functions would be enlarged over a five-year period to include identification of health needs, promotion of new services and the establishment of priorities in Indian health.

The Union of Ontario Indians has a mandate from its chiefs to nominate a health review working group to formulate specific policy on issues such as the function of the community health representatives, assessment of community needs, band council contracts and federal-provincial cost sharing. An extensive plan is proposed for training workshops for the working group as well as for special health representatives designated by each band who would, ultimately, become the members of district health councils. This consultation work would be coordinated by the Union's health and environment program.



Grand Council Treaty No. 9 has been charged by its chiefs to use the consultation funds for workshops in each of its six tribal administrative areas to discuss the possibility of setting up Indian health councils. Chiefs and health personnel would be invited to these workshops. These meetings are also seen as an excellent opportunity to discuss and seek solutions to current problems of local health committees and CHRs.

The proposal entitled "The Development of an Area Indian Health Board for the Treaty No. 3 Portion of Northwestern Ontario", prepared under the auspices of Treaty No. 3, is probably the most comprehensive plan for an Indian health board produced in Canada to date. It calls for the establishment of such a board in three phases. Phase 1, due for completion this fiscal year, involves the development, testing and acceptance of an area health board concept. Phase 2 is the implementation phase, outlining options for the local level development of band health committees and the necessary political sanctions at all levels. During this phase an administrative core group would be formed to act as a technical resource for health committees and the tribal council. The goal of Phase 3 is to have in operation a stable and recognized Indian health board structure. This plan, to be carried out by Treaty No. 3's health personnel, combines the functions and financing support for consultation with the existing health liaison program.

Nearly ten years ago, the Manitoba Indian Brotherhood recommended the formation of an Indian health board. Today it proposes to set up immediately a steering committee on Indian

health to study the feasibility of a Manitoba Indian health board. The committee would consist of members from each of the Brotherhood's nine regions or tribal councils. Health liaison workers in each region would link local health committees to the steering committee, which would itself eventually evolve into the board. Workshops would take place with the health committees and band councils of every reserve to assess needs, plan action, and feed the results directly to board representatives. This plan would be coordinated by the Brotherhood's health liaison program, which is one of the most extensive in the country.

The Federation of Saskatchewan Indians proposes to form a task force on Indian health which, over a three-year period, would address health policy questions, identify solutions and funding sources, and take appropriate action. This task force would evolve into the health and social policy board of the Federation. Each district government would appoint one member to sit on the board. Six regional fieldworkers, reporting to the district chiefs, would serve as resources to local health committees. The Federation's plans also call for a province-wide health conference to which would be invited federal and provincial health-related political representatives.

The Indian Association of Alberta has for several years advocated Indian control of Indian health services. Treaty No. 7 has recently proposed the formation of an Indian health care commission for Alberta consisting of seven members of the Association's bands plus seven health professionals from both the province and the federal government. The commission would provide research and planning services to tribal boards of health and staff training for local bands. Tribal boards of health responsible to the chiefs and councils would have full jurisdiction over delivery of health services on reserves. Each reserve would choose either to have its own local board of health or to join with other reserves into a tribal board.

The Union of British Columbia Indian Chiefs views the consultation process as an opportunity to determine the health care needs of bands, build an information base for health care planning and identify redundancies and shortages in the current system. Fieldworkers in the four districts and a coordinator, working under the health and social development portfolio of the Union, would undertake intensive discussions with as many bands as possible. A consolidated report from all districts would then be taken to the chiefs, and directions for the next phase of consultation would be determined.

The Yukon Native Brotherhood, which has now merged with the Council for Yukon Indians, proposes to engage a health coordinator and research and fieldwork personnel to develop its own technical capacity in health. In addition to specific research projects, this staff would coordinate training workshops for local CHRs, band social workers and alcohol workers. Emphasis would be on bringing in resource people from the communities themselves. The program would also initiate meetings in communities to discuss local health problems. The recent amalgamation of the Yukon's native organizations will place even greater demands on the capacity of the health program.

The Dene Nation proposes to bring together immediately representatives of its five regions to hold detailed discussions on Dene health and health care policy. During the 1980-81 fiscal year, there will be meetings at the local level; then there will be meetings held in each region, where future health consultation activities will be planned according to the direction given in the community-level discussions.

THE POLITICAL QUESTION

The Indians have common interests that unite them band to band. They have formed tribal and district councils to advance those common interests. They have formed provincial and territorial organizations to advance their interests at that level. And at the national level they have established the NIB. These organizations are, it is true, dealing with political issues. But health care, too, is a political issue. Certainly the issue as formulated in the new Indian Health Policy is a political one. For if people are to equip themselves to be in a position to manage their own health programs, they will have to organize themselves for the purpose. They will have to elect local health councils, communities will have to decide on programs and priorities, and appointed officials will have to be held accountable. These things are the stuff of politics. It would be a mistake to think that health policy can be developed and health programs run as if they were entirely questions of expertise, questions concerning the application of medical technology, questions to be resolved in an antiseptic atmosphere.[25]

I think that since the Indian people have created their own political organizations in each

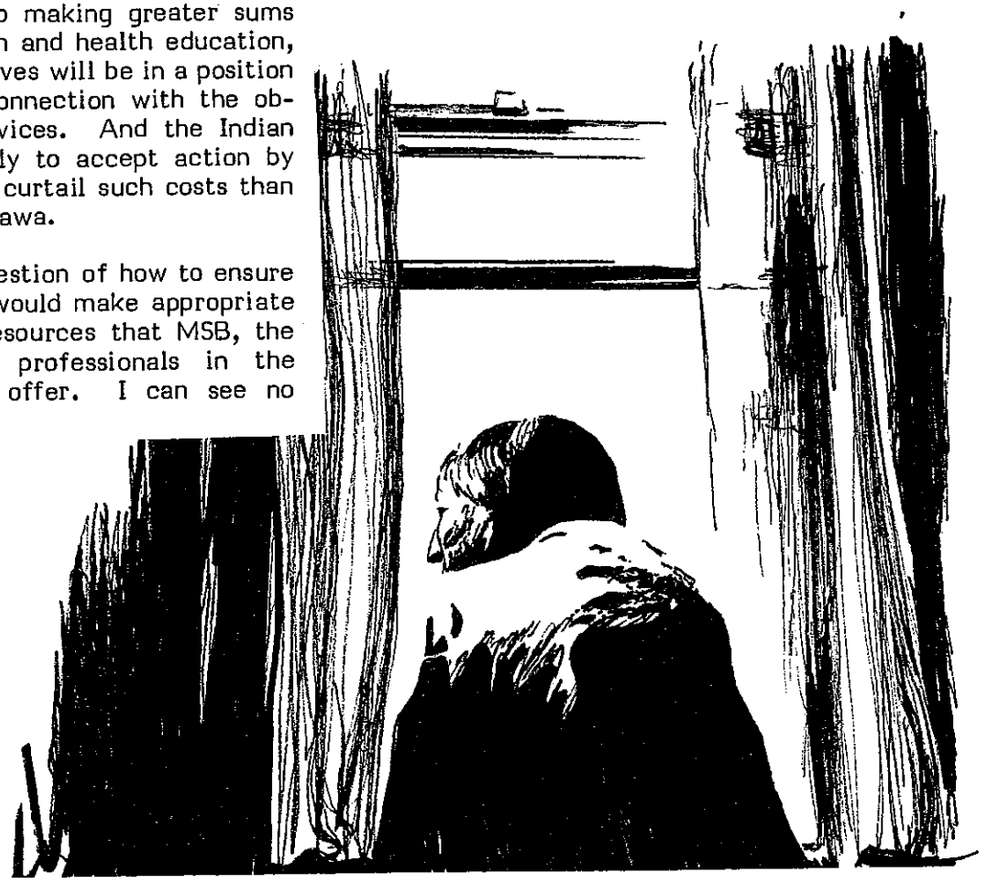
province, the government should call upon these same organizations to administer the funds to be provided for consultation. The political prestige, resources and influence of the PTOs should be used to advance the consultation process. Indian health consultation programs must, at the provincial level and the national level, be run by Indian people; they must be the creation of the organizations which the Indian people have built themselves.

Once the principle is accepted that Indian people must play a greater part in managing their health care programs, it follows that in due course Indians will have to establish some kind of structure beyond the band level for that purpose. The existing MSB structure does not consist merely of community-level personnel, such as the nurse at the nursing station. There are zone directors, regional directors, and so on. Health care for 300,000 people as widely dispersed as the Indian population of Canada cannot be provided without such a structure. So the government in future will have to recognize the importance of Indian political structures beyond the chief and band council level. It is vital that, at the regional and national levels, just as at the band level, we make use of existing Indian political organizations, rather than create new ones that would replicate existing structures and dissipate Indian energy and initiatives in a welter of new structures.

Such an arrangement has advantages that extend beyond health care itself. When Indian people become responsible for the allocation and expenditure of the money available for health care — necessarily a finite sum — they will be in a position to address the question of the cost of their health care. Take uninsured services. If the present cost — said to be $30 million — of uninsured services is excessive, if savings can be made, this will be a matter for the health councils to consider. The Indian people have said that they wish to see public health and health education emphasized in a new health care system; if costs are excessive, and if savings can be made, with a view to making greater sums available for public health and health education, the Indian people themselves will be in a position to deal with abuses in connection with the obtaining of uninsured services. And the Indian people are far more likely to accept action by Indian health councils to curtail such costs than by a fiat from far-off Ottawa.

Then there is the question of how to ensure that the health councils would make appropriate use of the advice and resources that MSB, the universities and health professionals in the private sector have to offer. I can see no difficulty in this regard.

Since 1973, the federal government has accepted the right of Indian communities to have their own schools, their own teachers and their own curriculum. Today, in province after province, programs are being established to train Indian teachers to teach in Indian communities, and schools are being established with a curriculum designed for Indian children.



This is happening because Indian people want schools where their children can learn Indian history, Indian languages, Indian lore and Indian rights. But it does not mean that Indian people are rejecting the advice and assistance of the education establishment or rejecting conventional education itself. They know their children must learn to speak English (or French, as the case may be), and must study mathematics, science and all of the things necessary to function in the dominant society. Likewise, the establishment of health councils does not mean that Indian people will reject the advice and assistance of MSB and health professionals or reject conventional medical care.

The matter of Indian health care is critical, as evidenced by a multitude of reports. Since the beginning of 1980 another report has become available that repeats the dreadful news: the report on infant mortality in the Northwest Territories, issued by the Department of National Health and Welfare and the University of Alberta.[26] Drastic measures are called for. I cite the Discussion Paper again:

> It has become apparent that government's efforts to improve the health of Indian people are no longer having the desired effect. Our standard medical tools do not seem to address the problems of high hospitalization rates, violence, anti-social behaviour, suicide — all indices of an accelerating crisis of health and social breakdown. We always thought that, as health professionals, we knew what Indians needed with respect to health care, and in areas where we concentrated our attention, such as communicable diseases and maternal and child health, we began to see improvements in health status. Just as DIAND (Department of Indian Affairs and Northern Development) managed other areas of Indian life, so National Health and Welfare managed those aspects of health care for which it exercised particular responsibility, such as public health, controlling policies, programs and resources. However, not only is health status unimproved by today's standards, the situation is incompatible with both the aspirations of the Indian people and the tenets of self-determination and human rights. It has contributed to a deep-rooted passivity vis-à-vis the health services which has almost destroyed the interest of the Indian people in providing for their own health needs.[27]

The Indians have already begun their journey from dependence to self-reliance. There can be no turning back. The tendency of the federal government's policy since 1973 has been to offer native people the opportunity of managing their own affairs, on the basis of institutional arrangements that recognize their common interest in such matters as education and health.

Critics of this approach have described it as a policy of separate development; that criticism is unsound. Native people in Canada are seeking the right to distinct institutions of their own as the original peoples of Canada. But they also want — and we want them to have — a complete right of access to the political, social and economic institutions that serve all Canadians. Only if we were to deny them such access could Canada be accused of pursuing a policy of separate development.

A NATIONAL INDIAN HEALTH COUNCIL

Established in 1978 as a technical subcommittee of the NIB the National Commission Inquiry on Indian Health (NCI) has been the vehicle for bringing together the health representatives of the PTOs. I sat in on the Commission's two most recent gatherings in Vancouver and Victoria and was impressed by the usefulness of the exchange of views and experiences in Indian health from across the country, and by the seriousness with which provincial and territorial representatives carry out their responsibilities to their chiefs and band councils. Although the NCI was established only two years ago, its members have already developed a capacity to formulate health policy and to tackle MSB on health questions affecting Indians.

Taking direction from its members, the Commission's small permanent staff has made a significant contribution to the formulation of Indian health policy at the national level. The NCI is a forum that is not dominated by MSB representatives or health professionals. It provides a distinctly Indian perspective on health issues. The NCI's policy analysis has stimulated a great deal of activity on the part of both Indian and non-Indian constituencies alike. The Discussion Paper prepared by MSB draws heavily

upon the Commission's research as do a number of the PTO documents on Indian health.

In the short term, the Commission's effectiveness is threatened by uncertain financial resources: funding runs out at the end of the current fiscal year. I recommend that the funding of the NCI be established on a permanent basis, with a minimum level of support of $150,000 per annum. This sum would come out of the $950,000 appropriated for consultation.

As the NCI develops links with Indian health efforts across the nation, demands on its technical capacity are likely to increase and become more specific. Such demands can be expected to relate to research, the development of health education materials, seminars for training members of health councils, consideration of demonstration projects, and so on. Additional funds, beyond the core operating funds mentioned above, will be required. I recommend that these additional monies should be made available as and when required.

Given the likelihood of such responsibilities devolving upon it, the NCI may wish to transform itself into a National Indian Health Council. I would strongly support such a step, at a time deemed most appropriate by the NIB itself. There is no question that the NCI is already carrying out some of the functions of such a council. It constitutes the obvious core of Indian expertise and commitment on which to build a National Indian Health Council. Such a council would be in a position to review all of the initiatives in Indian health taking place around the country. The council would be a body whose information base and perspective would constitute a horizon against which each Indian community could decide upon its own priorities and its own health program.

Such a council might usefully consider such areas as diet and nutrition; training of health professionals and health auxiliaries; the future of the National Native Alcohol Abuse Program (NNAAP); the role of the Department of Indian Affairs and Northern Development (DIAND); and the question of health care delivery to off-reserve Indians and urban Indians:

Diet and nutrition have already been the subject of studies by the NCI. There is an urgent necessity for this issue to be addressed on a continuing basis at the national level.

Then there is the question of training. It is acknowledged that for many Indian people there is limited access to the health care system because of the unwillingness of non-Indian profesionals to live in remote Indian communities. At the same time there have been difficulties encountered in training a sufficient number of native people at the MD and RN levels.

The goals of native training programs would be to provide qualified native personnel to work for their own people toward the promotion of health, the prevention of disease, and the early detection, diagnosis, and treatment of illness. There is much to be done to promote health careers among Indians.

It has been suggested that a special curriculum with limited goals would create new categories of native health workers, such as the community health representative established by MSB. These workers would be given a short period of initial training before moving on to actual job experience; they would be given periodic courses to update their competence. Others urge special intensive courses that would prepare prospective native students to qualify for admission to conventional health care training courses. These are difficult issues; they ought to be addressed by a National Indian Health Council, working with MSB, with the training institutions, and with health professionals in the private sector.

The NCI has already taken a stand on NNAAP.[28] Whether the program should continue to have its own separate structure or should be integrated with the Indian health care program, is a question that would appropriately come before a National Indian Health Council. A task force on NNAAP is being set up by the Department of National Health and Welfare to consider some of these questions. Its report might well constitute a basis for consideration of the future of NNAAP by a National Indian Health Council.

The relationship of housing, water supply, and sewage disposal to health is well known. These responsibilities fall under DIAND. A National Indian Health Council would provide a forum for the joint consideration of all aspects of Indian health.

The question of the health care of status Indians off reserves, many of them in the urban centres, is caught in the interstices of federal-provincial relations. The federal government takes the position that its responsibility for any registered Indian ceases when he has left his

reserve for one year. Such an Indian, though eligible for medicare, is the object of controversy between the federal and provincial governments as regards the payment of premiums. And such an Indian may find that he has no claim on the federal government for uninsured services. There are questions which a National Indian Health Council could take up.

The influx of Indian people, both status and non-status, and Metis to the cities is one of the most striking aspects of the urban landscape. This is a subject that must be considered to be on a national basis. It will require cooperation between the status Indians and the non-status Indians and Metis. A National Indian Health Council would be the appropriate body to address this subject.

The papers and research materials prepared by the NCI or, if it is succeeded by a National Indian Health Council, by such a council should be made available to Indian bands and Indian organizations which are not affiliated with the NIB as well as to those which are.

OTHER INDIAN BANDS AND ORGANIZATIONS

Although the NIB is the largest and most representative Indian organization in the country, it does not represent all of the Indian bands in Canada nor does every PTO represent all of the Indian bands in its region. So funds will have to be withheld from the $950,000, to be allocated to those organizations and bands that are not affiliated with the Brotherhood and the PTOs.

Some of these unaffiliated bands and organizations are proceeding with their own health programs.

The Nishga Tribal Council, for example, has been awarded a $66,000 contract[29] with the Department of National Health and Welfare. The project to be financed by the contract would establish the basis for the creation of a Nass Valley Board of Health with an elected membership, and a local diagnostic and treatment centre as well (the closest hospital is 80 miles away).

The contract came about through participation by band councils, under the leadership of the Nishga Tribal Council, acting on the basis of advice by a local physician, and planning by the Tribal Council's employed resource person. Officials of DIAND were involved; a commitment for continuing cooperation was obtained from the provincial Ministry of Health; and full funding has been provided by the Department of National Health and Welfare. Throughout, the Nishgas have received the advice and support of MSB officials.

The contract will finance the employment of a coordinator who will work

> ... under the direction of the Nishga Tribal Council and in cooperation with the appropriate Federal and/or Provincial agencies, to plan, develop, and implement improved medical facilities and to develop a Board of Health which will take over the administration for the treatment and public health services in the Nass Valley. When the Board of Health is formally established, it is envisioned that the Coordinator will become the first Executive Director.[30]

The beneficiaries of the improved services will include, not only the status Indians in the Nass Valley, but also all other Indian and non-Indian residents.

There will be innovative projects, like that of the Nishga Tribal Council, brought forward as the result of a new awareness and a new concern by Indian people about health and health care. Whether they emanate from Indian bands and Indian organizations affiliated or not affiliated with the NIB, they must not be regarded as constituting a charge on the consultation money.

THE FUNDING FORMULA

The formula submitted by the NIB[31a] is as satisfactory as any formula is likely to be. It provides for $150,000 to be allocated to the NIB for the NCI. It provides that 25 per cent of the balance of $800,000 be distributed on a core funding basis, the remaining 75 per cent on a per capita basis. There are some provinces in which the PTOs do not represent all of the Indian bands. I think it is likely that all of the Indian organizations and Indian bands in each province can find a common basis for working together in connection with the distribution of the funds. However, if they cannot, those bands not affilliated with the PTOs would be entitled to a share on a per capita basis of the consultation funds allocated in that province.

This brings me to the situation in the NWT and the Yukon. In both Territories steps are being taken to establish one organization to represent the status Indians, the non-status Indians and the Metis. In both Territories the federal government has acknowledged, as a matter of practice, its responsibility to provide for the health care of all persons of native origin. The Dene Nation, insofar as it may fairly claim to represent the non-status Indians as well as the status Indians in the NWT, has a claim to a larger share on a per capita basis than it would if it represented only the status Indians in the NWT. The same applies to the Council for Yukon Indians, which recently became the sole organization representing persons of Indian origin in the Yukon. But there is a vital principle at stake here: The cause of the non-status Indians and the Metis is one that has history on its side. Nevertheless the acknowledgement of the rights of non-status Indians and Metis should not result in any diminution of the rights of the status Indians. Otherwise, no progress can be made by any of them. So as not to compromise the rights of the status Indians, the claims of the Dene Nation and the Council for Yukon Indians to further funding, as organizations representing non-status Indians and Metis as well as status Indians, should be honoured, but not by allocating them an appropriate additional share of the $950,000. Instead, there should be additional consultation money set aside to cover any further allocation to be made to the Dene Nation and the Council for Yukon Indians.[31b]

THE INUIT

The federal government has the same acknowledged responsibility for the health care of the Inuit as it has for the Indians.[32]

Much that I have said about the origins of Indian ill-health and the present crisis applies equally to the Inuit. Yet there are special circumstances in the case of the Inuit. So the health policy, and in particular, the consultative machinery, designed for the Indians, will not, in all its aspects, be suitable to the Inuit.

The essential argument advanced by the Indian people is one that the Inuit too urge: that the restoration of Inuit health depends upon the Inuit people finding a distinct and comtemporary place for themselves in Canadian life. Their search will take them in new directions, directions of their own choosing. This will apply in the field of health care as well as in other fields.

The coming of government and industry, and the arrival of the consumer culture, have had a terrific impact on the Inuit. Michael Amarook, the president of Inuit Tapirisat of Canada (ITC),[33] speaking in Ottawa on November 6, 1979, discussed the consequences for the health of the Inuit:

> ...a lot of the Inuit health problems stem from the fact that our lifestyle has changed so dramatically during my lifetime. The influx of development from the south brought with it many diseases which were unknown to my father. It is true that in the old days we did not have access to nurses and doctors. But our lifestyle was a lot more healthy. Everybody lived off the land and ate good country food which is far more nutritious than most of the food we sometimes have to buy in the Hudson's Bay stores.[34]

Mr. Amarook pointed to some of the statistics.

> To understand what is happening to the Inuit, just take a look at the changes in our growing population. Twelve years ago, there were just over 10 thousand

Inuit living in the Northwest Territories. In 1977, there were over 15 thousand, a 50 per cent increase. Today, most of our population is very young and the health of our children, particularly those under five years old, is one of the things I want to comment on today.

A study by the Canadian Pediatric Society this year showed that the Inuit baby in the N.W.T. had an average of 14 different diseases in the year compared with only 4 for the non-native population. And that same report said that Inuit babies made the largest number of visits to medical personnel in comparison with other babies.

Something must be wrong.

In the Northwest Territories, there is a higher death rate among Inuit babies than there is for the non-native population.

For example, in 1977, 25 per cent of the deaths among Inuit occurred among children under four years old. For the non-native people, it was only 17.7 per cent. The figures for last year are nearly identical.

The infant mortality rates for Inuit have been dropping since 1970 from a high of over 100 deaths per thousand population to just under 40. But a disturbing fact is that the non-native rate for 1977 in the N.W.T. was only about 16 per thousand.[35]

Thus the tragedy of Indian ill health is matched by the tragedy of Inuit ill health. But in the case of the Inuit, the causes may, in some respects, be different and remedial measures may also assume a different aspect. This is illustrated by a recent study in the Northwest Territories of perinatal and infant mortality.[36] This study offers evidence that even with twice as many visits to health service personnel, infant mortality among the Inuit has been twice that among the Indian population. With a rate of 105 infant deaths per one thousand live births, the Inuit sustained an infant mortality five times that of the white population in the Northwest Territories and four times that found in Canada as a whole.

Looking just at the perinatal losses — stillbirths and deaths in the first week of life — the white population in the NWT sustained a loss of 10 per thousand live births, the Indians 28, and the Inuit 40 deaths, compared with a rate of 17.6 per thousand for the whole of Canada.

Several causes for these perinatal losses are indicated in the number of obstetrical deliveries conducted out of hospital, the inadequate resort to delivery by caesarian section (for the prevention of handicaps), the large number of very young mothers (21 per cent under 20 years of age), the 10 per cent incidence of births to mothers at very high risk because they had already given birth to 10 babies or more, the increased number of obstetrical and non-obstetrical complications of labour, and of course, the great distances that must be travelled for access to the health care system.

These are problems relating to infant mortality. But there are problems that affect the delivery of health care to Inuit of all ages. Mr. Amarook cited some of them:

> Language is also a problem. There are not any Inuit nurses in the N.W.T. Although the Inuit community representatives do their best, they are not a good substitute for professional medical personnel who can speak our language. This is a problem few Canadians have to face. You can imagine the outcry if non-native people living in Baker Lake had to deal with a nurse who only spoke Inuktitut. Yet this is what my people have to face every day with English-speaking nurses.
>
> Here are some of the other general problems about health care which face the Inuit in the Northwest Territories.
>
> - There is a high turnover of medical staff.
> - There are numerous clinics and nursing stations but only four major hospitals in the entire N.W.T.
> - The regional director for health in the N.W.T. reports to both Ottawa and the N.W.T. Commissioner. Can a servant serve two masters?
> - Is it a good idea to try to run a health delivery system from Ottawa or even from Yellowknife? Isn't the region so large that it would make more sense to bring the administration to the people?[37]

Some of these problems can be corrected in obvious ways; other only by addressing the root causes. The Inuit believe that Inuit self-determination and the restoration a sense of Inuit identity and self-esteem will provide the essential foundation for the improvement of Inuit health. Without these things, no matter what advantages the industrial system may bring, the condition of the Inuit can only deteriorate. The recent study[38] of the Inupiat on the North Slope of Alaska reveals how widespread is the incidence of alcohol, violence and death resulting from the sudden advance of the industrial frontier there.

The Inuit have set out their land claims proposals. Everyone in the NWT is aware of the Inuit proposal to establish a new territory, Nunavut. A Nunavut government would be responsible for health care in the new territory.

The Committee for Original Peoples Entitlement (COPE), which represents the Inuvialuit (the Inuit of the Western Arctic) signed an agreement-in-principle with the federal government on October 31st, 1978, for the settlement of their land claims.

But the issue of health care has acquired a special prominence among the Inuit and they have embarked on their own health programs. In April 1978, 12 Inuit communities in the Baffin Region sent delegates to attend a round-table discussion of health concerns at Resolute Bay. The Inuit took the leading role in the discussions; the professionals were there in an advisory capacity.

The outpost programs undertaken by Inuit communities, with the support of the Government of the Northwest Territories, to combat alcoholism are well-known.

Less well-known, but equally illustrative of what can be done, is the program begun by Inuit community health representatives in the Eastern Arctic. They put together a set of educational materials on diet patterns and began to colour-code food groups. The Health Committee at Pangnirtung, building on this work, obtained support from Canada Works for a nutrition project in 1978-79. The Committee sought, for instance, to have the Hudson's Bay Company store at Pangnirtung change its ordering practices. With the cooperation of the Bay staff, the 1978-79 soft drink order was cut by half. Similar projects are being planned at Hall Beach and Pond Inlet. Funds for the project have, however, run out. The Inuit should be provided with the resources to enable such programs to be continued and enlarged.

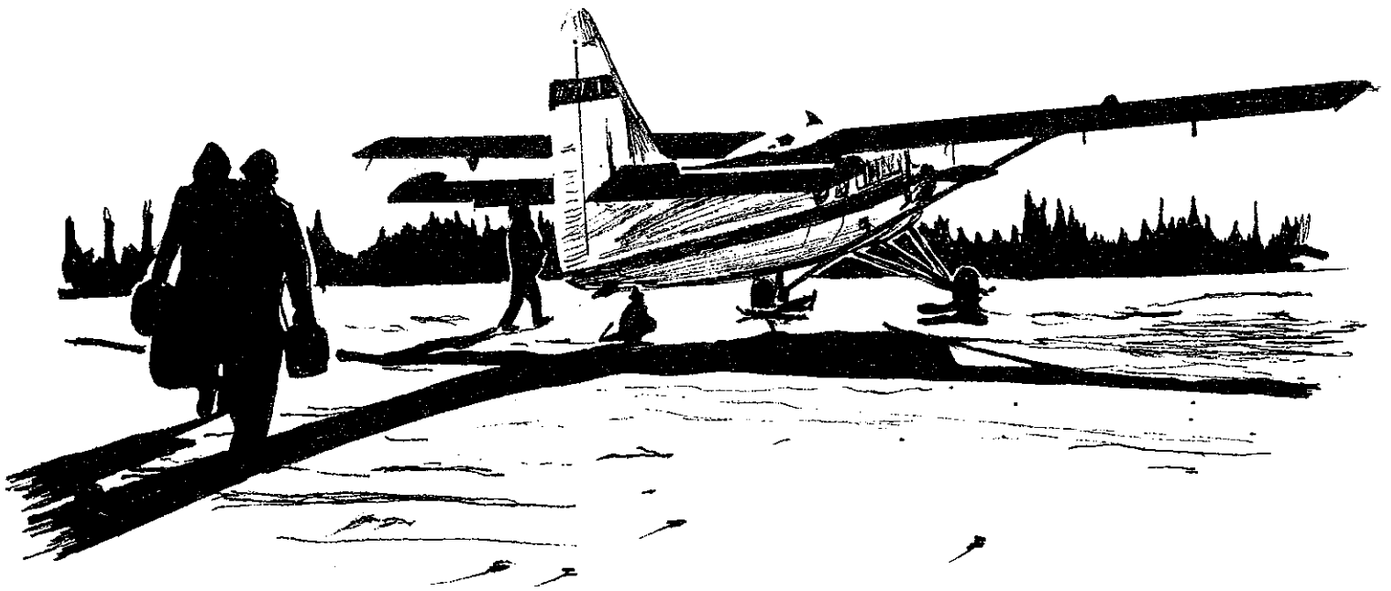
ITC has proposed an inquiry into the health delivery situation in Baker Lake and other communities in the Keewatin.[39] The purpose of the inquiry would be to identify and evaluate the levels of health care presently available, and to make recommendations to MSB and ITC for the improvement of health and health care delivery, throughout the Keewatin, including that available in the communities, in outpost camps, and to travellers on the land. Mr. Amarook has said that the scope of the inquiry should be wide enough to enable it to investigate complaints in other areas of Nunavut.

The ITC proposal also calls for an examination of the extent to which the health care system coordinates its activities with community structures, such as schools and hamlet offices. The study will also assess the requirement for, and practicality of, establishing a training program for Inuit nurses and paramedic personnel in Frobisher Bay.

ITC is seeking the means to establish a body of continuing and accessible expertise pertaining to Inuit health. The goal is to develop a body of trained Inuit leadership in the field of health care and to make that expertise available to the communities through meetings at the local level. This could be initiated by establishing a health portfolio at ITC.

The agreement-in-principle signed between the federal government and COPE related to the settlement of land claims, but it included provisions relating to social development. The announcement from the Minister of Indian Affairs and Northern Development said:

> To help meet the problems of social transition faced by the Inuvialuit there would be a Social Development Program, utilizing the Inuvialuit perspective, language and customs, and would deal with the social concerns such as housing, health and welfare. It would also advise government on programs concerning such matters as alcohol, dental care, nutrition; and initiate and develop special education programs. Each community would be involved in developing the program and the Inuvialuit would manage the various projects. The present value of the funding proposed to carry out this program is $3.5 million.[40]



Of course, since no final agreement has yet been worked out, no funding is presently available to COPE for these purposes. Nevertheless, COPE is undertaking a series of workshops relating to housing, health and welfare.

COPE faces problems of distance and communications. For instance, the experience of the Inupiat of the North Slope Borough of Alaska may well be of great interest and assistance to the Inuvialuit of the Western Arctic. The recent report, "Social Change and the Alcohol Problem on the Alaskan North Slope"[41] gives some idea of the scope of the problems of health care which the Inupiat are confronting there, problems which may already be observed in Canada's Western Arctic, though not as yet in such an advanced stage. But communication is difficult, since distances extend hundreds of miles and across national boundaries.

In my view, funds should be made available to the Inuit for purposes of developing Inuit awareness and expertise in the field of health care, and for arranging health consultations with MSB and with others. These tasks should be entrusted to ITC and COPE.

The funds should not come out of the funds provided by Cabinet Document 386-79CR(1), but should be the subject of a separate appropriation, to be negotiated with ITC and COPE..

NATIONAL CONFERENCE ON NATIVE HEALTH

I recommend that the federal government should hold a national conference on native health in 1981 or 1982, to be convened by the Minister of National Health and Welfare.

The conference should include representatives of all of the native peoples of Canada. Both status Indians and the Inuit, for whom the federal government has an acknowledged responsibility for health care, should be invited to attend. But they are not the only native peoples of Canada. There are the non-status Indians and Metis too. They also have a claim on the federal government based on their native origin. Their health problems are usually as acute as those of the status Indians and the Inuit; their concerns about ill-health among their people, and inadequate access to health care are concerns they share with the status Indians and the Inuit. Questions relating to diet, nutrition, alcohol, infant mortality, and equipping native people for health careers — all these are concerns of theirs too. Provision should be made for representatives of the non-status Indians and the Metis to attend the conference. Such a conference would not be complete without them.

The conference should consist predominantly of native people. It would be up to the native organizations to arrange for representation, which ought, of course, to come very largely from the local level. Organizations such as the Registered Nurses of Canadian Indian Ancestry and the Indian Homemakers of British Columbia should also be represented. But there should be representatives as well from MSB, health professionals in the private sector (such as the Canadian Medical Association, the Canadian College of Family Physicians, and the Indian and Inuit Committee of the Canadian Paediatric Society) and representatives from university medical and nursing schools. The Department of Indian Affairs and Northern Development should be represented, as its responsibilities in such fields as housing, water supply and sewage disposal bear directly on native health.

The conference should address the whole range of issues related to native health and health care. The conference should also examine the means being taken to develop new methods of consultation and new structures for the management of health care here and abroad.

This following list of health issues is by no means exhaustive, but in this connection the conference might well consider:

- The training of native people to serve in the health professions as doctors, nurses, medical assistants and community health representatives.
- The place of traditional native medicine in health care programs.
- Alcoholism and drug abuse.
- Infant mortality and infant care.
- Housing, home heating, water supply, and garbage and sewage disposal.
- Health problems of urban native people.

The conference would provide an opportunity for native peoples — Indian, Inuit and

Metis — to learn from one another, to discover what programs have been undertaken in all parts of the country in the field of native health care.

Where local and regional programs on traditional medicine, community health work or nutrition have been undertaken,[42] native people could tell about their experiences in this regard.

Guest speakers could be invited from other countries to discuss programs undertaken abroad to provide medical care to rural and indigenous peoples, programs relating to traditional medicine, and the use of medical auxiliaries. All of this would be of marked advantage not only to the native people but also to health professionals and to representatives of the medical schools and nursing schools.

Here in Canada we have our own CHRs in many Indian and Inuit communities. In the United States there is the Medex program serving native people in the Pacific Northwest and the South Pacific. Farther off there is the Behehorst scheme providing community health workers in the Guatemalan highlands, the village health workers in India, the health development workers in Tanzania and, of course, the barefoot doctors in China. All of these may have something to offer to Canada, and representatives of these programs abroad should be invited to attend.

As regards the development of modes of consultation and new structures for the management of health care, there are a number of possibilities.

The conference would provide an opportunity to exchange experiences where different models have been applied. Thus, for example, representatives of Treaty No. 3 might provide the conference with a progress report of their newly-formed Tribal Health Council. The Nishga Tribal Council might be in a position to report on the progress made in connection with the establishment of a local board of health in the Nass Valley.

Here, too, the experience of other countries will be important. Close to home there is the experience of the Seattle Indian Health Board, run by Indian people and staffed largely by Indian people, which provides health services to 25,000 native Americans in the Greater Seattle area.

Much would be gained by inviting representatives of the Indian Health Service in the United States. Even more, perhaps, would be gained by inviting representatives of those tribes in the U.S. that have established their own health councils and health departments. Invitations should, therefore, be extended to the Navajo Health Authority, the Papago Executive Health Staff and the United Southeastern Tribes.

I had earlier thought it might be possible to hold the conference this year. I now think that it ought not to be held until 1981 or even 1982 because such a conference will not be successful unless there is adequate preparation. There must be adequate funding too. And there ought to be a steering committee composed of representatives of the Department of National Health and Welfare, including the Medical Services Branch; the National Indian Brotherhood; the Inuit; and others. The native people should have very strong representation on the steering committee.

The cost of the conference itself should not come out of the funds set aside for consultation: it should be separately funded. Of course the activities of the Indian and Inuit organizations in the field of health education, and the work to be done in establishing health councils, will in themselves constitute preparatory work for the conference. Material prepared by all of the native organizations will be put to maximum use in the conference sessions. The proceedings of the National Native Health Seminar, to be held this fall, can be expected greatly to assist the work of the conference.

The findings of the Honourable Emmett Hall, who is conducting a national review of public health insurance programs in Canada, will also be available to the conference.

There will be difficulties in planning and holding such a conference. But it seems to me it offers enormous advantages to all concerned. The conference would provide an opportunity for the themes struck in the Indian Health Policy of September 19, 1979 to become widely known among those connected with the delivery of health services to native people. The conference should enable native people to bring their health care problems to the attention of the public and to indicate their views regarding the solutions that can be found. It should focus

the attention of health professionals throughout Canada and Canadians themselves on the state of native health. And it should lead to constructive proposals for the amelioration of the deep distress in which native people find themselves.

1. "Indian Health Policy", Government of Canada, September 19, 1979.

2. Order-in-Council P.C. 1979-3407, December 13, 1979.

3. Cited in *Friend and Foe*, Cornelius J. Jaenen, Toronto, 1976, p. 104. This quotation is taken from a paper by Professor Ramsay Cook of York University, "The Social and Economic Frontier in North America", 1980, unpublished, which includes an excellent discussion of the impact of European diseases upon the Indians.

4. Personal Communication, National Indian Brotherhood.

5. Figure quoted in a speech by Michael Amarook, "SOS Medicare Conference", Ottawa, November 6, 1979, p. 1.

6. "Indian Health Discussion Paper" (draft), prepared by a task force of Medical Services Branch, Department of National Health and Welfare, December 1979, p. 6. The paper is excellent. At this stage, however, it should not be regarded as representing departmental policy.

7. *Annual Report 1978*, Pacific Region, Medical Services Branch, Department of National Health and Welfare.

8. *Ibid.*

9. "Indian Health: The Dawn of a New Era", speech presented by Noel Starblanket at the Opening Ceremonies of the Battlefords Indian Health Centre, July 26, 1979, p. 6.

10. Starblanket, *op. cit.*, p. 6.

11. Government of Canada, *op. cit.*, p. 3.

12. Telegram from the Honourable David Crombie, Minister of National Health and Welfare, to Noel Starblanket, President, National Indian Brotherhood, September 19, 1979.

13. "Notes for a Speech by the Honourable Jake Epp, Minister of Indian Affairs and Northern Development, to the Executive Planning Committee, Quebec City", *Communiqué*, November 20, 1979.

14. Declaration of Alma-Ata, "Report of the International Conference on Primary Health Care", Alma-Ata, USSR, September 6-12, 1978, p. 16.

15. *Limits to Medicine*, Ivan Illich, in association with Marion Boyars, McClelland and Stewart Limited, Toronto, 1976.

16. Starblanket, *op. cit.*, pp. 2-3.

17. Cabinet Document 386-79CR(1), September 13, 1979.

18. By regional level, I mean the provincial level. The MSB is divided into regions that are coterminous with each of the provinces and territories, except for the Atlantic Region, which encompasses the four Atlantic provinces.

19. Speech presented to the Conference of Regional Directors, in Cornwall, October 22-24, 1979, by Dr. Lyall Black.

20. *Ibid.*

21. Medical Services Branch, Department of National Health and Welfare.

22. Medical Services Branch, Department of National Health and Welfare.

23. Medical Services Branch, Department of National Health and Welfare.

24. The following lists the proposals received by this Inquiry:

    "Proposal for the Establishment of a Participation Mechanism Involving Indian Health Development Councils", National Indian Brotherhood.

    "Request for Consultation Funds, January 1, 1980-March 31, 1981", Association of Iroquois and Allied Indians.

    "Proposal for the Use of the Consultation Funds 1979-80, 1980-81 Fiscal Years", Confederation of Indians of Quebec. Also, "Policy for the Delivery of Health and Welfare Services", Coalition of the Nations of the Confederation of Indians of Quebec.

    Letter and submission, Dene Nation, February 14, 1980.

    "Health Care in Northern Ontario: Policies and Plans for the 1980's" (draft),

Heather Ross for Grand Council Treaty No. 9, June 28, 1979.

"Proposal for a Health Education Program", Lennox Island Band Council, January 25, 1980.

"Position on Indian Health, Indian control of Indian Health", Manitoba Indian Brotherhood, July 11, 1979. Also, Proposal of the Steering Committee on Indian Health, February 1980, and "Health Liaison Program - Annual Report 1978-79".

"Memorandum to File: Health and Welfare Meeting, Prince Rupert, July 12, 1979", Health and Welfare Committee, Nishga Tribal Council.

"Concept Paper: The Development of an Area Indian Health Board for the Treaty No. 3 Portion of Northwestern Ontario", Vincent F. Tookenay for Ojibway Tribal Health Council — Grand Council Treaty No. 3. Also "Political Structure of Treaty No. 3".

"Report on Health and Medical Care Services to Indian People Resident on Reserves in the Treaty No. 7 Area", Health Research Team, Treaty No. 7, August 27, 1979.

"Consultation Funding Proposal", Union of British Columbia Indian Chiefs.

"Health Consultation Submission", Union of Ontario Indians, February 4, 1980.

"Presentation to National Commission Inquiry on Indian Health on December 11-13, 1979, Respecting National Health and Welfare Indian Consultation Funding", Yukon Native Brotherhood, December 5, 1979.

25. And see the views expressed in the address by Dr. H. Mahler, Director-General, World Health Organization, at the opening of the International Conference on Primary Health Care, Alma-Ata, USSR, September 6, 1978.

26. *The Northwest Territories Perinatal and Infant Mortality and Morbidity Study: A Report to the Government of Canada*, D. Spady, *et al.*, Edmonton, 1979.

27. Medical Services Branch, Department of National Health and Welfare, *op. cit.*, p. 45.

28. The reader is also referred to the report "Organizational Review of the National Native Alcohol Abuse Program" prepared by Hickling-Johnston, July 1979.

29. "Application for Funding to Proceed with the Implementation of an Improved Health and Welfare Delivery System in the Nass Valley", presented to the Department of National Health and Welfare by Nishga Tribal Council, September 1979.

30. Nishga Tribal Council, *op. cit.*, p. 3.

31[a]. National Indian Brotherhood, *op. cit.*, pp. 5-7.

31[b]. Should there by any alteration in the status of the Indians and Inuit of Newfoundland and Labrador, the same principle ought to apply.

32. Responsibility for health care of Inuit in Northern Quebec has been transferred to the provincial government.

33. ITC is the largest Inuit organization in Canada. It represents the Inuit of the Eastern and Central Arctic as well as those of Labrador. COPE represents the Inuvialuit of the Western Arctic.

34. Amarook, *op. cit.*, pp. 1-2.

35. *Ibid.*

36. Spady, *et al.*, *op. cit.*

37. Amarook, *op. cit.*, p. 4.

38. Samuel F. Klausner, *et al.*, *The Inupiat, Economics and Alcohol on the Alaskan North Slope*, Centre for Research on the Acts of Man, Philadelphia, Pennsylvania, December, 1979.

39. "Guidelines for Keewatin Health Study", Inuit Tapirisat of Canada, 1980.

40. "COPE and Federal Government Sign Agreement-in-Principle on COPE Claim", *Communiqué*, Department of Indian Affairs and Northern Development, October 31, 1978.

41. *Social Change and the Alcohol Problem on the Alaskan North Slope*, Centre for Research on the Acts of Man, Philadelphia, Pennsylvania.

42. Edward T. Jackson, "A Working Inventory of Community-Based Initiatives in the Health Field Being Undertaken by Indians and Inuit Peoples", included in the Appendix to this Report.

ACKNOWLEDGEMENTS

In this Commission of Inquiry I have been assisted by three consultants:

Dr. Edward Ragan, Ottawa, one of Canada's delegates to the International Conference on Primary Health Care, Alma Ata, USSR, in 1978.

Dr. Sydney Segal, Faculty of Medicine at the University of British Columbia.

Mr. Edward T. Jackson, International Council for Adult Education, Toronto.

In addition, Dr. Vincent Tookenay prepared a report on the United States Indian health care system for the Inquiry. Mrs. Shirley Callard served as Secretary to the Inquiry, and Mrs. Rosemary Wallbank edited this Report. It was typed by Mrs. Donna Agostino and Mrs. Amber Halliday.

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1

APPENDIX

CANADA

P.C. 1979-3407
13 December, 1979

PRIVY COUNCIL • CONSEIL PRIVÉ

HIS EXCELLENCY THE GOVERNOR GENERAL IN COUNCIL, on the recommendation of the Minister of Justice and the Minister of National Health and Welfare, pursuant to section 37 of the Judges Act, is pleased hereby

(a) to authorize the Honourable Mr. Justice Thomas R. Berger of the Supreme Court of British Columbia to act as a commissioner on an inquiry initiated by the Minister of National Health and Welfare to determine the methods of consultation which the Minister of National Health and Welfare should adopt to ensure the substantive participation by Indian and Inuit people in decisions affecting the provision of health care to them; and

(b) to authorize payment of reasonable travelling and other expenses incurred by the said Honourable Mr. Justice Thomas R. Berger away from his ordinary place of residence while acting in his capacity as a commissioner, in the same amount and under the same conditions as if he were performing a function or duty as a Judge pursuant to the Judges Act.

CERTIFIED TO BE A TRUE COPY - COPIE CERTIFIÉE CONFORME

Marcel Massé

CLERK OF THE PRIVY COUNCIL - LE GREFFIER DU CONSEIL PRIVÉ

APPENDIX

GOVERNMENT OF CANADA

INDIAN HEALTH POLICY

The following statement represents current Federal Government practice and policy in the field of Indian health. It differs from the Indian Health Policy statement of November 1974 in that it emphasizes issues which the Federal Government considers to be of greatest significance in the immediate future. Studies relating to Indian Health Policy and practice are being undertaken by the National Indian Brotherhood and some provincial Indian associations, studies which National Health and Welfare supports. The Federal Government is committed to joining with Indian representatives in a fundamental review of issues involved in Indian health when Indian representatives have developed their position, and the policy emerging from that review could supersede this policy. As an indication of good faith, the Federal Government has withdrawn the Guidelines for the Provision of Uninsured Health Benefits to Indian and Inuit people of September 1978, which will be replaced by professional medical or dental judgement, or by other fair and comparable Canadian Standards.

The Federal Indian Health Policy is based on the special relationship of the Indian people to the Federal Government, a relationship which both the Indian people and the Government are committed to preserving. It recognizes the circumstances under which many Indian communities exist, which have placed Indian people at a grave disadvantage compared to most other Canadians in terms of health, as in other ways.

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

The Federal Government's Indian Health Policy reflects these features in its approach to programs for Indian people. The over-riding fact from which the policy stems is the intolerably low level of health of many Indian people, who exist under conditions rooted in poverty and community decline. The Federal Government realizes that only Indian communities themselves can change these root causes and that to do so will require the wholehearted support of the larger Canadian community.

Hence, the goal of Federal Indian Health Policy is to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves.

APPENDIX

This increasing level of health in Indian communities must be built on three pillars. The first, and most significant, is community development, both socio-economic development and cultural and spiritual development, to remove the conditions of poverty and apathy which prevent the members of the community from achieving a state of physical, mental and social well-being.

The second pillar is the traditional relationship of the Indian people to the Federal Government, in which the Federal Government serves as advocate of the interests of Indian communities to the larger Canadian society and its institutions, and promotes the capacity of Indian communities to achieve their aspirations. This relationship must be strengthened by opening up communication with the Indian people and by encouraging their greater involvement in the planning, budgetting and delivery of health programs.

The third pillar is the Canadian health system. This system is one of specialized and interrelated elements, which may be the responsibility of federal, provincial or municipal governments, Indian bands, or the private sector. But these divisions are superficial in the light of the health system as a whole. The most significant federal roles in this interdependent system are in public health activities on reserves, health promotion, and the detection and mitigation of hazards to health in the environment. The most significant provincial and private roles are in the diagnosis and treatment of acute and chronic disease and in the rehabilitation of the sick. Indian communities have a significant role to play in health promotion, and in the adaptation of health services delivery to the specific needs of their community. Of course, this does not exhaust the many complexities of the system. The Federal Government is committed to maintaining an active role in the Canadian health system as it affects Indians. It is committed to encouraging provinces to maintain their role and to filling gaps in necessary diagnostic, treatment and rehabilitative services. It is committed to promoting the capacity of Indian communities to play an active, more positive role in the health system and in decisions affecting their health.

These three pillars of community development, the traditional relationship of the Indian people to the Federal Government, and the interrelated Canadian health system provide the means to end the tragedy of Indian ill-health in Canada.

APPENDIX

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 the 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 wellbeing, 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 people 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 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.

APPENDIX

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 the 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 diseases 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;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

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 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.

X

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, détente and disarmament

APPENDIX

could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

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 agencies, all health workers and the whole world community to support national and international commitment 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.

APPENDIX

INDIAN HEALTH
THE DAWN OF A NEW ERA

Presentation of Noel Starblanket at the opening ceremonies of the Battlefords Indian Health Centre - July 26, 1979.

I stand here today, on the land of my ancestors - proud, hopeful and courageous as I see the progress our people have made in assuming greater responsibility over their own affairs and institutions. As President of the National Indian Brotherhood and representing all of Canada's Indian people, I wish to publicly acknowledge those Indian planners and leaders here present, whose foresight and applied determination have made this day a reality.

To quote a familiar adage - there are three kinds of people in this world:

those who watch things happen
those who make things happen
and those who wonder what happened

Now we know what kind of people you are -
- congratulations -.

I believe it would be useful for us today to take a look back, to review yesterday - as a source of instruction and direction for tomorrow. Many of the things I shall say may not seem to befit a time of celebration and happiness, but they must be said - lest we forget that our task has only just begun.

As Dr. Graham Clarkson noted in the Functional Plan for Indians in the North Battleford area, "It has to be appreciated that there will be opposition to change. Health associations, institutions and professional organizations do not always look kindly to change especially when it involves greater community involvement, and the employment of new categories of health manpower. And let us not fool ourselves into thinking that the Health Services Branch is not tarred with the same brush. Bureaucracies as they grow and develop - and this includes Indian bureaucracies - have a habit of being able to give nine reasons why things cannot change for every reason why they should." Let us focus on what can be done.

I assert that the era of exclusive federal management and control of the health systems and programs which directly affect the Indian individual, the Indian family, and the Indian community is hastening to its end. Indian people must now express their rights to self-government, and to provide policy and program direction to all those organizations - whether government or private - who are committed to helping to improve their health status. The doubt and cynical attitude which pervades

APPENDIX

many of the professionals within these organizations, can only be eradicated when a community educates itself, takes pride in its self-sufficiency, and demonstrates to the providers of service how a community can become self-reliant, and therefore not entirely subject to the whims of an un-feeling and distant government.

However, structures must be set up so that band representation can participate in the decision making, priority setting, and planning exercises of the health delivery, and to convert to a community based and community designed and controlled health care system, even as has happened here. Wherever possible this should be the case. Admittedly certain personnel and budgetary concerns may require some degree of centralization, however, all of the principal parties in a community based health service must be able to work together in an integrated fashion if they are to have any effect on the health status of our people.

Also of vital importance, is the principle of an ever increasing development of, and reliance upon, local Indian people as the primary providers of skilled technicians, and health administrators. In Doctors and Healers, Alexander Dorozynski stated: "It does not seem that the Chinese barefoot doctor system as it has developed in its social, political and cultural background is readily exportable, as is. What is exportable however is the idea that non-medical healers can be of tremendous service in a country where the western style medical doctor does not correspond to economic or cultural realities."

To go a step further health care is not only everyone's right, but everyone's responsibility. Informed self-care should be the main goal of a health program, given that people, provided with clear simple information can prevent and treat most common health problems in their own homes, earlier, cheaper, and most often better than can doctors. Consequently, basic health care should not be delivered but encouraged, and medical knowledge should not be the guarded secret of a select few - but should be freely shared by everyone.

Ultimately the health system must encourage wellness, self-care, prevention, and family development. It must utilize traditional medicine mechanisms, and encourage self-reliance and dignity in the delivery of an essential community service.

Dr. Ivan Illich in Homosapiens tells us that: "The health of a population depends on the way in which political actions condition ... and create those circumstances that favor self-reliance, autonomy and dignity for all, particularly the weaker. In consequence, health levels will be at their optimum when the environment brings out autonomous, personal, responsible, coping ability."

The theme "Indian Control of Indian Health" is one of great practical and historical significance. Last year on November 9, in the midst of the health guidelines controversy the National Indian Brotherhood presented to the Minister of Health a formal declaration from which I excerpt: "For

decades, the history of Indian people and their leaders has been one of reacting to government decisions, and in this manner, Indians have been pushed and moulded into the government's way of thinking. As Indian people, we must truly have faith in our own ability to determine our destiny, and not to be governed always by the crisis at hand. If we react in the usual way - for the political reason of the moment - rather than through clear perception of the reality that faces us, then we will continue to move blindly in our attempts to find a new direction for our people."

"Attempts to standardize federal health policy have to the present been made without consultation and participation of the Indian people, and have been in violation of the legal and constitutional principles of Canadian federalism."

I am well pleased with Health Minister Crombie's very recent announcement that the health guidelines issue is now formally rejected by the present Government.

In 1963 it was the World Health Organization who stated that people have greater respect for and receive more benefit from those health services in which they have been consulted and in which they actively participate - the converse applies equally in terms of a people's power to thwart and deny a government's initiative or policies in which they have not been consulted.

It is apparent that this federal government of Canada is beginning to understand this cardinal principle of "self-determination" - belatedly, but nonetheless realistically.

It was not that long ago that the Indian communities spread across this land stood upon their own. Enjoying full occupancy and free use of this land, each community enjoying the pride, integration, and dignity that came from independence and self-reliance. This manner of living necessitated close harmony with nature, and a system of hygiene and healing based upon its laws. As Indian people we possessed a way of life that ensured our peak fitness and full physical, mental and spiritual development. The first European contacts universally acclaimed the health, well being, and vigour of the Indian people they met. However, with the invasion of foreigners, came their way of life, their foods, as well as their diseases.

The rapid decline in Indian health has been well documented by archaeological, anthropological, and historical data, and its many causes have been defined: forced departure from the traditional Indian diet, causing malnutrition and lowered resistance to disease; confinement to the demoralizing and unsanitary conditions common to reserve life, additionally causing even further departure from the traditional lifestyle; suppression of the traditional Indian health and healing practices; replacement of this with conventional western medical services inadequate in scope and effect, failing to deal with the root causes of disease and very high in relative cost; and finally coerced dependence on a shifting and paternalistic federal policy towards Indian people, contributing greatly to even further social disintegration.

APPENDIX

APPENDIX

To look at things from a national perspective one sees a picture of tragedy, and yet a crisis of hope.

This tragedy was well put, in debate, in the Parliament on June 14, 1978. I quote: "In human terms, present (Indian health) conditions are scandalous. An infant mortality rate of 40 per 1,000 live births among the Indian community compares with 21 per 1,000 live births among Canadians generally. A suicide rate of 20 per 100,000 population compares with a national figure of 9.7 per 100,000; 87 per cent of Indians live in sub-standard housing as compared to 11 per cent for the rest of Canadians; 54 per cent of Indian households receive incomes of under $2,263 per annum, while the figure for other Canadians receiving similar incomes is 20 per cent. The life expectancy for Indian people is 36 years as compared with 62 years for the rest of the population. Only 6 per cent of Indians complete high school education though the figure throughout Canada is 88 percent."

As Indian people we know only too well what these statistics mean - for they mean, our own old people, our own homes and our own children.

To be forced to live a life that is totally out of one's own control is a source of constant stress, and leads to the weakness and demoralization of individuals and of entire communities. We as Indian people have been forced into coerced dependence upon paternalistic and ever-shifting federal policies and this situation has contributed to a great extent to the manifestations of social ill health now seen among us, including alcohol and drug abuse, family breakdown, suicides, accidents, and violent deaths. There is increasing scientific evidence that the stress of dependence and uncertainty leads to physical sickness and disease as well.

Our people are becoming increasingly vocal in expressing that the all-important first step in combatting these social pathologies is for our communities to take their destiny back into their own hands, and to set their own goals and priorities. The few Indian communities that have succeeded in the struggle to regain control of their own affairs have demonstrated a remarkable increase in community spirit, and a corresponding decrease in problems with social diseases and violence. Such communities serve as living proof that the main barriers to improved Indian health are both social and political, not simply medical and that the relationship between paternalistic government attitudes and the ill-health of our people is a very real phenomenon.

Thus we as Indian people have determined, and it will be so, that today's conditions will not represent generations yet unborn.

The sun is just rising, and today we face a crisis of hope, the dawn of a new era, a turning point for our people. We can march with the sun to the brightness of a new and better day - through the total

control of our own lives and destinies - or we can retreat to the false security and darkness of government colonialist control.

Today we celebrate your having made the right choice, and it remains with you to continue your march with the sun, and remember it could well be that your example may cause your brothers across this land who are watching, to join you. I trust it shall be so.

Thank you.

APPENDIX

APPENDIX

SPEECH BY MICHAEL AMAROOK
PRESIDENT OF INUIT TAPIRISAT OF CANADA TO SOS MEDICARE CONFERENCE

A National Conference Organized by the Canadian Labour Congress

November 6, 1979 — Pearson Building, Ottawa, Ontario

Good morning ladies and gentlemen. It is a pleasure to be able to participate in this important conference. I am the president of Inuit Tapirisat of Canada, the national organization representing 22,500 Inuit across Canada.

I am very concerned about the shortcomings of health care in the North. Canadians must learn some of the difficulties northerners are facing today as we come to grips with this serious problem.

As I recently came out of the hospital here in Ottawa, I can personally comment on the great differences between being sick in the south and becoming ill in the area of the North where I come from — the Keewatin region of Nunavut (Our Land).

Here, there are a number of nearby hospitals, 24-hour emergency service and plenty of doctors. The closest hospital to Baker Lake, my home community, is 400 hundred air miles away in Churchill, Manitoba. Although there is a nursing station, we have no doctor in Baker Lake. Emergency patients must be taken on a two or three hour flight to hospital treatment. There is no other way to travel long distances in the North. The only way people can see a doctor is to travel to Churchill or wait for one to fly to Baker Lake.

The least I can say is I am glad that in this case I was in Ottawa rather than Baker Lake. Here my family was able to visit me in the hospital. It would have been impossible for them to have come with me to Churchill.

In 1955, when I was 14 years old, I had to go to a hospital in Brandon, Manitoba, for treatment of tuberculosis. I did not see my parents again for two years. During that time I had no way to communicate with them back in Baker Lake, and it was impossible for them to visit me because of the expense.

However, the health problems in Nunavut are far more serious than my own case. In fact, a lot of the Inuit health problems stem from the fact that our lifestyle has changed so dramatically during my lifetime. The influx of development from the south brought with it many diseases which were unknown to my father. It is true that in the old days we did not have access to nurses and doctors. But our lifestyle was a lot more healthy. Everybody lived off the land and ate good country food which is far

more nutritious than most of the food we sometimes have to buy in the Hudson's Bay stores.

To understand what is happening to the Inuit, just take a look at the changes in our growing population. Twelve years ago, there were just over 10 thousand Inuit living in the Northwest Territories. In 1977, there were over 15 thousand, a 50 per cent increase. Today, most of our population is very young and the health of our children, particularly those under five years old, is one of the things I want to comment on today.

A study by the Canadian Pediatric Society this year showed that the Inuit baby in the N.W.T. had an average of 14 different diseases in the year compared with only 4 for the non-native population. And that same report said that Inuit babies made the largest number of visits to medical personnel in comparison with other babies.

Something must be wrong.

In the Northwest Territories, there is a higher death rate among Inuit babies than there is for the non-native population.

For example, in 1977, 25 per cent of the deaths among Inuit occurred among children under four years old. For the non-native people, it was only 17.7 per cent. The figures for last year are nearly identical.

The infant mortality rates for Inuit have been dropping since 1970 from a high of over 100 deaths per 1,000 population to just under 40. But a disturbing fact is that the non-native rate for 1977 in the N.W.T. was only about 16 per thousand.

Some unsettling events have caused a lot of concern recently in my home community of Baker Lake. I have been receiving reports of insufficient health care and tragic consequences.

First, some facts about health care delivery in Baker Lake . Although Baker Lake is home to nearly 1,000 people, there isn't one doctor. In fact, not one of the seven communities in the Keewatin region has a doctor.

It's astounding because the population of all seven communities is close to 5,000. Doctors do travel from Churchill, but infrequently and rarely with any advance notice. Quite often bad weather prevents doctors from flying in and patients flying out. I heard last week there had been no travel out of Baker Lake for six days because of poor weather conditions.

I have received information of at least three unneccessary deaths in Baker Lake in the last few

APPENDIX

years. In two cases children with medical problems died while taking physical exercise at school. Their teachers were not told about their problems. This summer, a child under two years old died of meningitis. This death would not likely have occurred if the child had been able to see a doctor.

I will give a painful example from my own experience.

In 1965, I was out hunting for a week. While I was away, my three month old daughter became sick. My wife took her to the nursing station several times but three days later our baby died. We were never told why and we were not able to get her to a doctor.

In the absence of a full time doctor, unfair responsibilities are placed on the nurses at the nursing station. They are often required to make decisions and perform tasks that are carried out by doctors in the South.

The nursing station itself has problems. There are only three nurses in Baker Lake. The regular office hours are 9 a.m. to noon. There are special clinics in the afternoons. There is only one nurse on call after 5 o'clock. Naturally, it is difficult for her to answer all the demands for her services. It is also difficult for the nurse to leave the station to visit anybody as this leaves the station unattended.

Language is also a problem. There are not any Inuit nurses in the N.W.T. Although the Inuit community representatives do their best, they are not a good substitute for professional medical personnel who can speak our language. This is a problem few Canadians have to face. You can imagine the outcry if non-native people living in Baker Lake had to deal with a nurse who only spoke Inuktitut. Yet this is what my people have to face every day with English-speaking nurses.

Here are some of the other general problems about health care which face the Inuit in the Northwest Territories.

- There is a high turnover of medical staff.

- There are numerous clinics and nursing stations but only four major hospitals in the entire N.W.T.

- The regional director for health in the N.W.T. reports to both Ottawa and the N.W.T. Commissioner. Can a servant serve two masters?

- Is it a good idea to try to run a health delivery system from Ottawa or even from Yellowknife? Isn't the region so large that it would make more sense to bring the administration to the people?

I have a responsibility to speak for Inuit. The government has a responsibility to improve health care delivery in the North. It's time the federal government turned its attention to solutions. I have a number of them which I offer to the government, and share with you today.

1. Decentralize the health care delivery system, bring it closer to the people.

2. Recently Inuit Tapirisat of Canada proposed the creation of a new territory called Nunavut in the Eastern and Central Arctic. Decentralization of the health care delivery system would be very compatible with this idea.

3. We need to have a hospital for the Keewatin region. Churchill is at the southern extremity and in fact not even in the Keewatin region. No other region of the Arctic is so hard done by. We need to have our own hospital. Rankin Inlet, for example, would be a very good location for it.

4. I demand that the federal government undertake an immediate inquiry into the health delivery situation in Baker Lake and other communities in the Keewatin. Unneccessary deaths of children are testimony enough that something is wrong. The government should look into it without delay.

   The terms of the inquiry should be wide enough to investigate complaints in other parts of Nunavut.

5. Start a training program for Inuit nurses and paramedics as soon as possible. The long term benefits from this will be immeasurable.

6. More doctors must be made available to the N.W.T., and to Inuit communities in particular. The government should think of ways in which this goal can be fulfilled.

In order to investigate the problems I have raised and to come up with some solutions, I am asking Health Minister Crombie to call an inquiry into medical services in the Keewatin and other parts of Nunavut. I have received petitions from concerned citizens of the Keewatin supporting this idea.

This conference has given me the opportunity to expose to Canadians the poor quality of health care delivery in Canada's North. By working together we can save medicare and improve health care everywhere and demand that federal, provincial and territorial governments take some action.

APPENDIX

APPENDIX

A WORKING INVENTORY OF COMMUNITY-BASED INITIATIVES IN THE HEALTH FIELD BEING UNDERTAKEN BY THE INDIANS AND INUIT PEOPLES

Edward T. Jackson

February 21, 1980

INTRODUCTION

The need for innovative, community-based programs for Indian health in Canada has never been greater than it is today. Government spending continues under restraint. Serious health problems continue to plague the reserves. Perhaps most importantly, Indian people themselves continue to develop their capacity to take control of their own destiny, to solve their own problems.

The purpose of this paper is to provide a working inventory of community-based programs which are currently being developed by Indian people across the country and which may serve as useful models for Band Councils, Tribal Councils and Provincial/Territorial Organizations.

It is called a working inventory because it is not exhaustive. To survey all of the community-based activity ongoing throughout the country would take many months of study and many pages. A complete inventory would constitute extremely valuable contribution to the overall struggle for Indian health, but it is clearly a task to be carried out directly by, and explicitly for, Indian people.

The examples that follow, however, illustrate the range of possibilities. Community-based programs for Indian health involve Indian health centres, Indian health boards or councils, health liaison programs, health curriculum, environmental health, nutrition, breast feeding, homecare, mental and spiritual health, and traditional midwives. All promote local participation through Health Committees or the Band Council. Many relate to initiatives at the tribal, regional and provincial levels. Some have been facilitated by Health and Welfare personnel.

Although recent years have seen substantial gains in the development of community-based programs for Indian health, the funding of such work remains inadequate. Much of this activity has been chronically under-funded, or if not, funded merely on an ad hoc or piecemeal basis. What is problematic is how the experiences in community-based Indian health move from their present status as demonstration projects to full scale, national efforts with guaranteed continuity and financial security.

As well, there is the important question of how Indian people can effectively teach each other what they have learned with respect to community-based initiatives. More attention will need to be paid to bringing about the horizontal exchange of experiences across communities, tribal councils, regional and provincial/territorial organizations. This will require, as well, sufficient financial support and careful planning, but the dividends accruing to Indians and non-Indians will be great.

The same general comments apply equally to the case of the Inuit. They too are actively engaged in creating community-based health programs appropriate to their communities. Some of these efforts are included in what follows.

INDIAN HEALTH CENTRES

As the Medical Services Branch Discussion Paper points out, the Morley Health Centre in Alberta illustrates one organizational option available for Indian control of health facilities. The Centre reports to a Board of Trustees composed entirely of local Indian people. This Board makes overall policy for the Health Centre and all matters other than routine operations must be cleared through the Board. However, Medical Services Branch (MSB) remains responsible for the staffing and administration of the Centre.

A different organizational model is provided by the Battlefords Indian Health Centre in North Battleford, Saskatchewan. Here the Board, composed of nine District Chiefs, sets major policy but controls staffing decisions as well. Staff report directly to the Board through the Executive Director. The Centre's core budget is about $250,000 annually, supplemented by program funds. In addition to the Executive Director, personnel include an accountant, an Indian nurse, a nursing coordinator and a consulting physician. Plans now call for two Indian people to be trained to take over the functions of the Executive Director.

The struggle to set an Indian health centre for the Battleford area goes back at least five years. Local initiators, also influential members of the Federation of Saskatchewan Indians, chose to negotiate directly with Medical Services Branch in Ottawa rather than with the Region. In 1977, an inquiry was set up by the Minister of Health and Welfare to investigate the North Battleford situation. The report of this inquiry, known as the Clarkson Report, recommended that an Indian-controlled health centre for Indian people be put in place as soon as possible. Prior to this Dr. Clarkson had called a conference in late 1977 of the Indian community of North Battleford which made specific recommendations on health services for the area and was attended by Health and Welfare Canada personnel. In 1978, key Indian representatives from the District made a visit to the Seattle Indian Health Centre to study the operations of that model.

APPENDIX

APPENDIX

Now, after many delays and a number of unanticipated problems, the programs of the Battlefords Indian Health Centre are beginning to move forward successfully. Staff realize their work is under national scrutiny, but resist rushing the development of their programs. They are moving carefully, respectful of community wishes and needs. Two programs are in a transfer stage from MSB to the Centre: the Nursing Program and the Community Health Representative Program. At the same time the staff is encouraging the local creation of health committees chaired by Band Councillors and composed of lay people and perhaps Community Health Representatives (CHRs). At least two such committees were expected to be operational by early 1980. Ultimately, these committees will provide the Centre with guidance in terms of local health needs and service improvements.

Staff acknowledge that there are many problems to be overcome, not the least of which is that local people have little history of meaningful involvement in health-related decision making and will have to learn that they have the knowledge and experience - or are capable of acquiring it - to make decisions themselves. Similarly, outside health personnel must learn about traditional Indian ways if they are to function effectively. As well, the logistical problems, particularly of bad roads and inadequate bus service linking the Centre with the reserves, must be addressed.

Two proposals to the Minister of Health and Welfare Canada seek to extend the model of Indian control of policy, administration and programs in health to other areas of the country. The Blood Reserve in Alberta has very recently been granted about $40,000 to set up its own committee to review local needs for an Indian health facility as well as for outreach programs involving paramedicals, nutrition, and pre-and post-natal mothers. A major focus of the review is the difference in the level of services, equipment and staffing between the local Indian hospital and a number of non-Indian hospitals in the vicinity. The Blood people will study the most effective means of setting up an Indian hospital in addition to other programs. The Nechi Institute, itself an Alberta-based Indian institution, will assist in the design and implementation of appropriate training methods.

The second proposal, for which funding has also recently been confirmed, comes from the Nishga Tribal Council of British Columbia. The Nishga plan is described in more detail in the section of the Report entitled "Other Indian Bands and Organizations". In essence, the proposal calls for a year-long project to lay the groundwork for a Nass Valley Board of Health and at the same time develop recommendations for a new local diagnostic and treatment centre. The Board will be responsible for the administration of the treatment and preventive medicine functions, as well as for the setting of general policy.

An important feature of the proposal is the support it has received from a wide range of government departments, particularly Medical Services Branch, Department of Indian Affairs and Northern Development and the provincial Ministry of Health. It is planned that the Centre will serve not only status Indians in the Nass Valley but also all other native and non-Indian residents. The

Nishgas, who already have brought their education system under Indian control, view the Nass Valley Health Board and the new health facility, as the next logical steps towards self-determination, and plan to follow this sequentially by bringing all other social welfare programs under Nishga control.

HEALTH LIAISON PROGRAMS

Many Provincial/Territorial Organizations (PTOs) also run health liaison programs. This work is especially well developed in western Canada. In Saskatchewan, for example, the Federation of Saskatchewan Indians operates a health liaison program:

> The program operates basically on a liaison and communication basis. In the past, this has been done with programs and information from National Health and Welfare being relayed to the reserve level by the Health Liaison Workers. In return the Health Liaison Workers pick up information, complaints and problems from the Bands and relay them back to the Department...the problems are aired at monthly meetings where an attempt is made to resolve such problems.

Health Liaison Workers operate currently out of six district Indian government offices, with the Battlefords Indian Health Centre covering the seventh district. A recent major study by the Prince Albert chiefs has proposed to assess boarding home needs in the district.

The Manitoba Indian Brotherhood's Health Liaison Program is funded at a rate of $85,000 a year by Health and Welfare Canada. The program involves policy-level advocacy on such questions as uninsured health benefits, Indian child welfare, and liaison with MSB on Community Health Representative contracts. Other activities include liaison with the Native Alcohol Abuse Program; Northern Medical Unit Fly-in Services, On-Reserve Nurse's Training; and the Medical Boarding House Committee. Among the program's long-term objectives is the development of a Manitoba Indian Health Board. The MIB's Health Liaison Program, also administers the Medical Interpreters and Hospital Visitors Program, which involves five native interpreters serving urban medical centres. The major complaint is that the Health Liaison Program, as a whole, is under-funded. As a result it has only one fieldworker. According to staff, a fundamental necessity for meaningful community involvement is sufficient financial support for fieldworkers in all regions.

One of the more illustrative cases of community participation in defining health needs occurred on the Garden Hill Reserve in Manitoba in 1979. The local Health Committee organized a three-day workshop on community health, inviting health liaison staff from the Manitoba Indian Brotherhood as well as other agency representatives. The workshop included a tour of the community as well as extensive discussion sessions. In workshop sessions, practical recommendations were made on health and related social and economic problems, on how to make use of outside and community resources, on specific actions to be taken, and on possible funding sources. Transportation for patients, CHR training, and the role of the health committee vis-à-vis the CHR emerged as issues of high priority.

APPENDIX

APPENDIX

The Health Liaison Programs at the Union of British Columbia Indian Chiefs and at the Union of Ontario Indians (UOI) are fully integrated into efforts to address environmental health as well. At the Union of Ontario Indians, however, there is also a new focus on the role of the Community Health Representative. The UOI cites the case of the Ojibway Great Lakes Inter-Tribal Council in Wisconsin where health programs have been brought under Indian control:

> From their experience it is evident that the community workers can serve as vital links between Indian government and Band members in gathering ideas for health policy. They can also be an organizing force to set up volunteer Health Boards.

The UOI would like to have CHRs on every reserve that requests them, and to "Indianize" the training procedures. One reserve in the UOI jurisdiction, the Mississauga Band, has brought all health services under Band control, including CHR contracts, uninsured health services, and transportation.

One of the key questions which the UOI and others are addressing is the relationship between the CHRs and the health committee on a given reserve. The UOI views the health committee as the body responsible for making all recommendations on health. The CHR serves as a resource person to the health committee and may or may not be a voting member of the committee. Other PTOs, such as Treaty No. 3, the MIB and the Federation of Saskatchewan Indians seem to agree. It is also increasingly clear that health committees must have political sanction and support from their band councils to be effective. Most importantly, however, health committees can only be set up at a pace and in a form appropriate to local conditions.

CURRICULUM DEVELOPMENT

Under the Health Liaison Program of the Federation of Saskatchewan Indians, special funding has been obtained to develop a health curriculum:

> The intention is to implement a community-oriented approach: the residents of the community will themselves decide upon the subject matter of the health curriculum from kindergarten through grade 8. The course of studies will be developed in the form of a series of health-related learning activities, based on the direction provided by the elders, Chiefs and Councils, school committees and parents from Saskatchewan Indian Reserves.

This work is being undertaken in cooperation with the Saskatchewan Indian Cultural College in Saskatoon. A plan of operations and working philosophy is detailed in the recent document Kapasick Kootscaway Scanow.

The health curriculum team has held several community consultations throughout the province's six Indian government districts. A general band meeting is called to discuss the question: "What do you want your children to learn in the subject area of health?" If the general meeting is not well attended, the curriculum team, along with district health liaison officers, local CHRs, and residents carry out door-to-door interviews asking the same question. A frequency count of the health issues requested at these meetings and through the surveys is undertaken. The team then formulates, synthesizes and pares down the content. Upon production, the material is field tested to ensure that parents and teachers are involved in the evaluation and revision of the curriculum.

In a recent proposal, the Lennox Band Council of Prince Edward Island has proposed a training program for local health educators to develop materials and hold workshops on nutrition, diabetes, child-care, prenatal care, weight control, drugs and alcohol.

ENVIRONMENTAL HEALTH

All agree that a coordinated approach to the environmental causes of disease is urgently needed. Water, sewer, sanitation and housing conditions in Indian communities remain far below the accepted health and safety standards for non-native Canadians. Improvement of these services and training in the maintenance of improved facilities, together with an array of other preventive and environmental health programs, are essential to improving the general health of Indian people.

Although to date there have been few reported examples of such initiatives, those that do exist are instructive. In Cold River, Alberta, clean water and adequate sewage disposal have brought about an improvement in Indian health. In the Cree community of Moose Factory on James Bay, a planning committee representing all local constituencies (including status and non-status Indian people) has worked for over a year with government departments and outside consultants to improve water and sanitation services.

Among the most interesting experiences, perhaps, is that of a locally-directed environmental assessment of sanitation and water supply options in Big Trout Lake, in northwestern Ontario. In response to a plan to install an expensive sewerage system in the community which would service only non-native homes, and the subsequent dynamiting of grave sites by construction workers, the Council, in 1976, passed a Band Council Resolution to stop all construction on the sewer line and to conduct their own assessment of the most appropriate technical options.

By late 1977, the Band had hired a team of consultants, including a public health engineer, a limnologist, an architect specializing in sanitation and water, a sociologist and an adult educator. The team worked through 1978, first with the Band Council, and then later with the Health Committee, cooperatively carrying out research on existing water quality, water collection and use and sanitation facilities. Public meetings, committee meetings, household interviews and community radio were used

APPENDIX

APPENDIX

to gather and feed back information. Based on the direction given by the community, the consultants recommended, at the end of the first year, a matrix of water and waste technology options which moved from lowest to highest complexity and cost. The sewer was rejected as inappropriate. Technologies which seemed more appropriate included improved latrines, improved handpumps, and a trucked water and waste system that could be maintained by the Band and would immediately service the majority Indian homes and the minority non-Indian homes.

During the second year (1979), residents of Big Trout Lake evaluated the proposed technologies. A summary of the findings and recommendations of the Band's consultants was prepared in Cree syllabics and distributed throughout the community. Public meetings were held to clarify the environmental and social implications of each option. A group of Big Trout Lake women met to evaluate the recommendations in detail and came up with their own ideas and modifications about building protective shelters over the pumps, heating the pumps, attaching outhouses to the homes, the placement of water drums, and necessary changes in the structure of their homes to accommodate a trucked system for water and wastes.

Community members themselves selected a location suitable for a natural lagoon to hold trucked wastes. The Health Committee chose two residents to be sent to Winnipeg for a brief training session in well development and handpump repair methods, and developed a proposal to the Department of Indian Affairs and Northern Development to double the number of existing handpumps and to provide support for the pump repairmen. Three representatives of the Health Committee also undertook a study tour to Baker Lake, Northwest Territories, to study the operations and problems of a trucked water/waste system in a similar-sized native community, and they brought back many photos and much analysis of what they had seen.

In late 1979 the band council met with representatives from the Department of Indian Affairs and Northern Development, Environment Canada, Department of Transport and Health and Welfare Canada and presented to them a band council resolution supporting the low-cost improvements and the trucked system, and requesting funds to begin a demonstration project from which other reserves could learn. It is nearly four years since the band rejected the sewer and stopped its construction by a band council resolution. After much opposition and delay on the part of government, it appears that the band may succeed in obtaining funds for the technical options it deems most environmentally, socially and culturally appropriate.

NUTRITION

In October, 1979, the Sioux Lookout Zone Hospital in northern Ontario initiated a community-based nutrition program with the communities of Bearskin Lake, Weagamow, Wunnimum and Big Trout Lake. Two community workers on each reserve observe community eating habits and advise pregnant women on nutrition and breast feeding. They try to teach people how to budget to get the most nutritional value for their money. The workers are also interviewing elders and recording traditional herbal medicines and food.

Particular attention is paid to the importance of wild food. The workers emphasize that organ meats (lungs, liver, heart and intestines) contain the greatest amount of nutrition. Traditional Indian broth of fish bones and fish heads is an excellent source of calcium, while traditional blood soup and bone marrow are equally good sources of iron. In carrying out research in their communities, the community workers have found that often older people and younger people who are single parents run out of food altogether, largely because of mail delays of family allowance and welfare cheques and dependence upon non-traditional, store-bought foods. The high cost of nutritious foods in northern stores due to high transportation costs, lack of competition and the stocking policies of northern stores - further increases the desirability of wild food. the project, therefore, encourages the relearning of hunting and trapping skills on the part of younger people in the area.

In 1977 and 1978, members of the Wemmindji (Paint Hills) health committee in the James Bay area of Quebec began, with the assistance of a nutrition consultant, to investigate local sources of Vitamin C. They went out into the bush and picked several samples, such as mint leaves, Labrador tea leaves, spruce boughs and the red-purple flowers from the fireweed plant. They then came back, made teas from their samples, and had people who were attending the nursing station clinic try them. Spruce and mint teas were found to be the general favourites, but the elders said that Labrador tea was the one they preferred most. People remarked that it was both funny and sad that a white women from the south had shown young women about the bush teas, when the elders knew this all along but never had been asked by the young people. It was observed that bush teas, in addition to providing ample amounts of high quality Vitamin C, are also caffeine free.

In a related effort in 1978, the same reserve turned its attention to improving the quality of store-bought foods and the provision of nutrition education for local consumers. Both the Hudson's Bay Company and the Co-op store agreed to stock small tins of apple juice and orange juice and soon reported that the popularity of the juices was greater than that of soft drinks.

Three years ago, CHRs employed by Medical Services Branch in the eastern Arctic put educational materials together on traditional diet patterns and began to colour code food groups. The health committee of Pagnirtung in the Northwest Territories, building on this work, obtained Canada Works support for a community nutrition project in 1978-1979. This project sought to colour code all the foods in the local Hudson Bay Store as well as provide other consumer-oriented details, such as "best before" dates, in both syllabics (Inuktitut) and English. The cooperation of the Bay was obtained and sustained. In addition, the committee successfully urged the Bay to change its ordering practices. For example, the 1978-1979 soft-drink order was cut by half. People remarked that the Bay generally began to provide more responsive service as a result of the project.

Funds for the project, however, ran out with the federal dismantling of Canada Works. Although the nutrition project has been judged by many as one of the most successful community ventures in Pagnirtung, further government support has not been forthcoming. Project leaders are now

APPENDIX

APPENDIX

turning to churches and private foundations for financial assistance. Area interest in the project remains high though, and similar nutrition projects are in the planning stages at Hall Beach and Pond Inlet in the eastern Arctic.

BREAST FEEDING

A report recently issued by the Anglican Church of Canada shows that "Canada's native infants suffer from poor health and higher death rates when compared with the rest of the infant population, are liable to be admitted to hospital more often and for longer periods and are more prone to gastroenteritis and middle-ear infections as a result of bottle feeding". Widespread advertising by the infant formula industry has been a major contributor to the increase of bottle feeding in native communities.

In the Northwest Territories, northern doctors and nurses are trying to convince mothers to return to the traditional practices of breast feeding. However, one problem encountered is the high percentage of babies born out of wedlock and then adopted, losing the opportunity to be breast fed by their natural mothers. But with the decline in industrial expansion in the Northwest Territories illegitimacy rates have begun to drop, and officials report more progress in breast feeding.

In the January, 1980, issue of the Ontario Indian, Dr. Michael Stogre lists some general advantages of breast feeding: the process of "bonding" between mother and infant; avoidance of allergies associated with cow's milk; some decrease in the buildup of plaques in arteries leading to heart disease; decrease in incidence of breast cancer in nursing mothers; the utilization of a natural resource of great value. Add to these the more obvious advantages of breast feeding, such as its availability, portability, and ability to protect the baby against infection, and the case for breast feeding becomes even stronger.

HOMECARE

In late 1979, a new health project, Pa-me-e'-ti-win (Homecare), was started on Sandy Lake Reserve in northern Ontario. The health committee, with the assistance of local nursing staff, obtained financial support for the effort from the Sick Children's Foundation of Toronto. Four part-time workers and a full-time coordinator - all women - are employed on the project.

Workers visit bedridden people in the community who request care. "We bathe them and wash their hair, and tell them about nutrition, without trying to change their eating habits or their diets", explains the coordinator. The workers also visit old people, who are still able to look after themselves, "to encourage and advise them about different things". They also check the medication of the elderly and arrange to have their prescriptions refilled.

The project also addresses the needs of pregnant mothers. "We teach and tell them about pregnancy in general. We also go into nutrition a lot and advise these young mothers about breast feeding", the coordinator observes. This work is done in someone's home, where the mothers feel more comfortable and more willing to talk about their problems. The mothers are also encouraged to attend weekly pre-natal clinics at the nursing station.

In addition, the project is involved with well babies. Discussion groups about baby care, nutrition, and immunization are held with mothers. Advice is given on what to do when the baby has a high fever, and again breast feeding is encouraged. Project workers also go to the school to check the children's hair for lice. Plans are being made to hold sessions with the children on personal hygiene as well.

A woman counsellor works on the project, and represents the team at band council meetings. She and the project coordinator serve as liaison between the nursing staff and the people of the community. An important function of the homecare workers is to discuss with new nurses and doctors the traditions and lifestyles of Sandy Lake, in effect working as cross-cultural trainers for outsiders entering the Cree culture.

MENTAL AND SPIRITUAL HEALTH

"If there ever has been a lack of help from the outside, it has been a lack of spiritual help", says one of the workers in the Sioux Lookout Zone community health program. Started in August, 1979, the program is carried out by ten community mental health counsellors in Sandy Lake, Sachigo, Pikangikum and Lac Seul.

Both elders and younger people in the four communities have taken on the job of mental health counsellors. The younger mental health workers attempt to get the young people and their parents involved in recreational activities, functioning as an important bridge between the young and the old on the reserve. "In many ways the young people have been left out of things", says the same worker. The overall response to the program has been great. "The workers keep complete confidentiality and this means that they are trusted by the people", the worker notes.

At their first meeting together, the counsellors recommended that a native healer be hired by the zone hospital. The hospital on two occasions in the past has referred people to native healers, both times with success. Although transport costs for such services may be subsidized by the zone, it was generally agreed that to pay a money fee for the services of the healers would be inappropriate and perhaps, in the long run, could undermine traditional medicine.

APPENDIX

In Kenora, the local hospital administrator agreed last year that an Indian shaman should be available to offer counsel and advice to Indian patients. Spiritual reawakening and traditional treatment, reported by Alberta's Nechi Institute and others, has led to a reduction in alcoholism. Today, there are few who would deny the potency of traditional Indian medicine. On the agenda for a number of parts of the country are closer working relationships between medicine men and physicians; assistance for traditional Indian healers; training programs for traditional Indian healers and orientation of other health personnel - both Indian and non-Indian - in dealing with traditional health practices.

TRADITIONAL MIDWIVES

Considerable discussion has taken place in Canada concerning the importance of the role of traditional midwives on reserves. In Manitoba, for example, Dr. Tom Basket of the Department of Northern Health, Faculty of Medicine, University of Manitoba, has been exploring possible program support for midwives. Yet to date there has been little concrete financial commitment forthcoming. For the moment, we must look to that part of the Iroquois Nation located in Upper State New York for a progressive program model.

The Iroquois midwife group is seeking to return the natural process of childbirth to the hands of the community rather than the medical establishment. Eight Iroquois women have been or will be trained and equipped as midwives incorporating modern medical techniques with traditional birthing practices, the midwives would consult with women elders on herbs that are helpful in easing labour, cleaning the baby and blood, and strengthening the new mother. A local obstetrician is assisting the midwives with births which develop complications. The midwives expect an increase in both healthy mothers and babies as a result of this project.

APPENDIX

ADDITIONAL READINGS

The following is a set of selected readings for those interested in new developments in native health care management and delivery. The papers were generated in the course of the Inquiry's work, or came to the attention of the Inquiry.

1. Mahler, H. Address by Director-General of the World Health Organization at the Opening Ceremony. Alma-Ata, U.S.S.R., September 6, 1978.

2. Black, Lyall (Assistant Deputy Minister, Medical Services Branch). Speech on the new Indian Health Policy. Cornwall, Ontario, October 24, 1979.

3. Canada, National Health and Welfare. "Indian Health Discussion Paper". Draft prepared by a task force of the Medical Services Branch. Ottawa, December, 1979.

4. Coombs, John. *Community Supportive Health.* Ottawa, March, 1979.

5. Obomsawin, Ray. *Traditional Health and Nutrition.* Ottawa, August 1, 1979.

6. Canada, National Commission Inquiry on Indian Health. *The Development of Indian Health Councils.* Ottawa, February, 1980.

7. Ragan, Ed. *The Role of the Community Health Worker.* Ottawa, January, 1980.

8. Ragan, Ed. *The Role of Traditional Medicine.* Ottawa, January 1980.

9. Segal, Sydney. *Health Care Training for Native People.* Vancouver, February, 1980.

10. Segal, Sydney. *Outreach from Universities in Native Health Care.* Vancouver, February, 1980.

11. Tookenay, V. *Report on U.S. Indian Health Care.* Ottawa, February, 1980.

12. Campbell, Moni. "Appropriate Technologies for Water Supply and Sanitation in Northern Ontario Communities". Royal Commission on the Northern Environment. To be published. Toronto, 1980.

13. Farkas, Carol Spindell. *Survey of Northern Canadian Indian Dietary Patterns and Food Intake.* University of Waterloo. Waterloo, 1979.