“By Their Own Efforts”:
First Nations Health Policy in Canada, 1940s-1970s

by

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A thesis

presented to the University of Waterloo

in fulfilment of the

thesis requirement for the degree of

Doctor of Philosophy

in

History

Waterloo, Ontario, Canada, 2023

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Author's Declaration

I hereby declare that I am the sole author of this thesis. This a true copy of the thesis, including any required final revisions, as accepted by my examiners.

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Abstract

This dissertation explores the early years of Ottawa's 20th century integration policy with a focus on the impact of settler-colonial power and priorities on First Nations' access to Canadian health care systems under it. Using critical discourse analysis and the theoretical frameworks of Post-Colonialism and Critical Race Theory to read "along the grain of colonial common sense," this study explores settler archives to examine the discourses, policies, and practices of settler political and bureaucratic leadership from the 1940s to the 1970s. I argue that Ottawa's policy of integration, despite settler pronouncements of its break from the past, represented a profound continuity of settler desires for Indigenous erasure and White settler power. As a result, many settler politicians and department officials chose willful blindness to First Nations' assertions of their Indigenous or treaty rights to health care—deemed to be threats to the status quo. In their place, settler leadership drew on racialized myths of First Nations landlessness and "a primitive unproductive" culture to claim exclusive sovereignty, to "justify" settler incursion, and to offer access to settler health care systems on settler terms. Ultimately, Ottawa's approach produced a system of profound harm. It left Ottawa's Indian Health Service unprioritized and underfunded, its mandate unwanted by provincial governments, and its policies the target of resistance from many First Nations individuals and communities.

My dissertation joins with a rising number of health care historians who recognize that the history of settler-colonialism and systemic racism is a necessary addition to the history of health care in Canada. Specifically, my research will result in a richer understanding of how racialization continued to impact First Nations access to health care during a political period in Canadian history when overt racial discrimination was no longer sanctioned and details how settler efforts to develop policy in "First Nations best interests" operated largely to serve settler aims.

Acknowledgements

Many years ago, in Dr. Jackie Duffin's historiography of medicine class at Queen's University, the history of heath care captured my attention with a great and sudden vigour. In that class, Jackie offered her students a turn of phrase that has guided my engagement with history ever since: "history is the historian" or as British Historian Edward Hallett Carr put it: "study the historian before you begin to study the facts." To have a clearer understanding of this historian, I have the privilege of thanking the many people who have shaped both me and this thesis.

First and foremost, I must thank my family for generations of support, but especially my parents Anne and Mark. I cannot sum up a lifetime of love and care in a few lines, but I want them to know that this thesis would not exist without them. Thank you for raising me to be curious and for demonstrating how to live a life attuned to justice. I am also grateful for my sisters Rachel and Kira who kept me grounded and who were always just a phone call away when needed. My grandmother Landon, who passed away just as this thesis was being completed, also deserves special mention. Not only did she provide a home for me on my many research trips to Ottawa, but, more importantly, she was a powerful role model to me. It is to her that I dedicate this work.

From my master's degree at Waterloo through to the completion of this PhD, my supervisor Dr. Heather MacDougall has provided guidance, lively conversation, and a rigorous attention to detail that has strengthened my writing and fostered my confidence as a scholar. I'm also thankful that her commitment to seeing me finish this research never waived. My committee also made valuable contributions to my graduate experience and to my dissertation. In addition to her thoughtful suggestions on my research and writing, I am indebted to Dr. Susan Roy for her feedback on funding proposals, her help navigating administrative policies and procedures of graduate school, and for her commitment to departmental community-building. As a member of the Tri-University program, I had added benefit of accessing scholars outside of Waterloo for my committee. Dr. Susan Neylan's reflexive and critical approach to historical inquiry shaped my research methodology from my master's class at Laurier and I am grateful for her insightful feedback on my dissertation. Her probing but also conversational feedback made important improvements to my final product. Finally, I am grateful to Dr. Lianne Leddy who provided valuable feedback, shared references, and informed my understanding of positionality. I am also grateful for her empathetic discussions of the dissertation writing process. I must also make a special mention of gratitude to Dr. Ian Mosby and Dr. Jasmin Habib. Serving as external and internal-external examiners respectively, they both demonstrated a thorough engagement with my dissertation, offered astute insights, and asked compelling questions.

The trenches of graduate school were made infinitely better by dear comrades in arms, especially Dr. Jesse Abbott, Dr. Sarah McTavish, Eliza Richardson, Heather Ellis, Brittany Dunn, Eric Story, and as an honorary member, Mariah Story. I am forever grateful for the conversations and coffee runs. I also owe a debt of gratitude to the members of Canadian Society for the History of Medicine and the Canadian Society for the History of Nursing whose friendly collegiality, mentorship, and engagement with my research provided an intellectual home outside my own institution.

I have not only had the privilege of completing a PhD in the Tri-University History Program, but I also had the profound pleasure of meeting my husband in it. Brandon, thank you for your partnership on this journey. Your careful reading of my work and your ceaseless willingness to sit with me, while I worked through new ideas and formulated new understandings that later became arguments, left a profound impact on both me and my work. Through the highs and lows you have always been there. I can't wait to see where we go next.

Lastly, this research would not have been possible without the generous support of many agencies for which I am very grateful. In part, these include the Social Sciences and Humanities Research Council, The Government of Ontario, the University of Waterloo, and Associated Medical Services.

Dedication

In loving memory of my grandmother

Landon Pearson née Mackenzie
(1930-2023)

For paving the way, and for always wanting it done.

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List of Abbreviations

AO	Archives of Ontario
BNA Act	British North America Act
CCF	Canadian Commonwealth Federation
CRT	Critical Race Theory
DCH	Dominion Council of Health
DNHW	Department of National Health and Welfare
HIDSA	Hospital Insurance and Diagnostic Services Act
LAC	Library and Archives Canada
IAB	Indian Affairs Branch
IEA	Indian-Eskimo Association
IHS	Indian Health Services
MSB	Medical Services Branch
OMSIP	Ontario Medical Services Insurance Plan
RCAP	Royal Commission on Aboriginal Peoples
TRC	Truth and Reconciliation Commission

Introduction

I remember listening to the radio when the CBC aired acclaimed storyteller Thomas King's Massey Lecture, "The Truth About Stories." Throughout his presentation King reminded the audience, "the truth about stories is that's all we are."[1] Stories hold immense power to define how we come to know ourselves and the past. Crucially, stories can also help us to see and to problematize harmful beliefs and to assess their consequences. So, to begin, I offer three stories that have ignited and sustained my interest in the history of First Nations peoples' health care access.

In 1946, Brigadier Oliver M. Martin, Magistrate of the County of York, and member of the Six Nations of the Grand River, offered his submission to the Special Joint Committee of the Senate and House of Commons appointed to examine the *Indian Act*. Martin told the Committee how his sister had become ill and was sent by her doctor at the Six Nations reserve to the Toronto General Hospital. Martin went on to explain that when his sister arrived at the hospital, she was refused treatment because she was a status Indian and therefore fell under federal jurisdiction. Martin's sister later died without treatment.[2]

Over 50 years later, in 1999, Jordan River Anderson, a young Cree boy from Norway House First Nation in Northern Manitoba, was born in Winnipeg suffering from complex medical problems.

[1] Thomas King, *The Truth About Stories: A Native Narrative* (Toronto: House of Anansi Press, 2003), 2.
[2] Speech of Oliver M. Martin to *Special Joint Committee of the Senate and the House of Commons appointed to continue and complete the examination and consideration of the Indian Act*, August 8, 1946. Canada, *Minutes of Proceedings and Evidence, 1946* (Ottawa: King's Most Excellent Majesty Controller of Stationary Printer, 1946): 744-766.

At the age of two, Jordan stabilized, and doctors said he could go home. For three-years the federal and provincial governments quarrelled over jurisdiction and whose responsibility it was to pay for Jordan's at-home care (neither expressed much interest in doing so). Jordan slipped into a coma and died at the age of five, having never spent a day in his family home.[3]

In 2021, Joyce Echaquan, a 37-year-old Atikamekw mother, became the subject of national news after she filmed nurses at a Quebec hospital attacking her with racial insults and mockery. During this traumatic hospital encounter and without proper medical care, Joyce died. Following an inquiry into the incident, despite much evidence to the contrary, Quebec Premier Francois Legault stressed that no systemic racism exists in Quebec.[4]

Though decades separate these three episodes, in which Indigenous peoples experienced inadequate, and harmful, health care systems, their similarities prompted me to ask questions. As a historian, what could I learn about the narratives, structures, policies, and ideas that underlay these experiences? What stories had settlers told themselves about the rationales for their decisions? As a settler, I acknowledge that I receive benefits from the structures of settler-colonialism, including the systems of health care that I investigate, and I recognize the need for accountability of these structures and of the harms caused. The aim of this research is to ask critical questions about First Nations' health care access within the borders of what is known as Canada. Simply put, this research examines how and why First Nations communities were granted or

[3] "Jordan's Principle," Government of Canada, February 18, 2023. canada.ca/en/indigenous-services-canada/jordans-principle/boy-behind-jordans-principle.html

[4] Julia Page, "Hospital orderly, caught on video mocking Joyce Echaquan before she died, tells inquest she meant no harm." *CBC News,* May 19, 2021, https://www.cbc.ca/news/canada/montreal/joyce-echaquan-coroner-inquest-may-19-1.6032387 and René Bruemmer, "After Echaquan Report, Legault repeats there is no systemic racism in Quebec," *Montreal Gazette,* October 5, 2021, https://montrealgazette.com/news/quebec/after-echaquan-report-legault-repeats-there-is-no-systemic-racism-in-quebec

denied access to settler systems of health care. As the Director of the Centre for Aboriginal Health Research at the University of Victoria Charlotte Reading has argued, "in order to fully appreciate the current health disparities facing Aboriginal peoples, we must first explore the historical roots upon which current structures have evolved."[5] It is time for new his*tories*.

More specifically, the focus of this study is two-fold. First, it employs interpretative frameworks of Post-Colonialism and Critical Race Theory to ascertain the impact of settler-colonialism and systemic racism on settler rationales for First Nations' health care access in the early period of Ottawa's First Nations integration policy. Second, as part of the Truth and Reconciliation Commission's 2015 call to engage in "truth telling," this study aims to highlight the suffering that resulted from chosen pathways of action or inaction.[6] Here, I join with scholar Paulette Regan who uses a focus on settler truth telling to decolonize socio-political memory.[7] As Regan notes, this truth telling aims to challenge earlier scholarship whose narrative content involved a "selective forgetting" in order to celebrate settler achievements and to obscure the myriad harms and injustices of settler colonialism.[8] In addition, settler truth telling guides scholarship to be attuned to settler colonialism's on-going harms, a reality that Indigenous peoples in Canada have never been able to forget. "We should not" Regan stresses "lose sight of the ultimate need for substantive changes to existing economic structures, political, institutional, and legal systems."[9] Thus, my

[5] Charlotte Reading, "Structural Determinants of Aboriginal Peoples' Health," in *Determinants of Indigenous Peoples' Health in Canada: Beyond the Social* (3-15), eds. Margo Greenwood et al. (Toronto: Canadian Scholar's Press): 5.
[6] *Final Report of the Truth and Reconciliation Commission of Canada, Vol 1: Summary, Honouring the Truth, and Reconciling for the Future.* (Toronto: James Lorimer & Company Ltd, 2015): 322.
[7] Paulette Regan, *Unsettling the Settler Within: Indian Residential Schools, Truth Telling, and Reconciliation in Canada* (Vancouver: University of British Columbia Press, 2010), 69.
[8] For example, Regan points to Jack Granatstein's controversial, *Who Killed Canadian History,* in which his historical truth "is predicated on minimizing the suffering of IRS survivors, equating it with victimhood and implying that it is of no great consequence to Canada's history." Regan, *Unsettling the Settler Within,* 70.
[9] Regan, *Unsettling the Settler Within,* 175.

research is a response to the Truth and Reconciliation Commission's call to action 18 in which the commissioners "call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties."[10] Telling a fuller story of Canadian history will be unpleasant—unsettling to use Regan's words again—but the endeavour is a crucial one.

Note on Terminology

The term Indian is a historically inaccurate misnomer for First Nations peoples. To underscore the constructed nature of races, I have chosen to remove quotation marks and to capitalize equally the terms Indian and White to signify their use as racialized titles rather than stand-alone adjectives. I do, however, use quotation marks when referring to phrases of the historical period under study. For example, "the Indian problem," or "the Indian." In addition to my focus on its use as a racialized identifier, the term Indian will also be used to refer to the legal category of Indian status. The federal government has outlined three categories of individuals in relation to legal Indian status: 1) Status Indians are people who are entitled to have their names included on the Indian Register, an official list maintained by the federal government…only status Indians are recognized as Indian under the *Indian Act*; 2) Non-Status Indians, are people who consider themselves Indians or members of a First Nation but whom the Government of Canada does not recognized as Indians under the *Indian Act*…non-Status Indians are not entitled to the same rights and benefits available

[10] *Final Report of the Truth and Reconciliation Commission of Canada, Vol 1: Summary, Honouring the Truth, and Reconciling for the Future.* (Toronto: James Lorimer & Company Ltd, 2015): 322.

to Status Indians; 3) Treaty Indians are Status Indians who belong to a First Nation that signed a treaty with the Crown.

Background on Health Jurisdiction

The architecture for substantive involvement of settler governments in the health care of Canadians began at the provincial level. Following the British North America Act's designation of health care as a matter of provincial jurisdiction, throughout the 1880s provinces arranged what historian Jay Cassel described as "the basic administrative frameworks" and "new spheres of authority" for provincial public health management. Ontario, for example, established its first permanent Provincial Board of Health and passed key public health acts between 1882 and 1884.[11] In 1924, Ontario created its first Department of Health. In contrast, the federal government remained distant from the field of health protection and provision. This distance was especially true in the case of Indigenous peoples, for whom the 1867 British North America Act had assigned Ottawa jurisdiction. Its Section 91(24) articulates that the Parliament of Canada has "exclusive legislative authority" over "Indians, and Lands reserved for Indians," but the *Indian Act* failed to articulate Ottawa's responsibility to supply health care services. Coupled with the historic disinterest of provincial governments to address this gap, the lack of clarity has caused Indigenous peoples to fall into a jurisdictional void characterized far more by buck-passing than by adequate care. To this day Ottawa has yet to define for itself any specific legislative responsibility for the provision of health care to First Nations peoples.

[11] Jay Cassel, "Public Health in Canada," in *The History of Public Health and the Modern State,* ed. Dorothy Porter, (Leiden: Brill Publishers, 1994).

Despite this legislative absence, treaty claims, settler fears, and historical precedent facilitated federal involvement in First Nations health care provision. In 1876, representatives of the Crown and of Cree, Assiniboine and Ojibwa communities signed Treaty 6, which included a "medicine chest clause," in exchange for sharing access to Indigenous lands with settler newcomers.[12] Scholars have also gathered significant evidence to suggest that the provision of medical care was an oral promise made to First Nations communities during many treaty negotiations.[13] Moreover, physician and anthropologist T. Kue Young reminds readers that "even before the medicine chest clause of 1876, individual physicians, either full-time or part time were attached to various Indian Agents to the country" as well as attending many treaty annuity payment trips.[14] Thus, federal commitments and patterns of practice established, then reinforced, expectations that a relationship with settlers came with certain medical care privileges.

As many scholars have demonstrated, the rise of health care services for Indigenous communities in Canada were born out of protective concerns.[15] On the one hand, frameworks of White settler

[12] Crown, and later federal, treaty negotiations between settlers and Indigenous communities were undertaken in recognition of the prior sovereignty of Indigenous nations in the land that became known as Canada. This prior sovereignty was first acknowledged in settler documents with the Royal Proclamation of 1763. As Robert J. Surtees has argued, however, because the Royal Proclamation outlined the conditions under which the Crown could purchase Indigenous lands, the legacy of the document is problematic. Surtees explains, the Proclamation "certainly recognized Aboriginal proprietorship, but at the same time provided a means by which that right could be formally alienated." Robert J. Surtees, "Land Cessions, 1763-1830," in *Aboriginal Ontario: Historical Perspectives on the First Nations,* ed. by Edward S. Rogers and Donald B. Smith (Toronto: Dundurn Press, 1994), 94.

[13] Mary Jane Logan McCallum and Maureen Lux, "Medicare versus Medicine Chest: Court Challenges and Treaty Rights to Health Care," in *Medicare's Histories: Origins, Omissions, and Opportunities in Canada,* ed. Esyllt W. Jones, James Hanley, and Delia Gavrus (Winnipeg: University of Manitoba Press, 2022), 103-130; see also Yvonne Boyer and Sheyenne Spence, "Identifying and Advancing the Treaty Right to Health…Signed from 1871 and 1906 in Manitoba," *Revue francaise d'études américaines* 144, no. 3 (2015): 98; Yvonne Boyer, "Aboriginal Health: A Constitutional Rights Analysis," Discussion Paper Series in Aboriginal Health U*niversity of Saskatchewan Native Law Centre*, (June 2003), 9-10.

[14] T. Kue Young, "Indian Health Services in Canada: A Sociohistorical Perspective," *Social Science & Medicine*, 18 no. 3 (1984): 258.

[15] John Tobias has succinctly summarized the goals of First Nations' policy in Canada as "protection, civilization, and assimilation." He argued that the federal government was willing to accept a special status for First Nations peoples in Canada because they were believed to be "incapable of dealing with persons of European ancestry without being exploited." John L. Tobias, "Protection, Civilization, Assimilation: An Outline History of Canada's

superiority fostered the "vanishing Indian" myth in which Indigenous bodies were presented as too weak for the "modern" world and therefore as a people they were doomed to disappear without the intercession of European medicine and culture.[16] On the other, the erroneous belief in the weakness of Indigenous bodies transformed them into feared vectors of disease. Settler attention thus focused as much, if not more, attention on protecting 'healthy' White communities.[17] The racialized "Vanishing Indian" was simultaneously disappearing and dangerous. In response, the federal government committed to increasing health care services to Indigenous communities and entrenched their desire to keep First Nations individuals isolated on reserves.[18]

Of equal significance for federal policy makers was to facilitate the assimilation of First Nations peoples. Known as "experiments in civilization," the federal government used reserve spaces to encourage First Nations individuals to embrace White-Euro-Christian economic, educational, and religious systems.[19] As historian John Tobias has explained, the paradox that First Nations communities had to be isolated to become better Canadians remained a tolerated dissonance until the 1940s.[20] When the segregated and targeted assimilative training of First Nations communities

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Indian Policy," in *As Long as the Sun Shines and Water Flows: A Reader in Canadian Native Studies,* ed. Ian L. Getty and Antoine S. Lussier (Vancouver: University of British Columbia Press, 1983).

[16] For more on the "Vanishing Indian" trope see, Daniel Francis, *The Imaginary Indian: The Image of the Indian in Canadian Culture* (Vancouver: Arsenal Pulp Press, 2012).

[17] Alfred Crosby, "Virgin Soil Epidemics as a Factor in the Aboriginal Depopulation in America," *The William and Mary Quarterly* 33, no. 2 (April 1976): 289-299. Virgin soil epidemics, Crosby had argued, was the explanatory framework for the catastrophic mortality rates in North and South America that had resulted from the immunological inexperience of Indigenous populations to European diseases. This framework served to reinforce notions of 'racial susceptibility,' and that of a weaker race. Since the start of the 21st century, this position has been repeatedly refuted. David S. Jones, "Virgin Soils Revisited,' *William and Mary Quarterly* LX, no 4 (October 2003): 742; Maureen Lux, *Medicine that Walks: Disease, Medicine and Canadian Plains Native People 1880-1940* (Toronto: University of Toronto Press, 2001); Mary-Ellen Kelm, "Diagnosing the Discursive Indian: Medicine, Gender, and the 'Dying Race," *Ethnohistory* 52, no. 2 (2005): 371-406.

[18] James Daschuk, *Clearing the Plains: Disease, Politics of Starvation, and the Loss of Aboriginal Life* (Regina: University of Regina Press, 2013); Lux, *Medicine that Walks*.

[19] Tobias, "Protection, Civilization, Assimilation," 41.

[20] Tobias, "Protection, Civilization, Assimilation," 43.

did not produce a large-scale repudiation of Indigenous systems, Canada pushed forward more aggressive policies. In 1857 and 1869 respectively, Canada passed the *Gradual Civilization Act* and *The Gradual Enfranchisement Act*. Both used settler-defined standards to force First Nations individuals to give up any form of special status in Canada. When First Nations legislation was consolidated in 1876 in the form of the *Indian Act* it endorsed and expanded on these strategies of cultural, political, economic, and spiritual destabilization.[21] Whether in body or in culture, First Nations peoples were deemed to be "a dying race" in need of White saviours.

By the 20th century, federal health care efforts for Indigenous communities began to intensify. In 1904, Clifford Sifton appointed Dr. Peter H. Bryce as chief medical officer for the Departments of the Interior and Indian Affairs.[22] Federal contributions were, however, limited. Despite criticism from Bryce himself about Ottawa's insufficient attention to Indigenous health concerns, especially tuberculosis in residential schools, Indian Affairs leadership remained committed to limited expenditure.[23] Bryce's attempts to challenge departmental priorities left a bitter stain; his position remained vacant for several years and he was ultimately pensioned off in 1921. It was not until 1927 that Indian Affairs replaced Bryce and created the position of Superintendent of Health Services. The incumbent for the position was Dr. E. L. Stone. Under Stone, the federal government

[21] Across various pieces of legislation, First Nations individuals could be forcibly enfranchised for a variety of reasons. These included: gaining a university education, leaving reserves for over a defined period, and for First Nations women, marrying any man who did not have "Indian Status" as defined by the federal government. See Bob Joseph, *21 Things You May Not Known About the Indian Act*: *Helping Canadians Make Reconciliation with Indigenous Peoples a Reality* (Port Coquitlam: Indigenous Relations Press, 2018), 29-30; Mary-Ellen Kelm and Keith D. Smith, *Talking Back to the Indian Act: Critical Readings in Settler Colonial Histories* (Toronto: University of Toronto Press, 2018), 4-5, 111-112.
[22] Young, "Indian Health Services in Canada, 258.
[23] Megan Sproule-Jones, "Crusading for the Forgotten: Dr. Peter Bryce, Public Health, and Prairie Native Residential Schools," *Canadian Bulletin of Medical History* 13, no. 2 (Fall 1996): 199-224.

maintained its focus on segregated services and began to develop a system of "Indian hospitals" and nursing stations designed to treat Indigenous communities exclusively.

By 1945, however, politicians had grown wary of the failures of protective-assimilative segregation. Thus, jurisdiction for the health of Indigenous peoples in Canada was transferred from its home in the Department of Mines and Resources to the newly created Department of National Health and Welfare (DNHW). This relocation reflected a shifted state vision of First Nations peoples in Canada. No longer deemed a "dying race" that required the maintenance of a racially based health care system within the Indian Affairs Branch, the federal government aimed to help First Nations peoples "help themselves" through the dismantlement of a segregated health care system. Specifically, Ottawa wanted First Nations peoples to learn to access health care services not as federal wards, but as provincial citizens. The creation of the Indian Health Service within the DNHW was to facilitate this transition.[24] In time, it was hoped, First Nations peoples would not require a separate federal Indian Health Service. No longer would politicians and senior officials advocate for the separation of First Nations peoples while they "trained" to become Canadians. Instead, they would be invited to join Canadian society as equal members of the community. A policy of assimilation through racial segregation gave way to a policy of integration and the offer of equality.

While the language of integration policy called for a greater involvement of First Nations peoples in the management of their own affairs, this dissertation explores how the discourses and policies of "equality" remained an outgrowth of older colonial logics that failed to inaugurate a new period

[24] A shift in the conceptualization of First Nations policy was also reflected in the movement of Indian Affairs from the Department of Mines and Resources to the Department of Citizenship and Immigration from 1950 until 1965.

of tripartite collaboration between federal, provincial, and First Nations governments. In so doing, my research reveals that paternalistic power differentials and settler-colonial value-systems continued to dominate the health policy landscape. Settler politicians and department officials at both federal and provincial levels of the Canadian government repeatedly chose to deny First Nations' claims to a treaty or Indigenous right to health care. Instead, settler institutions drew on myths of First Nations landlessness and "a primitive unproductive" culture to compel First Nations' integration into settler society and Canadian sovereignty.[25] This acceptance was positioned as the only pathway to dignified and permanent quality health care.

Methodology

The temporal focus of this study begins with the creation of the Indian Health Services Branch within the Department of National Health and Welfare in 1945. The IHS lasted as a separate branch of the DNHW until 1962 when it merged with Northern Health Services and five other federal health programs to form the Medical Services Branch (MSB). For the sake of clarity, I have used the term "IHS" to refer to the federal government's administrative hub for First Nations health policy and service provision throughout.[26] While this study focuses mainly on the years 1945-

[25] Political scientist Peter Russell argues that the Canadian government's sovereignty in the land now known as Canada is a claim rather than a fact. According to Russell, "the essential feature of the sovereignty claim is that those who make it for themselves or for the state they represent claim to be the highest source of legitimate power for the people and territory of their political community…those who assert sovereignty are not in actual control of all that people do in the territory over which they claim to be sovereign. But it is an assertion that all who are in the sovereign's territory or are subject to its authority are obliged to comply with the law and commands of the sovereign's authorized rulers." Peter H. Russell, *Sovereignty: The Biography of a Claim* (Toronto: University of Toronto Press, 2021), 10. Certainly, as Russell highlights, the founding Constitution of Canada makes no mention of Indigenous nations. Instead, "Indians and land reserved for Indians" are mentioned as a matter of federal jurisdiction. "This sole reference," Russell argues, "heralded the Canadian state's determination to dominate them and eventually eliminate them as a distinct component of the Canadian peoples." Russell, *Sovereignty,* 75.

[26] This choice also excludes the bureaucratic development that changed Indian Health Services to Indian and Northern Health Services in 1955. Canada's health care efforts to Indigenous communities in the north is without question an important subject of study, but it is beyond the scope of this particular project.

1969, I have chosen to extend (briefly) its purview to the 1970s to add to a growing literature that decentres the 1969 White Paper as a watershed moment of change. While my aim is not to minimize the significant wave of activism that was generated in response to the White Paper, as Sarah Nickel has argued, disproportionate attention to the 1969 White Paper and its aftermath has minimized the resistance efforts of First Nations communities in the years and decades that preceded it.[27] With a temporal scope that stretches from the 1940s to the 1970s, I hope to contextualize the continuities of settler-colonial policy and to highlight the long-standing agency and resistance of many First Nations individuals and communities to the policies, programs, and priorities of Canada's settler-colonial state.

It is essential to highlight that my reading of First Nations health care history is shaped by my experiences as a White settler, whose work is conducted in and funded by settler institutions. My approach to the study of settler colonialism and race in the history of First Nations health care access draws on written records found in colonial archives. Specifically, the primary source base for this study consisted mainly of the records of the Department of National Health and Welfare, the records of the Social and Family Services Department of Ontario, and the recorded debates of both the federal and provincial legislatures, known as Hansard. This approach presented me with ample written material on which to measure and analyze discourse within and with settler institutions through the entire period under study. In addition, as a settler on Indigenous territory I hold the responsibility of being a good guest on their land.[28] This responsibility involves a critical examination of the settler systems that have provided me and my family with profound levels of

[27] Sarah Nickel, "Reconsidering 1969: The *White Paper* and the Making of the Modern Indigenous Rights Movement," *The Canadian Historical Review* 100, no. 2 (June 2019): 223-238.
[28] This research was conducted mainly on the traditional territory of the Neutral, Anishinaabeg and Haudenosaunee peoples.

privilege while concurrently causing much harm to Indigenous individuals and nations. In examining how settler-colonial power and its problematic policies have persisted over decades, I hope to bring forward knowledge that can lead to meaningful improvements to First Nations well-being and access to care.

This dissertation is not meant to be a comprehensive history of the post-war Indian Health Services. Instead, it uses a critical discourse analysis approach to elucidate the historic, and on-going, tensions between settler-colonial objectives, race-based beliefs, and the provision of health care services as a treaty or Indigenous right. It was, therefore, guided by questions such as: How did policy and program stakeholders engage with a well-meaning but misguided belief that they operated in First Nations best interest when crafting First Nations health care policy? In what way did debates about the rights and responsibilities of Canadian citizenships determine the nature of health care policy offered? What degree of difference in First Nations policy was considered "acceptable"? How did a policy of integration view treaty rights to health care or provincial jurisdiction? If integration was not assimilation, how were the discourses and structures of health management believed to have changed? What ideas were consistently reaffirmed, what ideas were challenged, when and why? What perspectives were ignored? And finally, what impact did settler priorities and policies have on the material conditions of First Nations health care access? In the words of anthropologist Ann Laura Stoller, this approach involves not a "reading against the grain" but "along the grain to map the contours of colonial common sense."[29]

[29] Ann Laura Stoller, *Along the Archival Grain: Colonial Cultures and Their Affective States* (Princeton: Princeton University Press, 2009), quoted in Michelle T. King, "Working With/In the Archives," in *Research Methods for History 2nd Edition*, ed. Simon Gunn and Lucy Faire (Edinburgh: Edinburgh University Press, 2016), 21.

My methodology also derives inspiration from other settler scholars who, while not in a position to decipher Indigenous worldviews, draw on the insights of Indigenous methodologies for their critical assessment of settler documents. Specifically, historians Mary Ellen Kelm and Kevin D. Smith call on historians to situate their historical sources within the relationships they represent.[30] As Kelm and Smith remind readers, "Indigenous scholars from around the world emphasize relationships—recognizing them, renewing them, honouring them—are central to Indigenous ways of knowing, ways of being and ways of making ethical decisions." Thus, they continue, "understanding how [documents] and the people who created them were enmeshed in relationships offers important insights to historians."[31] Mohawk historian Susan Hill, for example, confirms Kelm and Smith's view when she describes the importance Haudenosaunee communities place on their relationship to land. Hill explains,

> Haudenosaunee historical knowledge does record the name of important leaders—male and female—and important events, but the emphasis is always placed on the constant elements of the Haudenosaunee world. A human lifespan is extremely limited, not to mention self-centred, but other parts of the natural world provide a better guide and better perspective for examining the past. For the Haudenosaunee, land is possibly the best point of reference for considering history. Historical knowledge and lessons embodied in the Haudenosaunee cultural history demonstrate land and territory as the prime determinants of Haudenosaunee identity.[32]

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[30] Mary-Ellen Kelm and Kevin D. Smith, *Talking Back to the Indian Act: Critical Readings in Settler Colonial Histories* (Toronto: University of Toronto Press, 2018), 19.

[31] Kelm and Smith, *Talking Back,* 17-18. Kelm and Smith draw attention to the following work, conducted by Indigenous scholars, on the subject: Aileen Moreton-Robinson, "Relationality: A Key Presupposition of an Indigenous Social Research Paradigm," *Sources and Methods in Indigenous Studies* 7 (2017): 69, 71,73; K. Tsianina Lomawaima, "Mind, Heart, Hands: Thinking, Feeling, and Doing in Indigenous History Methodology," in *Sources and Methods in Indigenous Studies,* ed. Chris Andersen and Jean M. O'Brien (Routledge, 2016), 60-68; Margaret Kovach, *Indigenous Methodologies: Characteristics, Conversations, and Contexts* (Toronto, University of Toronto Press, 2010)*;* Kim Tallbear, "Standing with and Speaking as Faith: A Feminist Indigenous Approach to Inquiry," *Journal of Research Practice*, 10 no. 2 (2014); Shawn Wilson*, Research is Ceremony: Indigenous Research Methods* (Halifax: Fernwood Publishing, 2008), 7, 15.

[32] Susan M. Hill, *The Clay We Are Made Of: Haudenosaunee Land Tenure on the Grand River* (Winnipeg: University of Manitoba Press, 2017), 3.

In contrast, settler government officials and politicians were embedded in very different beliefs and honoured different relationships.[33] Understanding the nature of settler relationships and their perspective of Indigenous relationships is an essential question to ask of settler health policy history.

The scope of this study is deliberately limited. My research focuses on public discourse found in settler archives. It is therefore not an in-depth examination of community activism, although I have made considerable efforts to draw out narratives of First Nations' resistance to settler-colonial paternalism and hegemony. Throughout the history of colonization in Canada, Indigenous peoples have, and continue to resist the hegemonic power of the settler-state, to consciously adopt segments of its offerings, or to reframe its rhetoric and goals.[34] Being attentive to this resistance is as important as being attentive to the dynamics of colonial power. In fact, this awareness reveals with greater clarity the various moments when settler-governments ignored calls for the reconciliation of their relationship with Indigenous peoples. As anthropologist Sally Weaver's work demonstrates, an "accurate rationalization of Indian position cannot be done within government by ministers and civil servants whose liberal ideology and personal ambitions distort the Indian viewpoint."[35] Their views, however, can be studied to reveal with greater clarity settler perspectives, objectives, and their consequences.

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[33] Kelm and Smith, *Talking Back to the Indian Act,* 19.
[34] For examples of the contemporary maintenance and actualization of Indigenous perspectives on health and wellness see: Margo Greenwood, Sarah de Leeuw, Nicole Marie Lindsay, and Charlotte Reading, eds. *Determinants of Indigenous Peoples' Health in Canada: Beyond the Social* (Toronto: Canadian Scholar's Press, 2015); Kim Anderson, Barbara Clow, and Margaret Haworth-Brockman, "Carriers of Water: Aboriginal Women's Experiences, Relationships, and Reflections," *Journal of Cleaner Production* 60 (2013): 11-17; Kim Anderson, *Life Stages and Native Women: Memory, Teachings, and Story Medicine* (Winnipeg: University of Manitoba Press, 2011).
[35] Sally Weaver, *Making Canadian Indian Policy: The Hidden Agenda 1968-1970* (Toronto: University of Toronto Press, 1981), xiii.

As a settler-scholar, however, I do not feel it is my place to offer a detailed record or analysis of community wishes beyond a broad call to end colonialism and to honour treaty rights. Neither is this dissertation a prosopography of individuals to highlight the personal circumstances that facilitate the perpetuation of settler-colonialism. Instead, it examines the systemic ideologies of settler colonialism and evaluates their impact on the nature of First Nations health care access in the post-war period. It is also important to note that I have limited my study to discourses about and policies for First Nations peoples in Canada. The political complexities that have shaped the positions of Métis and Inuit populations in relation to Canada deserve their own dedicated analysis.

With a keen awareness that First Nations communities across Canada represent a vast diversity of peoples, I have attempted to limit the scope of this study to counter a long history of settler-homogenization. Thus, while this research engages with policy designed for a national project of settler-colonialism, case studies were drawn largely from the Ontario context. In addition to a desire for specificity over homogenization, a focus on Ontario will, I hope, create adequate space for a deep examination of jurisdictional debates between the federal government and Ontario. The priorities, policies, and financial situation of Canada's provinces and territories was too large a topic to examine for this dissertation. The particularities of the spaces and places not covered in this study are certainly rich and crucial avenues of future inquiry.

Ontario was selected as the focus province for this study for several reasons. In the first instance, I was born and raised, have studied, and worked, on Indigenous territories in what is known widely as Ontario. As part of a commitment to understand the histories of the land around me, I considered Ontario to be a vital focus for this research. Second, the ways in which national policies for First

Nations health were entrenched or adapted within the Ontario context remains an understudied area within First Nations' health care access history. Between 1781 and 1930, representatives of the British Crown and later the government of Canada, signed 46 treaties and land agreements with Indigenous peoples within the political boundaries of what is known as Ontario.[36] The plethora of such agreements makes Ontario a valuable subject for a study of the discourses of health care access in a settler-colonial context. Unlike British Columbia, where few treaties were enacted, the presence and absence of treaty rights in health care access discourse offers essential insights to how settler-colonialism operates in theory and in practice. Finally, Ontario offers a valuable area of analysis because it was both home to the largest number of status-First Nations individuals and led the way in its apparent willingness to extend provincial programs to on-reserve communities.

Like the 1996 Royal Commission on Aboriginal Peoples (RCAP), this study uses an inclusive and behavioural definition of policy. That is, policy is understood to be "what a government decides to do or not to do…[it] is not necessarily labelled or formally identified as policy, though it often is."[37] This approach is especially important for the study of First Nations health policy where priorities were evident as much in the absences as in articulated plans. Turning again to RCAP, this study also takes its definition of policy discourse as "the communication of ideas, concepts,

[36] Edward, J. Hedican, *First Nations of Ontario: Social and Historical Transitions* (Toronto: Canadian Scholars, 2017), 109.

[37] *Royal Commission on Aboriginal Peoples, Public Policy and Aboriginal Peoples 1965 Vol 1: Soliloquy and Dialogue—Overview of the Major Trends in Public Policy Relating to Aboriginal Peoples*, by Katherine Graham, Carolyn Dittburner, and Frances Abele. (Ottawa: Minister of Public Works and Government Services, 1996): 38; Other scholars, such as Jane Whalen, use a more expansive definition of policy to include "what happens on the ground." While this study appreciates the complex interplay between official policy and its actualization in local settings, the focus of this dissertation is on what policy makers hoped would occur to reveal high ranking priorities of settler governments. Jane Elizabeth Whalen, "Wasting Away: The Impact of Policy and Policymakers on the Rise of Tuberculosis on Aboriginal Communities, 1867-1945" (PhD diss., Wilfrid Laurier University, 2013).

explanations, justifications, written or spoken, concerning policy."[38] Whether in the form of dialogue between interested actors or on its own, policy discourse is a rich field for scholarly inquiry to expose the rhetorical building blocks of a particular social and political order. This study also takes a broad definition of policy makers as any person with power to influence or determine policies and practices, including senior government officials and politicians.

Important insights about health policy creation can also be found in political scientist Carolyn Tuohy's most recent work, *Remaking Policy*. In particular, Tuohy draws important attention to both the dynamics of the time, through what she refers to as an "institutional regime," and its policy frameworks.[39] These concepts contend that policy analysts must be attuned to "certain organizing principles [of a period] regarding the basis of entitlement and obligation of citizens and the functional role of the state, [which] thereby legitimatize the resulting distribution of costs and benefits so long as those principles are observed."[40] In other words, to understand policy development and implementation one must consider not only the material resources available but, also, evaluate the perceptions and priorities of policy makers as political and cultural beings. Shifting political, bureaucratic, health, and cultural contexts must be discerned and examined to understand why policy actors made the choices they did. This approach offers an important bridge

[38] *Royal Commission on Aboriginal Peoples, Public Policy and Aboriginal Peoples 1965 Vol 1: Soliloquy and Dialogue—Overview of the Major Trends in Public Policy Relating to Aboriginal Peoples*, by Katherine Graham, Carolyn Dittburner, and Frances Abele. (Ottawa: Minister of Public Works and Government Services, 1996): 38.
[39] Carolyn Tuohy, *Remaking Policy: Scale, Pace, and Political Strategy in Health Care Reform* (Toronto: University of Toronto Press, 2018).
[40] Tuohy, *Remaking Policy,* 7-8. Richard Simeon likewise points to the need to be attentive to broader social contexts in order to understand policy developments. Simeon writes, "it seems clear that neither sociological nor institutional factors alone can account for the actual performance of political systems or for their policy-making processes. More likely there is a subtle interplay between three sets of factors: (1) broad social and cultural characteristics, (b) institutional and constitutional factors, and (c) the particular norms, attitudes, goals, and perspectives of decision-makers and the particular demands and problems facing the system at any given time. Richard Simeon, *Federal-Provincial Diplomacy: The Making of Recent Policy in Canada, 3rd ed.* (Toronto: University of Toronto Press, 2006), 8.

for political and cultural history as it underscores the need to understand how specific policy makers drew on changing cultural perceptions of Indigenous peoples for the creation of health policy.

In this endeavor two frameworks guided my analysis. The first is post-colonialism. This framework does not suggest that colonialism has ended but, rather, underscores the "need to revisit, remember and 'interrogate' colonialism in new ways."[41] Specifically, it attempts to understand the degree to which colonial relationships exploit inequalities of power and utilize discourses of racial evolution to assert the superiority of the colonizer over the colonized.[42] Building on a growing body of scholarship, I position my study within a literature that understands Canada to be a settler-colonial state. Scholars Emma Battell Lowman and Adam J. Barker offer one of the clearest articulations of the settler-colonial project. In brief, this project is one of elimination, indigenization, and transcendence. Settler societies, they argue,

> seek to eliminate competing assertions of sovereignty, and so seek to eliminate Indigenous peoples and their land-based relationships. Then, settler society seeks to erase the evidence of those competing sovereignties having existed…then seeks to claim an 'indigenous' status by right of being the only legitimate peoples on the territories, posing as post-colonial societies...Finally, colonialism is transcended—put into the past—when settler societies fully replace Indigenous sovereignties on the land.[43]

[41] Annette J. Browne, Victoria L. Smye, and Collen Varcoe, "The Relevance of Postcolonial Theoretical Perspectives to Research in Aboriginal Health," *Canadian Journal of Nursing Research* 37, no. 4 (2005): 20.
[42] Annette J. Browne et. al "The Relevance of Postcolonial Theoretical Perspectives," 20.
[43] Emma Battell Lowman and Adam J. Barker, *Settler: Identity and Colonialism in 21st Century Canada* (Halifax: Fernwood Publishing, 2015), 31. See also Peter H. Russell who describes the process of Canada's sovereignty claim as a form of fraud. Russell explains, "The First Nations had not been conquered, and while there was a strong interest in establishing a peaceful relationship and getting some tangible benefits, no [First Nation] was so desperate that it would knowingly sign away its rights and make itself totally dependent on the largesse of the white man." Russell, *Sovereignty,* 6.

Elsewhere, anthropologist Patrick Wolfe has described this process as the structuring of settler society to employ the "logic of elimination" in its relationships to Indigenous communities.[44] The aim of this study is to situate the history of First Nations health care access within this broader colonial project to recognize its influence on the priorities, rhetoric, and actions of settler actors.

Of equal inspiration to this study is education scholars Eve Tuck and K. Wayne Yang's articulation of the varied ways in which settlers have distanced themselves from complicity in the harms of settler colonialism. What Tuck and Yang refer to as "settler moves to innocence" provides my research with a useful analytical framework through which to situate First Nation's health policy within a broader settler agenda. Specifically, this concept frames the denial of guilt for land theft and harms as actions taken to "rescue settler futurity" in spaces of stolen access.[45] Put another way, I align my scholarship with a growing scholarly community who seek to challenge the argued benevolence of the Canadian settler state and its intention to operate in "First Nations' best interest."[46] No current study on the history of settler-colonialization's impact on First Nations health care can ignore the new lexicon historian Mary Jane Logan McCallum provides the field.

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[44] Patrick Wolfe, "Settler Colonialism and the Elimination of the Native," *Journal of Genocide Research* 8, no. 4 (December 2006): 387-388.

[45] Eve Tuck and K. Wayne Yang, "Decolonization is not a metaphor," *Decolonization: Indigeneity, Education and Society* 1, no. 1 (2012): 1-40.

[46] Travis Hay, *Inventing the Thirty Gene: The Science of Settler Colonialism* (Winnipeg: University of Manitoba Press, 2021); Catherine Carstairs and Ian Mosby, "Colonial Extractions: Oral Health Care and Indigenous Peoples in Canada, 1945-79," *The Canadian Historical Review* 10, no. 2 (June 2020): 192-216; Mary Jane Logan McCallum, *Structures of Indifference: An Indigenous Life and Death in a Canadian City* (Winnipeg: University of Manitoba Press, 2018); Mary Jane Logan McCallum, "Starvation, Experimentation, Segregation, and Trauma: Words for Reading Indigenous Health History," *The Canadian Historical Review* 98, no. 1 (March 2017): 96-113; *Canada and Colonial Genocide,* ed. by Andrew Woolford and Jeff Benvenuto (New York: Routledge, 2017); Maureen Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s* (Toronto: University of Toronto Press, 2016); Karen Stote, *An Act of Genocide: Colonialism and the Sterilization of Aboriginal Women* (Halifax: Fernwood Publishing, 2015); Ian Mosby, "Administering Colonial Science: Nutrition Research and Human Biomedical Experimentation in Aboriginal Communities and Residential Schools, 1942-1953," *Histoire sociale* 46, no. 91 (May 2013): 145-172; James Daschuk, *Clearing the Plains: Disease, Politics of Starvation, and the Loss of Aboriginal Life* (Regina: University of Regina Press, 2013); Cindy Blackstock, "The Occasional Evil of Angels: Learning from the Experiences of Aboriginal Peoples and Social Work," *First Peoples Child and Family Review* 4, no.1 (2009): 28-39; Harold Cardinal, *The Unjust Society* (Vancouver: Douglas & McIntyre, 1969).

For McCallum, Indigenous health history in Canada is a history of "starvation, experimentation, segregation, and trauma."[47] Indeed, my research investigates this history in its interrogation of the political and bureaucratic discourses that created such a harmful health care system. Such an approach does not challenge the belief that many settler individuals have worked with good intentions, but it stresses that the discursive and material harms of settler colonialism must be studied with at least equal fervor.

This stance is formed as a direct response to a history and historiography in Canada where "[colonial] machinery…was designed to create a perfect crime—a crime where the victims are unable to see or name the crime *as a crime.*"[48] Settlers in positions of health policy leadership within the state were continually asked to choose a decolonial pathway of relationship building with First Nations peoples. But such calls were largely ignored and suffering continued. Instead, First Nations individuals and communities were invited to accept a "Eurocentrism", which education scholar Marie Battiste and lawyer Sakej Young Blood Henderson note, "postulates the superiority of Europeans over non-Europeans" and frames European conclusions as rational truth.[49]

To understand the specific ways in which settler-colonialism has operated in Canada, my research also pays particular attention to the employment of systemic racism to reinforce perceptions of White superiority and delegitimize First Nations peoples as capable, sovereign peoples. While

[47] Mary Jane Logan McCallum, "Starvation, Experimentation, Segregation, and Trauma: Words for Reading Indigenous Health History," *The Canadian Historical Review* 98, no. 1 (March 2017): 96-113.
[48] Leanne Betasamosake Simpson, *As We Have Always Done: Indigenous Freedom Through Radical Resistance* (Minneapolis: University of Minnesota Press, 2017), 15.
[49] Marie Battiste and Sakej Young Blood Henderson, "Eurocentrism and the European Ethnographic Tradition," in *Racism, Colonialism, and Indigeneity in Canada: A Reader,* eds. M. Cannon & L. Sunseri (Oxford: Oxford University Press, 2017), 11.

systemic racism is not an exclusive tool of settler-colonial societies, the use of an "organizing grammar of race," no doubt played a role in the efficacy of settler colonial narratives.[50] As historian Jean M. O'Brien has articulated, race, and specifically the evocation of White supremacy, "comes into being when colonizers must share spaces with those they seek to dominate, making other people's homes their own."[51] For this reason, this research draws heavily on the insights of Critical Race Theory (CRT). CRT developed as a theoretical framework in American legal studies in the 1970s. Its birth, led by scholars such as legal scholar Derrick Bell Jr., was a direct response to critical legal studies whose silence on the topic of race failed to recognize racism as an embedded reality of American society.[52] Those who turned to Critical Race Theory felt that even when race was acknowledged, they were dissatisfied that racism was treated as an aberration from normal social and system functioning. For Critical Race theorists, this stance failed to reveal the ways in which racialized ideas have been infused into the structures of North American society rather than being the result of a 'few bad apples.'

The three major themes of CRT each have important insights to offer the history of colonial health systems. First, building from the rise of post-structuralism in the 1980s and 1990s, those who employ Critical Race Theory examine the making of race and understand "races" to be flexible "categories that society invests, manipulates, or retires when convenient."[53] Races, from this standpoint, are not biological realities but rather socially constructed ideas that act upon the world

[50] Anthropologist Patrick Wolfe has explored the settler-colonial use of the "organizing grammar of race" to further the aims of the settler colonial state in other international contexts. Patrick Wolfe, "Settler Colonialism and the Elimination of the Native," *Journal of Genocide Research* 8, no. 4 (December 2006): 387-388.
[51] Jean M. O'Brien, "Tracing Settler Colonialism's Eliminatory Logic in *Traces of History," American Quarterly* 69, no. 2 (2017): 249-250.
[52] Kimberlé Crenshaw, Neil Gotanda, Gary Peller, and Kendall Thomas, ed. *Critical Race Theory: The Key Writings that Formed the Movement,* (New York: The New York Press, 1995).
[53] Richard Delgado and Jean Stefanic, *Critical Race Theory: An Introduction 3rd Edition* (New York: New York University Press, 2017), 7.

through racist attitudes and discourses. For example, Critical Race Theorists position themselves to ask how concepts such as normal/abnormal, healthy/ill, capable/inept have been inscribed with racialized meanings as well as problematize who is given the power of definition. Through this lens, racialized conflicts that on the surface appear to be jurisdictional debates between different levels of government over whose responsibility it is to pay for First Nations health services, are revealed to involve racialized ideas about the Indian as a burden and White citizens as worthy of care.[54] Critical Race Theorists also expose how historical and contemporary racialized discourses have attempted to justify the social, economic and political domination of Whiteness in society.

Second, Critical Race scholar Cheryl Harris coined the phrase "Whiteness as property" to expose material racism.[55] Harris' phrase reflects how Whiteness is assigned material privileges, such as admission to particular social networks, preference in hiring, and control of land access, which affords those who can access Whiteness a powerful economic position. In contrast, racialized minorities are denied access to such privileges because they are often, for example, excluded from certain social networks, discriminated against in hiring, and dispossessed of their land. CRT therefore calls scholars to examine the various ways that Whiteness has been a source of material privilege in economies based on race exploitation.[56] In the same vein, CRT also uses this knowledge to challenge victim-blaming or narratives of cultural-deficit.

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[54] Frances Henry and Carol Tator outline a number of thematic discourses that work to enhance and/or to hide realities of racialization. Some examples relevant to the history of Indigenous health care in Canada include discourse of denial; discourse of colour-blindness; discourse of equal opportunity; discourse of blaming the victim; discourse of White victimization; discourse of liberal values. See Frances Henry and Carol Tator, *The Colour of Democracy: Racism in Canadian Society* 4th Ed. (Toronto: Nelson Education, 2010).

[55] See Cheryl Harris, "Whiteness as Property," in *Critical Race Theory: The Key Writings That Formed the Movement,* ed. Kimberlé Crenshaw, Neil Gotanda, Gary Peller, and Kendall Thomas (New York: The New York Press, 1995), 276-291.

[56] Lowman and Barker explain that "powerful as it is, the ideologies, social behaviours, and supposed benefits of white supremacy overlap productively but incompletely with those of settler colonialism. This overlap is significant, but it is important to understand that being Settler Canadian is not necessarily predicated on experiencing the

Finally, CRT acknowledges that racism is ordinary rather than exceptional. Critical Race Theorists challenge liberalism's belief that the institutions of society reflect a racially neutral baseline and that the role of these institutions is to ensure that they remain at—or return to—their neutral baseline.[57] Instead, theorists call for an examination of how racial ideas have played a formative role in the establishment of institutions and wider societal belief systems. For example, Critical Race Theory raises concerns about Pierre Trudeau's efforts in the 1960s to create a "just society" by removing the *Indian Act* without challenging the behaviours, values, and practices of dominant society that disadvantaged First Nations peoples. Thus, important questions can be raised about the way policy makers conceived of race and racialization even in political climates aiming to bring formal equality through policy and legislation.

Historiography

Examining the Making of Race and the Colonial Agenda

In the second half of the 20th century, international and national developments began to shift the context of historical writing. At an international level, widespread decolonization movements of the 1950s and 1960s as well as the fight for African American civil rights in the United States began to raise questions about the hagiographic and teleological nature of early historiography.[58]

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benefits or the oppressions of white supremacy, nor is it necessary to be accepted by all other Settler people." Lowman and Barker, *Settler,* 70.

[57] Critical Race Theory scholars are discontented with liberalism as a framework for addressing American's racial problems. Many liberals believe in colour blindness and neutral principles of constitutional law. Delgado and Stefanic, *Critical Race Theory,* 25. See also Crenshaw et. al. *Critical Race Theory*.

[58] For Canadian history see Arthur Lower, *From Colony to Nation* (Toronto: Longmans and Green, 1946) and the *Centenary Series* first commissioned by McCelland and Stewart in 1967. Examples in medical historiography include William Canniff's work who described physicians in his 1894 history as "distinguished men who have taken an active part in the government of the country…[they] were men of high education, and possessed of noble qualities which fitted them to fill various positions of public trust." William Canniff, *The Medical Profession in Upper Canada 1783-1850: A Historical Narrative with the Original Documents Relating to the Profession including some brief biographies (*Toronto: William Briggs, 1894), v. See also, G. Rosen, "Levels of Integration in Medical Historiography: A Review," *Journal of the History of Medicine* 4, no. 4 (Autumn 1949): 465. Mirko D. Grmek,

Rather than triumphant nationalism, societies were called to consider the darker implications of their imperial pasts. In Canada, the Bilingualism and Biculturalism Commission (1963-69) generated discussion on the need to problematize the dominance of one group over another, but also sparked increased attention for those placed beyond 'the founding races' of the English and French. Vocal criticisms of Ukrainian-Canadians who asserted a founding status as worthy of attention as the French, supported a new view of Canadian history.[59] In addition, an interest in new voices was also a product of the intense backlash from Indigenous communities regarding colonialism's treatment of Indigenous peoples. In particular, the introduction of the 1969 White Paper on Indian Policy which attempted to dismiss the unique status of Indigenous peoples in Canada generated calls for a different narrative. Notable responses included Harold Cardinal's *Unjust Society*, The Indian Association of Alberta's *Citizen Plus*, and George Manuel's *The Fourth World*.[60] By the 1990s, testimonies of high-profile leaders like Phil Fontaine about the abuses of residential schools facilitated new avenues of historical inquiry. So too did the findings of the

"Introduction," in *Western Medical Thought from Antiquity to the Middle Ages,* ed. Mirko D. Grmek (Cambridge: Harvard University Press, 1998), 17. Narratives of progress in both fields had important consequences for writing on Indigenous peoples. Physicians Robert McKechnie's *Strong Medicine: History of Healing on the Northwest Coast* and T.F. Rose's *From Shaman to Modern Medicine* reflect the trend of placing Indigenous peoples and their healing practices as a "pre-history." Both authors refrain from a complete dismissal of Indigenous healers but deny Indigenous healing practices any merit in the present. Tellingly, the last subheading in McKechnie's chapter which describes Indigenous healing practices uses the title "The Power Wanes." Similarly, in the preface to his monograph, Rose argues that "nearly all of the important aspects of local medicine have emerged within a lifetime." For McKechnie and Rose, the content of medicine's past, Indigenous or otherwise, offered few prescriptions for its future. Thus, more often than not Indigenous history was seen as neither Canadian nor health care history. Robert E. McKechnie, *Strong Medicine: History of Healing on the Northwest Coast* (Vancouver: J.J. Douglas, 1972); T.F. Rose, *From Shaman to Modern Medicine: A Century of Healing Arts in British Columbia* (Vancouver: Mitchell Press, 1972).

[59] Graham Fraser, ed., *The Fate of Canada: F.R. Scott's Journal of the Royal Commission on Bilingualism and Biculturalism, 1963-1971* (Montreal-Kingston: McGill-Queens Press, 2021): xiv, 157. Historian Robert Perin described the period of the 1960s in historical scholarship as one of "ethnic euphoria in which the experiences of ethnic groups that had once been sidelined in scholarship were now given greater consideration. Roberto Perin, "Clio as an Ethnic: The Third Force in Canadian Historiography" *The Canadian Historical Review* 64, no. 4 (December 1983): 442.

[60] Harold Cardinal, *Unjust Society* (Vancouver: Douglas & McIntyre, 1969); Indian Association of Alberta, *Citizen Plus,* (1970). https://caid.ca/RedPaper1970.pdf; George Manuel, *The Fourth World: An Indian Reality* (Don Mills: Collier-Macmillan, 1974).

Royal Commission on Aboriginal Peoples (RCAP), which stressed "Canada's image of itself and its image in the eyes of others will be enhanced by changes that properly acknowledge the indigenous North American foundations upon which this country has been built." Given the current state of settler-colonial narratives, the Commissioners continued, "Aboriginal people generally do not see themselves, their cultures, or their values reflected in Canada's public institutions."[61] These developments informed a new historiographical climate in which studies of racialization and colonialism attracted attention.

Early scholarship in the field embraced this call. The first response among historians was to ask critical questions about how scholarship had understood race, and specifically, to question how the racialized terminology of "the Indian" had been made.[62] Paige Raibmon's *Authentic Indians: Episodes of Encounter from the Late Nineteenth-Century Northwest Coast* explores how reified constructions of Indigenous peoples developed and examines their negative impacts. Centred on three episodes of encounter, Raibmon contributes to scholarly analysis of race through her examination of the qualities associated with an "authentic" racialized population. In particular, she elucidates how settler perceptions of the "authenticity" of Indigenous peoples rested on a series of binaries: Indian/White; traditional/modern; uncivilized/civilized.[63] Consequently, when organizers of the Chicago World Fair used Indigenous peoples in their displays, they presented a timeless vision of the exotic other— "authentic Indians"—for their viewers' excitement, not

[61] Canada. Royal Commission on Aboriginal Peoples, Looking Forward and Looking Back, Vol 1 (Ottawa: Canada Communication Group—Publishing): 7.
[62] According to historian James Walker, early historians most used the epithet "savage" to describe Indigenous peoples in Canada. Following closely behind were the descriptors 'treacherous, blood thirsty, dirty, fiendish, superstitious, and fickle. James W. St. G. Walker, "The Indian in Canadian Historical Writing," *Historical Papers* 6, no. 1 (1971): 21-51.
[63] Paige Raibmon, *Authentic Indians: Episodes of Encounter from the Late-Nineteenth-Century Northwest Coast* (Durham and London: Duke University Press, 2005), 7.

contemporary Indigenous existence. Raibmon's monograph is a useful critical analysis of the creation and persistence of these imposed identities.

The second significant shift of this period was to turn historical inquiry to the construction of Whiteness. As a racial identity, Whiteness long existed under the radar of scholarly attention. Thus, questions of what exactly Whiteness is and how was it made, remained unanswered. Notable in this category are Myra Rutherdale's book *Women and the White Man's God: Gender and Race in Canadian Mission Field*, Sarah Carter's *The Importance of Being Monogamous: Marriage and Nation-Building in Western Canada to 1915*, and Adele Perry's *On the Edge of Empire: Gender, Race, and the Making of British Columbia 1849-1871*. Collectively, these studies highlight that far from an accounting of immutable truths, the study of Whiteness—and race more broadly—should be a study of process and power. As Rutherdale convincingly demonstrates racial identities of White and Aboriginal were "constructed and reconstructed in Anglo-Canadian missionaries as relationships were forged and varying needs were met."[64] White people not only racialized the 'other' but also concurrently produced their own identity.[65]

In contrast, Carter and Perry focused less on the negotiations of racialized encounters than on the

[64] For example, women's close relations with each other in nursing and teaching environments challenged the exotic image of Indigenous women as wholly different from White Christian women. Myra Rutherdale, *Women and the White Man's God: Gender and Race in Canadian Mission Field* (Vancouver: University of British Columbia Press, 2002), xiv. See also, Kristin Burnett's *Taking Medicine: Women's Healing Work and Colonial Contact in Southern Alberta 1880-1930*. In particular, Burnett highlights how a focus of women's therapeutic work demonstrates circumstances of "cultural persistence, resistance, and change" among Indigenous women but also reveals how western women's healing work was implicated in western settlement and the "creation of colonial regimes." Kristin Burnett, *Taking Medicine: Women's Healing Work and Colonial Contact in Southern Alberta 1880-1930* (Vancouver: University of British Columbia Press, 2010).

[65] As she explains, "while missionary women were constructing images of Aboriginal culture, they were simultaneously reconceptualising themselves—perhaps for the first time in their particular standpoints in the mission field—as White, Christian, and superior." Rutherdale, *Women and the White Man's God*, 154.

imposition of Whiteness and anxieties around its success. Carter's central contribution is to elucidate how the discourse of marriage became a proxy for discussions of the development of the White Canadian nation.[66] In her work, she underscores the need to understand what those in positions of power constitute as normal and how those who deviate from that norm are discriminated against. Whereas earlier scholars of minorities described the discrimination these populations faced, Whiteness studies gave more attention to why and how that discrimination was produced in the first place. Likewise, Perry examines how beliefs about empire and imperialism impacted beliefs about Whiteness and worth. Through her review of diaries, manuscripts, records of the British colonial office and voluntary associations, she conveys the anxiety of British reformers who saw their settlement project deviate from the dream of a White, Christian, and respectable empire. That this project of a White settlement was "ultimately a pipe dream" in the period under study, was unimportant for Perry.[67] What is useful is the examination of how White reformers expressed and acted upon their anxiety when the racial lines they believed to be rigid were in practice transgressed. In so doing, she explored the meanings and making of Whiteness itself and the anxieties of those with access to it to maintain their power and privilege in Canadian society.

More recently, Timothy Stanley builds from this scholarship on Whiteness and normalcy in his study of the separate schooling initiative in British Columbia and the resistance of the Chinese Canadian community between 1922-1923. Investigating both 'normal' and 'other,' *Contesting White Supremacy* uses a multilayered approach to identity and offers the triad construction of

[66] Sarah Carter, *The Importance of Being Monogamous: Marriage and Nation-Building in Western Canada to 1915* (Edmonton: University of Alberta Press, 2008), 4.
[67] Adele Perry, *On the Edge of Empire: Gender, Race, and the Making of British Columbia, 1849-1871* (Toronto: University of Toronto Press, 2001), 4.

'Whiteness as norm,' 'Chinese as alien,' and 'Indian as invisible,' to signify how racialization is about power.[68] Its usefulness lies in part in its capacity to unite the long-separated fields of Indigenous and immigrant history; just as the construction of Whiteness facilitated discrimination against ethnic minorities who immigrated to Canada, so too have these same immigrant groups been at times complicit in the racialization of Indigenous peoples and their dispossession from their land. It is an argument that compels further investigation in future historiographies of race. It also highlights his argument that there is not racism but racism*s* (just as there are antiracisms). Thus, there is a rich scholarship that convincingly demonstrates the necessity of examining Whiteness in Canadian history. In doing so, the multiple consequences of and responses to this construction can become clearer.

During this period of historiographical re-examination, many health care historians were also ready to look to the past with new questions. Emerging scholarship made the case that the study of Indigenous racialization must form an essential part of Canadian health care historiography and in so doing began to bridge the subfields of Indigenous and medical history. An early path breaker in this field was Mary-Ellen Kelm whose monograph, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-1950*, is a thorough study of racialization's influence on settler constructions of medical knowledge. While focusing on British Columbia, Kelm's scholarship uses discourse analysis to shift historical inquiry from an earlier effort to record "the dying race" to an articulation of how and why settler communities found the portrayal of First Nations bodies as weak to be a useful colonial tool. It facilitated the settler notion of bodily superiority, to claim rightful use of land, and to limit expenditure on health care services for an already disadvantaged

[68] Timothy Stanley, *Contesting White Supremacy: School Segregation, Anti-Racism, and the Making of Chinese Canadians* (Vancouver: University of British Columbia Press, 2011), 48.

population. Kelm provides essential insight into the negative influence of colonial infrastructure, stereotypes, and objectives on the organization of First Nations health care.[69]

Health care historians also led the way in their examinations of Indigenous racialization to argue that this process became an early and powerful tool in the settler governments' compendium of Indigenous displacement. Maureen Lux, James Daschuk, Jane Whalen, and Ian Mosby all argue that Indigenous ill-health cannot be understood outside of this political, economic, and social context.[70] Lux demonstrates, for example, the importance of historians asking questions not previously included in traditional health care history. How, for example, did western settlement, the operation of residential schools, and the federal government's insincere treaty-making all contribute to the ill-health? How did the framing of Indigenous peoples as a "diseased menace" inform public health policy and ultimately serve colonial agendas? In *Clearing the Plains,* Daschuk engages with what he terms "the politics of starvation" to situate the ill-health of Indigenous peoples on the Plains within a wider socio-economic colonial context. As a result, he, like Lux, convincingly demonstrates how colonial governments exploited the weakened position of Indigenous communities to achieve settler objectives of land access.[71] Significantly, Daschuk's argument is not blind to the impact that newly introduced pathogens can have on a population; he

[69] See also Mary Ellen Kelm, "Diagnosing the Discursive Indian: Medicine, Gender, and the 'Dying Race," *Ethnohistory* 52, no. 2 (2005): 371-406.
[70] Maureen Lux, *Medicine that Walks: Disease, Medicine and Canadian Plains Native People 1880-1940* (Toronto: University of Toronto Press, 2001); James Daschuk, *Clearing the Plains: Disease, Politics of Starvation, and the Loss of Aboriginal Life* (Regina: University of Regina Press, 2013); Jane Elizabeth Whalen, "Wasting Away: The Impact of Policy and Policymakers on the Rise of Tuberculosis on Aboriginal Communities, 1867-1945" (PhD diss., Wilfrid Laurier University, 2013), 17.
[71] In no uncertain terms, Daschuk describes the actions of the colonial government at the end of the 19th century as "draconian" due to its withholding of rations to compel compliance with the imposition of the reserve system. See also John L. Tobias' "Canada's Subjugation of the Plains Cree, 1879-1885." Tobias offers a more significant focus on the agency of First Nations communities, namely the Ojibwa and the Saulteaux, to adapt to the changing conditions in the West. John L. Tobias, "Canada's Subjugation of the Plains Cree, 1879-1885," *Canadian Historical Review* 64, no. 4 (December 1983): 519-548.

uses a *longue durée* style of analysis to examine Indigenous peoples' experience of, and adaption to, disease epidemics prior to the enactment of settler-colonial policy. As a result, his discussion of the influence of colonial agendas on First Nations ill-health is all the clearer because the argument is not one of inept and passive Indigenous peoples but, rather, of the consequences of a newly coercive colonial power.[72]

In a move away from the prairies, Whalen makes similar accusations of settler indifference to Indigenous suffering. Investigating the impact of race-based settler colonial policies with a focus on federal decision-making around tuberculosis, she argues that the government's "overwhelming commitment to assimilation" was prioritized over evidence that certain assimilationist practices were in fact facilitating the spread of TB. As result, Whalen argues, dedicated political will to colonial objectives permitted First Nations communities to "waste away."[73] While this type of scholarship is less attentive to how Indigenous communities have adapted to these various assaults on their health, policy-focused histories of health care policy created for and directed at First Nations communities, Whalen demonstrates, have merit for their close examination of the worldviews, priorities, and action plans of settler-colonial actors.[74] Indeed, Ian Mosby's

[72] In addition, Kelm nuances earlier historiography that frames First Nations' acceptance of Western medical attention as an acknowledgement of a superior system of healing. Instead, Kelm argues communities actively chose to access a variety of medical systems (both Western and Indigenous) to maximize well-being. Kelm describes numerous examples of instances when Indigenous peoples turned to western medicine as a temporary measure. For example, Sto: lo Elder Nancy Phillip "gave birth to her last child in hospital because the child came while she was away in Washington picking hops. All but one of her other deliveries had been at home with the help of community midwives." Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-1950* (Vancouver: University of British Columbia Press, 1998), 156.

[73] For a history of the federal government's nutrition experiments on malnourished children in Indian Residential Schools, see Ian Mosby, "Administering Colonial Science: Nutrition Research and Biomedical Experimentation in Aboriginal Communities and Residential Schools, 1942-1952," *Histoire Sociale* 46, no. 91 (May 2013): 145-172.

[74] For a similar examination in the field of welfare historiography see Hugh Shewell's '*Enough to Keep Them Alive:' Indian Welfare in Canada, 1873-1965* (2004). Shewell examined the ideological development and concrete practice of Indigenous welfare policy across Canada. In particular, he demonstrates how "welfare-relief, social assistance—has been used by the state as a weapon to undermine First Nations cultures and to induce their assimilation and hence disappearance into dominant Canadian economic and social order." Shewell elucidated the darker side of social welfare as well as the ideologies that facilitated coercive action. Hugh Shewell, '*Enough to Keep Them Alive:' Indian Welfare in Canada, 1873-1965* (Toronto: University of Toronto Press, 2004).

scholarship reveals how critical research in the field of settler service provision can profoundly alter how we understand colonial actions that operated "under the guise of benevolent administration and even charity."[75] In his article, "Administering Colonial Science," Mosby both brings to light an unexamined episode and argues that settler "research" should be more accurately recorded as exploitative experimentation in a system of systemic violence. While further research is needed to complement such studies, top-down national overviews reveal how federal health care policy was employed in the service of broader colonial objectives and add to our collective understandings of how federal government decision-making has negatively impacted Indigenous health. Indeed, such scholarship convinced me of the need to examine the intellectual constructs and conceptual frameworks of settler actors in my own period of study.

New Scopes and On-going Revision

The temporal span of these and similar studies, however, overwhelmingly focuses on the first half of the twentieth century, a concentration which has left important questions understudied about the degree of continuity and change from the ideas and practices around Indigenous health policy from the first half of the 20th century into the decades that followed. In a logical extension from her earlier work, Lux's second monograph on colonial health examines the federal government's system of "Indian Hospitals" from 1920-1980. By addressing the operation of the Department of National Health and Welfare's Indian hospitals in the second half of the 20th century, including the rationales for their eventual closures, Lux carefully elucidates both the changes and, importantly, the continuities of colonial practice. While Medicare today arguably constitutes a sacred idol of Canada's national ethos, *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s*

[75] Mosby, 171.

reveals that this often-glorified story of Canada's universal hospital and medical care insurance programs requires the erasure of Indigenous peoples' experience from the narrative. When the focus shifts to Indigenous patients, the narrative that develops is not one of universal access but, rather, of segregation, underfunding, and steadfast denial of treaty rights. A fact underscored in Ian Mosby and Catherine Carstairs' work on the "rushed, inadequate, inconsistent, and sometimes cruel" nature of Ottawa's oral health care provision to Indigenous peoples.[76] Such revisionist scholarship challenges the notion of a benevolent Canadian state and calls for further interpretation of its settler colonial past. Using theories of citizenship and liberalism, Lux demonstrates that First Nations citizenship in the settler-state was incomplete and controlled. Significantly, Lux also addresses the crucial subject of First Nations' activism around the issue of hospital access for First Nations peoples. Lux describes a health care system in which First Nations peoples were "vulnerable but never completely victimized."[77] In particular, the efforts of the Siksika Nation in southern Alberta to maintain federally supported health care institutions as a benefit of treaty negotiations and not an act of settler benevolence forms a key contribution to the historiography of First Nations health care access. Despite the exclusion of First Nations peoples from the ground-floor of Medicare developments, they continued to advocate for a seat at the table.

A recent extension to this line of inquiry is Mary Jane Logan McCallum and Maureen Lux's "Medicare versus Medicine Chest." The article draws focused attention to First Nations' repeated calls for the federal government to honour a treaty right to health care in Canada.[78] Specifically, McCallum and Lux confront the federal government's long-standing view that health care services

[76] Catherine Carstairs and Ian Mosby, "Colonial Extractions: Oral Health Care and Indigenous Peoples in Canada, 1945-79," *The Canadian Historical Review* 10, no. 2 (June 2020): 192.
[77] Lux, *Separate Beds,* 102.
[78] McCallum and Lux, "Medicare versus Medicine Chest, 103-130.

could only be offered to First Nations peoples as an expression of charity and not of treaty obligations. Furthermore, they challenge Ottawa's belief that such services could only be permanently offered on terms equal to those extended to Canadians.

My research aims to expand on this work with the use of Critical Race Theory to more fully examine how the racialization of First Nations peoples impacted both discourses and structures that surrounded First Nations' access to systems of settler health care. In addition, my study focuses more intently on an examination of why the federal government so aggressively sought to offer First Nations' health care access only on terms equal with Canadians.[79] Drawing on political scientist Heidi Kiiwetinepinesiik Stark's assertion that settler colonialism attempts to reduce First Nations' claims to sovereignty while "actively producing both the settler state and its accompanying legitimizing narratives," my research argues that it is essential to thoroughly examine the discursive nature of renewed attention to First Nations peoples in post-1945 Canadian society.[80] How were First Nations' and federal government's responsibility conceived on individual or broader levels? How did conceptions change in new political environments and what happened? Did the federal government's integration policy reflect a changed relationship between First Nations communities and Ottawa? How did stakeholders negotiate the jurisdictional complexities of provincial mandates for health and federal mandates for First Nations communities during a time when federal-provincial cost sharing programs were on the rise? In addition, given that this equality implied that First Nations were to access health care services through provincial

[79] See also, Heidi Bohaker and Franca Iacovetta, "Making Aboriginal People 'Immigrants Too': A Comparison of Citizenship Programs for Newcomers and Indigenous Peoples in Postwar Canada, 1940s-1960s," *The Canadian Historical Review* 90, no. 3 (September 2009): 427-461.
[80] Heidi Kilwetinepinesiik Stark, "Criminal Empire: The Making of the Savage in a Lawless Land," *Theory & Event* 19, no. 4 (2016): muse.jhu.edu/article/633282.

departments, the jurisdictional debates between Ottawa and the provinces constitute a rich field for historical inquiry. Significantly, limited historical attention has been devoted to this area of research in the context of post-war Ontario. This study addresses that need.

In addition to the works outlined above, various scholars have also contributed analysis of intersecting concepts and systems worthy of attention by health care historians. In her monograph, *Indigenous Women, Work, and History 1940-1980,* Mary Jane Logan McCallum challenges a historiography that presents modern Indigenous history as a narrative "solely [of] decline, loss, and colonialism."[81] As McCallum deftly reveals, First Nations individuals were never free from the imperialism of the Canadian state which sought to transform them into wage-earning Canadian citizens. Nevertheless, individuals in various labour fields repeatedly navigated many of the challenges the settler state imposed, while simultaneously maintaining and developing ways to express their indigeneity in the modern world. Awareness of the simultaneous rejection of settler-colonialism and its reification of "authentic" indigeneity to past practices in Canada is essential to understand the complex relationship between Canada and First Nations communities in the post-war period.[82] In addition, historians have begun to examine the ways settler-colonialism and capitalism have been aligned to support settler interests and power. Both John Lutz's *Makúk: A*

[81] Mary Jane Logan McCallum, *Indigenous Women, Work, and History, 1940-1980* (Winnipeg, University of Manitoba Press, 2014), 9.

[82] See also, Laurie Mejer Drees, "Training Aboriginal Nurses: The Indian Health Services in Northwestern Canada, 1939-85" in *Caregiving on the Periphery* ed. Myra Rutherdale (Kingston and Montreal: Queen's-McGill Press, 2010). Drees gives a descriptive account of the training and work experience of Indigenous nurses in the IHS system from 1939 to 1970 and argues that while the IHS implemented a variety of training initiatives to hire Indigenous labour, the intent was not to create a class of professional workers. Instead, the focus of programs was to inculcate the values of western biomedicine and limit challenges to White medical authority. Drees' descriptive account reveals that when Indigenous people provided labour for the IHS, they were likely restricted to the lower levels of the health care hierarchy. See also, Laurie Mejer Drees, *Healing Histories: Stories from Canada's Indian Hospitals* (Edmonton: University of Alberta Press, 2013) and Drees, "Indian Hospitals and Aboriginal Nurses: Canada and Alaska," *Canadian Bulletin of Medical History* 27, no. 1 (2010): 139-161.

New History of Aboriginal-White Relations and Sean Carleton's *Lessons in Legitimacy: Colonialism, Capitalism, and the Rise of State Schooling in British Columbia,* are key examples. Whereas Lutz examines the expansion of capitalism in British Columbia and First Nations' on-going negotiation and adaption of an alternative economic order, Carleton considers the history of various kinds of primary and secondary schooling in British Columbia to understand how this schooling sought to "catalyze and legitimize the making of British Columbia as a capitalist settler society."[83] Specifically, Carleton demonstrates how settler anxieties about the legitimacy of their presence on the land produced policies and programs of education that strove to frame an individual's relationship to land as extractive and economically productive—a process which Leanne Betasamosake Simpson describes as "a death dance for Indigenous peoples."[84] My study builds on these works to examine how these same anxieties produced narratives and policies within the health care field. Specifically, I consider how land dispossession and capitalist engagement were fundamental benchmarks demanded of First Nations peoples to access permanent and quality health care.[85]

Of crucial importance to the intersections of health and colonialism in Canada is the study of the impact of settler resource extraction. Scholars such as Brittany Luby in *Dammed: The Politics of*

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[83] Sean Carleton, *Lessons in Legitimacy: Colonialism, Capitalism, and the Rise of State Schooling in British Columbia* (Vancouver: University of British Columbia Press, 2022), 5*;* See also, Sarah Rotz, "'They took our beads, it was a fair trade, get over it': Settler colonial logics, racial hierarchies and material dominance in Canadian agriculture," *GeoForum* 82 (June 2017):158-169; Sarah Carter, *Imperial Plots, Women, Land, and the Spadework of British Colonialism on the Canadian Prairies* (Winnipeg: University of Manitoba Press, 2016).

[84] Simpson, *As We Have Always* Done, 101. Simpson centres their critique on the coercive dispossession of First Nations peoples from their land with specific attention to how settler colonialism strives to break "the intimate connection of Nishnaabeg bodies (and minds and spirits) to each other and to the practices and associated knowledges that connect us to land, because this is the base of our power. This means land and bodies are commodified as capital under settler colonialism and are naturalized as objectives for exploitation." Simpson, *As We Have Always Done,* 41.

[85] Carleton, *Lessons in Legitimacy,* 5. See also Tyler A. Shipley, *Canada in the World: Settler Capitalism and the Colonial Imagination* (Halifax: Fernwood Publishing, 2020).

Loss and Survival in Anishinaabe Territory and Lianne Leddy in *Serpent River Resurgence: Confronting Uranium Mining at Elliot Lake,* demonstrate that settler-led resource extraction projects in the 1950s produced significant economic benefits for settler communities and created space for First Nations individuals to engage in steady wage work.[86] Crucially, however, such projects also poisoned lands, bodies, and impaired the expression of Anishnaabek epistemologies. Both Luby and Leddy reveal how affected communities worked tirelessly to adapt to the damages that such projects wrought and continually strove to maintain healthy relationships with the land and settler communities. Unfortunately, as both scholars demonstrate, such efforts were often met with limited federal or provincial interest. In so doing, these scholars complicate the narrative of Canada's post-war economic prosperity. Settler governments used their policy of integration to invite First Nations communities to share in the prosperity that settler economic systems claimed to offer. Experience instead taught communities that settler governments were willing to sacrifice their well-being in favour of short-term economic imperatives. Luby and Leddy thus offer two essential reminders—settler economic imperatives remained a higher priority to settler governments in the post-war period than the well-being of First Nations communities and that many communities never relinquished their desire to work with their own people and with settler governments for a healthier future. This context cannot be forgotten in any study of settler colonialism and First Nations health care access.

Chapter Outline

[86] Brittany Luby, *Dammed: The Politics of Loss and Survival in Anishinaabe Territory* (Winnipeg: University of Manitoba Press, 2020); Lianne Leddy, *Serpent River Resurgence: Confronting Uranium Mining at Elliot Lake* (Toronto: University of Toronto Press, 2022).

The first three chapters of this dissertation explore the political, bureaucratic, and jurisdictional responses to integration policy. Chapter one, "An Invitation to Citizenship," offers a discussion of the political discourses in Ottawa during the early days of the post-war period. Specifically, it examines the rationales for the creation of a policy of integration—the organizing principle for the period— and evaluates how racialized notions of Indianness and Whiteness were employed to justify Ottawa's efforts. This chapter also seeks to explain how the invitation to First Nations individuals to end their segregation and to join Canadians as equal citizens, was far from a break with past settler-colonial priorities. Instead, as this chapter argues, integration constituted another program of Indigenous erasure.

Chapter two then moves on to an examination of the impact of integration policy in the field of federal health care provision. Under a policy of integration, the IHS maintained that the provision of health care services to status-Indians was only an expression of charity not of treaty or Indigenous right. Thus, this chapter clarifies how in its first ten years, the IHS continued to assert the objectives of settler-colonialism. In addition, this chapter reveals how, under the leadership of Dr. Percy Moore, the IHS negotiated a strange position in which integration required it to expand its services to help underserviced communities while at the same time plan for the eventual withdrawal of its services. In the end, the casualty of this negotiation was high-quality health care.

Chapter three closes this study's analysis of the first ten years of integration with a focused analysis of Ontario's engagement with integration policy. Ottawa may have been confident that First Nations individuals should have a place in the provinces as provincial citizens, but Ontario was hardly as assured. The spirit of universalism and social rights that had spread across the post-war

world had certainly come to Ontario, but other priorities and concerns remained. Like their federal counterparts, politicians in Ontario were very willing to employ racialization and the rationales of settler-colonialism to claim White superiority and to entrench the power of settler-colonial structures. They did so at the expense of First Nations well-being and relationship reconciliation.

Chapter four initiates a new period of analysis, 1956 to 1969, when Ottawa began to intensify its integration efforts. This chapter examines the continued tensions of integration policy in the face of on-going First Nations' challenges to the imposition of settler perspectives and increased resistance to federal expenditure on services for First Nations individuals over and above the cost of "regular" citizens. As this chapter demonstrates, settler politicians and bureaucrats handled these tensions with solutions that stymied First Nations' access to high quality health care.

Finally, Chapter five offers a focused examination of the ways in which Ottawa attempted to devolve its assumed responsibility for First Nations health care provision to First Nations individuals and communities as well as the provinces. Here, Ontario is again used as a case study of the on-going jurisdictional debates that have long plagued debates about the terms of First Nations health care access and the means of its delivery. While this chapter shows some willingness to collaborate, Ottawa's denial of treaty rights and First Nations partnership, and Ontario's reliance on systemic racialized difference resulted in a period when few were satisfied with the outcomes.

Chapter 1

An Invitation to Citizenship

> The time has come when we should clothe them with the dignity of citizenship and assimilate them into Canadian life.
> MP David Arnold Croll, 1948[1]

> Defining the problem that policy is to solve is the first and the most crucial step in policy making.
> Sally Weaver, *Making Indian Policy*[2]

On May 7, 1945, the front page of Toronto's *Evening Standard* proclaimed, "it's all over!"[3] The Second World War had come to an end. After six years of fighting, tens of thousands of people killed or wounded, and the mass mobilization of the home front, Canadians anxiously awaited peacetime. Even before the end of the war, Prime Minister William Lyon Mackenzie King had begun to consider post-war plans for Canada. Instead of a return to the peacetime status quo, however, King would lead a reorientation of government priorities. The social unrest and economic depression that had followed the First World War had laid bare the fragilities of government post-war priorities that valued material development over the social security of its peoples. King's government was anxious not to allow similar challenges to follow this most recent world war. In addition, the war against the Nazi Regime had prompted reflections on discrimination and forced embarrassing contradictions in Canada to be considered, if not challenged. While Canadian

[1] David Arnold Croll. Canada. Parliament. House of Commons. Edited Hansard. 20th Parliament, 4th Session (June 15, 1948) Retrieved from LiPaD: The Linked Parliamentary Data Project website. https://www.lipad.ca/full/permalink/1535121/

[2] Sally Weaver, *Making Canadian Indian Policy: The Hidden Agenda 1968-1970* (Toronto: University of Toronto Press, 1981), 11.

[3] C. Cadeau, "The End of World War II in Canada," All About Canadian History. March 21, 2021. https://cdnhistorybits.wordpress.com/2015/11/11/ve-day-vj-day-canada/

soldiers fought overseas against Nazi oppression, its own government had interned racialized minorities as "enemy aliens." Thus, when King and his cabinet were faced with the familiar problems of potential post-war instability and racial discrimination, politicians expressed an openness to consider new ways to solve old problems.

As this chapter will explore, the federal government in Ottawa decided to align themselves with the view that states had a responsibility to raise the standard of living of its citizens to a basic social minimum without discrimination based on race. Such a decision, however, was far from a simple extension of government aid. Indeed, this choice raises many questions. Would new approaches to social suffering impact settler attitudes that had long framed First Nations peoples as the "Indian problem" and the "inferior other?"[4] Would political will to improve human wellbeing challenge government paternalism and First Nations legal wardship? How would citizenship discourse inform how federal politicians understood their relationship with and responsibilities to First Nations communities? Why and how did federal policy makers maintain the belief that they had the authority to determine "the best interests" of First Nations peoples in Canada?

Using the frameworks of Critical Race Theory and Post-colonial theory to examine the language of post-war Canadian politics, it becomes clear that politicians and bureaucrats alike believed in a hierarchy of value and care in which the White settler citizen was at the top. The remedy to the

[4] The "Indian problem" was a concept that framed First Nations peoples in Canada as a racialized complication to the settler Canadian state. In particular, First Nations peoples were thought to be problematic because their existence challenged the myth that Turtle Island had been *terra nullius* when European settlers arrived. In order to frame Canada's occupation of the land as legitimate, First Nations' sovereign distinctiveness had to be removed. Moreover, the "Indian problem" concept was flexible to the needs of settlers. When politicians and government officials acknowledged the earlier presence of First Nations peoples on this land, their distinctiveness was as a primitive people. The government thus treated the "Indian problem" as the management of wards under the power of the Canadian state.

failures of a past policy of First Nations wardship was therefore not to anticipate First Nations disappearance in a policy of assimilation but instead to offer an invitation into a "superior" White Canadian citizenship through a new policy of integration. As citizens, politicians hoped, First Nations distinctiveness (read as opportunity for discrimination) would be removed. Moreover, First Nations segregation from provincial services would end and their overall wellbeing was expected to improve. Such plans, however, beg questions. Why did the settler state seek to offer First Nations people citizenship rather than acknowledge their distinct nationhood and adapt systems to end discrimination based on systemic colonial racism? Why, if First Nations peoples wanted access to growing social services, were they expected to embrace Canadian citizenship?

The overall aim of this chapter is to scrutinize the values and priorities that informed Ottawa's early post-war approach to First Nations policy in Canada and to reveal the obstacles to the fundamental reframing of the relationship between settler society and First Nations peoples. First, it explores the new discourses of post-war Canadian citizenship to understand why integration policy became Ottawa's chosen path. Second, it offers a critical assessment of how integration policy remained, in many ways, an outgrowth of Canada's earlier policy of assimilation. Finally, it reflects on the partnerships, narratives, and responsibilities Ottawa was, and was not, willing to respect or develop.

Establishing Post-War Social Citizenship and the End of Racial Segregation

Less than two years after the outbreak of the Second World War, politicians began to imagine the possibilities of the post-war world. Ever mindful of fiscal restraints, leaders of Allied countries

proposed a new set of national and international priorities. In January of 1941, Franklin Roosevelt delivered his State of the Union address, known now as the Four Freedoms Speech, in which he argued that everyone in the world should enjoy freedom of speech, freedom of worship, freedom from want and freedom from fear. Later that year, Roosevelt and Winston Churchill issued the Atlantic Charter that included a call for global co-operation to secure better economic and social conditions for all.[5] The following year, Sir William Beveridge, a social economist working for the British government, published his landmark report *Social Insurance and Allied Services*. Known as the Beveridge Report, it became a signal to the wider world that Britain's administration had taken up the mantle of change. Championing the establishment of a 'cradle to grave' social welfare system, the Beveridge Report included calls to implement a free national health service and generated much support from the British people for its advocacy of national standards of living for all citizens. Significantly, the Beveridge report both reflected and reinforced the rising international commitment to a "spirit of universalism" that not only catalyzed the development of welfare states but also entrenched beliefs that equal access to wellbeing was a right of citizenship.[6] Amidst such a zeitgeist, how would Canada respond?

[5] By 1942, twenty-six Allied nations had pledged their support for the charter.

[6] Reflecting decades later, Marsh remembered the early 1940s as a time when "social security had become not only an avowed national aim, but an international idea." Leonard Marsh, *Report on Social Security in Canada* (Toronto: University of Toronto Press, 1975), xvii. Historian Dorothy Porter described the "spirit of universalism" that had spread in both the United Kingdom and France. Furthermore, Porter argued that the subsequent rise of the welfare state "legitimated a citizenship of rights and entitlement which had been first articulated in the political philosophies of the Enlightenment." Dorothy Porter, *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times* (London: Routledge, 1999), 212. Similarly, the Royal Commission on Aboriginal Peoples noted how, "the end of the second World War and the creation of the United Nations unleased a national mood of egalitarianism and a growing interest in individual human rights." Royal Commission on Aboriginal Peoples, Public Policy and Aboriginal Peoples Vol 1: Looking Forward, Looking Back, (Ottawa: Minister of Public Works and Government Services, 1996): 283.

In September 1941, Ottawa established the Advisory Committee on Reconstruction and appointed the President of McGill University, Dr. Cyril James, to serve as its chair. James commissioned Leonard Marsh, a noted social scientist who had studied with Beveridge in London, to assess the current health of social welfare programs in Canada.[7] Presented to the House of Commons Special Committee on Social Security in January 1943, Marsh's *Report on Social Security for Canada* became, according to historian Michael Bliss, "the most important single document in the history of the development of the welfare state in Canada."[8] Remembering the social and economic insecurity of the 1930s, the Marsh report called for the organized provision for "the risks and contingencies of family life that are beyond the capacity of most [people] to finance adequately from their own resources."[9] Like the Beveridge Report, Marsh's plan called for the establishment of a "social minimum" to which all Canadians could expect to be raised.[10]

Alongside the Marsh Report, physician John J. Heagerty, Director of Public Health Services in the Department of Pensions and Health, led a charge to revitalize the Liberal party's discussion of national health insurance, a topic on the party's platform since the end of the First World War.[11] In 1942, Minister of Pensions and Health Ian Mackenzie had appointed Heagerty to chair an interdepartmental advisory committee to assess the feasibility of national health insurance in

[7] Beveridge had played a role in framing Marsh's early understanding of economics. As a student at the London School of Economics, Marsh participated in research under the supervision of Beveridge and Sir Llewelyn Smith. Michael Bliss, "Preface" in *Report on Social Security for Canada* by Leonard Marsh (Toronto: University of Toronto Press, 1975), ix.
[8] Michael Bliss, "Preface" in *Report on Social Security for Canada* by Leonard Marsh (Toronto: University of Toronto Press, 1975), ix.
[9] Leonard Marsh, *Report on Social Security in Canada* (Toronto: University of Toronto Press, 1975), 7.
[10] Marsh suggested that the exact definition of this social minimum had yet to be articulated, or at least agreed upon. He did, however, clearly outline categories of social need: unemployment, sickness and medical care, disability, old age and retirement, premature death, and family needs. Leonard Marsh, *Report on Social Security in Canada,* 21-22; 30.
[11] Heather MacDougall, "Into Thin Air: Making National Health Policy, 1939-45," *Canadian Bulletin of Medical History* 26, no. 2 (2009): 283-313.

Canada. A long-time advocate for health insurance, Heagerty's 558-page final report unsurprisingly articulated a ringing endorsement of a comprehensive national plan.

Both Mackenzie and Heagerty had reason to hope that their call for national health insurance would succeed. Such a belief was born, in part, due to the growing political pressure from the Cooperative Commonwealth Federation (CCF). CCF Member of Parliament A.M. Nicholson (Mackenzie, SK), for example, argued to his colleagues in the House of Commons in 1944 that "the people of this country expect and deserve that legislation be placed on the statute books…to remove the inequalities in the medical services in different parts of Canada."[12] Facing a rise in political and popular pressure, the Heagerty and Marsh reports reveal that a notable group of Canadian politicians and officials had embraced Beveridge's call that the post-war period presented an opportunity for change that ought to be seized. As Beveridge explained, "a revolutionary moment in the world's history is a time for revolutions, not for patching."[13] Together, Heagerty and Mackenzie championed provincially administered contributory health plans with national co-ordination of standards and accompanying federal grants.

While enthusiasm for the idea of national health insurance had grown, historian Heather MacDougall has demonstrated that plans for health insurance, and social policy more broadly, faced fierce competition from the skeptics in Finance who placed their trust in Keynesian

[12] Alexander Malcom Nicholson, Canada. Parliament. House of Commons. Edited Hansard. 19th Parliament, 5th Session (February 23, 1944). Retrieved from LiPaD: The Linked Parliamentary Data Project website. https://www.lipad.ca/full/permalink/1331496/

[13] Sir William Beveridge on the presentation of his report, *Social Insurance and Allied Services, to the British parliament on the 24 November 1942.* Chris Day, "The Beveridge Report and the Foundations of the Welfare State," The British National Archives, December 2017, Accessed March 24th, 2021. https://blog.nationalarchives.gov.uk/beveridge-report-foundations-welfare-state/

economics and full-employment schemes for post-war recovery.[14] Thus, known for his conciliatory approach, by 1944 Mackenzie King had channeled these competing visions into a three-pronged departmental approach to guide Canada's post-war planning. First, on the 23rd of February, King moved the second reading of Bill 149 to establish a Department of National Health and Welfare. Second, King sought approval for the establishment of a Department of Veterans' Affairs under the leadership of Ian Mackenzie "to have charge of the rehabilitation and reestablishment of members of the armed forces, and the administration of veterans' pensions and allowances." Finally, King directed the creation of a Department of Reconstruction under C.D. Howe "to promote and coordinate planning for national development and post-war employment."[15] Addressing the House of Commons in February of 1944, King argued, "human personality, its recognition and development are of more importance than the protection of property, privilege or position and the increase of human well-being infinitely more important than the increase of material wealth."[16] In support of the international welfare zeitgeist, King moved forward with the creation of family allowances, a program he described as "one of the most important measures ever placed before any parliament in any country."[17] Next, one month after the federal election of 1945, King's government released a Green Book containing a series of federal proposals for the expansion of the welfare state in Canada to be discussed at the Dominion-Provincial conference scheduled for August of that year.

[14] MacDougall, "Into Thin Air," 299.
[15] William Lyon Mackenzie King, House of Commons. Edited Hansard. 19th Parliament, 5th Session. (February 23, 1944). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/1944/02/23/1/
[16] William Lyon Mackenzie King, House of Commons. Edited Hansard (February 23, 1944). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1331441/
[17] William Lyon Mackenzie King, House of Commons. Edited Hansard. 19th Parliament, 5th Session (February 23, 1944). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1355311/

A revolutionary commitment to welfare, however, was not to be realised. Despite what political scientist Malcolm Taylor described as "the mood of rebellion against the universal risks of unemployment and sickness, disability and old age, widowhood and poverty," the outcome of the Dominion-Provincial conference cast dark shadows over hopes of creating an expansive welfare state in contemporary Canada.[18] Nevertheless, King's implementation of Family Allowances demonstrates that welfare programs, to some degree, were seen as a viable activity by government to raise the standard of living for those Canadians economically and socially disadvantaged. Thus, as the federal government negotiated a new level of involvement in social welfare policy, Canadians participated in a changing articulation of the citizen-state relationship.[19] Specifically, the post-war citizenship contract would no longer ignore the social rights of its citizens. Social citizenship, historian Derek Heater explains, was "the belief that since all citizens are assumed to be fundamentally equal in status and dignity, none should be so depressed in economic or social conditions as to mock this assumption." In return for citizens' engagement in democratic processes and loyalty, it fell on a citizen's state to "smooth out any gross inequalities by the guarantee of a basic standard of living."[20] Equality, universalism, and human betterment became the ideals of this new contract.

The spirit of change kindled in the closing phases of the Second World War also sparked critical reflection on the treatment of diverse populations within Canada's borders. If equality and

[18] Malcolm Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System and Their Outcomes* (Montreal and Kingston: MQUP, 1987), 2.
[19] In 1946, the Canadian Citizenship Act was passed. Previously, those born in Canada were considered Canadian nationals and British subjects. For a discussion of early efforts to foster loyalty to a new Canadian citizenship among recent immigrants see Leslie A. Pal, "Identity, citizenship and mobilization: The Nationalities Branch and World War Two," *Canadian Public Administration* 32, no. 5 (Fall 1989): 407-426.
[20] Derek Heater, *Citizenship: The Civic Ideal in World History, Politics and Education 3rd Ed.* (Manchester: Manchester University Press, 2004), 272.

universalism were set to infuse citizenship discourse, then the reality of racial discrimination in Canadian society had to be addressed. In 1944, the Ontario government, under the leadership of Premier George Drew, passed the *Racial Discrimination Act*, the first of its kind in Canada. In the following year's federal election, Conservative candidate for Toronto-Spadina, Major George Hees, called on his fellow Canadians to model their behaviour on the openness of Canadian soldiers; "learn to judge each other as the fighting men did overseas," Hees campaigned, "without regard to how they worshiped or where their fathers and mothers came from."[21] Although the effectiveness of such efforts was limited, their actualization signaled a changed political context, one in which official overt racial discrimination was no longer sanctioned.[22]

Not to be left out of the scope of Canadian reform, First Nations peoples became a focal point of the racial discrimination debate. As historian J.R. Miller argued, in the aftermath of a world war fought "against institutional racism and barbarity…it was impossible not to notice that the bases of Canadian Indian policy lay in assumptions about the moral and economic inferiority of particular racial groups."[23] Certainly, the signs of Canada's neglect of First Nations' well-being were plainly evident by many metrics. According to historian Jane Whalen, during the years of the Second World War, the allocation for the Indian Affairs Branch declined to a mere 0.1% of the federal budget.[24] It is hardly surprising then to discover that in the penultimate year of the war, the death rate among Indigenous peoples from tuberculosis was twelve times higher than the rest of

[21] "Candidate Hits Racial, Religious Discrimination." *Globe and Mail*, June 7, 1945, 5. ProQuest Historical Newspapers.
[22] It is worthwhile to note that a 1948 study published in Maclean's Magazine found that 51 per cent of the 500 students surveyed showed "negative attitudes toward various religious and color [sic] groups." Eva-Lis Wuorio, "Are Canadians Intolerant?" *Maclean's Magazine* March 15, 1948. P 12 [12; 53-55]
[23] J.R. Miller, *Skyscrapers Hide the Heavens: A History of Indian-White Relations in Canada 3rd Ed.* (Toronto: University of Toronto Press, 2000), 324.
[24] Jane Elizabeth Whalen, "Wasting Away: The Impact of Policy and Policymakers on the Rise of Tuberculosis in Aboriginal Communities, 1867-1945" (PhD diss., Wilfrid Laurier University, 2013): 260.

the Canadian population.[25] In 1944, MPP C.H. Taylor (CCF, Temiskaming) of the Ontario legislature described Canada's treatment of First Nations peoples as "disgraceful" and went on to paint a bleak picture of communities suffering from tuberculosis, receiving unsatisfactory education, and experiencing infringement on their hunting rights. Taylor then urged that the provinces exert pressure on the federal government to improve the situation of First Nations peoples in Canada.[26]

Experiences in the Second World War also strengthened First Nations' own criticism of government policy. In December of 1945, members of the North American Indian Brotherhood invited Indian Affairs officials to attend a meeting at which they presented a twenty-point political agenda to address their concerns about Indian administration.[27] Further, veteran Roderick Reginald Hill of the Six Nations of the Grand River denounced government duplicity in accepting First Nations services in the war effort only to reinforce racial restrictions that limited access to social services once they returned.[28] As historians R. Scott Sheffield and Noah Riseman demonstrated, First Nations war veterans, although promised equal access to veterans services, often faced multiple barriers.[29] In addition, war-time sacrifices from First Nations communities, deepened First Nations' frustration at the dismissal of their treaty rights. William F. Powless of Ohsweken

[25] Whalen, "Wasting Away," 260.
[26] Mr. C.H. Taylor, Ontario, Legislative Assembly, *Hansard,* 26 March 1946, Vol 3: 1326. https://archive.org/details/v3hansard1946ontauoft/page/192/mode/2up
[27] John F. Leslie, "Assimilation, Integration or Termination: The Development of Canadian Indian Policy, 1943-1963" (PhD Diss., Carleton University, 1999), 104.
[28] Karl Carisse, "Becoming Canadian: Federal-Provincial Indian Policy and the Integration of Natives, 1946-1969: The Case of Ontario" (MA Thesis, University of Ottawa, 2000), 34. The Annual Report of the Indian Affairs Branch records that more than 2,600 First Nations volunteers were accepted to join Canada's military effort. Canada. Department of Mines and Resources. Indian Affairs Branch, Annual Report, Fiscal Year Ended 15 March 1945, 160.
[29] R. Scott Sheffield and Noah Riseman explained, for example, that the Veterans Land Act required a veteran to have title to the land upon which they lived in order to qualify for financial credit. First Nations veterans who lived on reserves were thus disqualified as title for their land was understood to rest with the Crown. R. Scott Sheffield and Noah Riseman, *Indigenous Peoples and the Second World War: The Politics, Experiences and Legacies of War in the US, Canada, Australia and New Zealand* (Cambridge: Cambridge University Press, 2018), 260-262.

represented the frustration of many First Nations peoples in a *Globe and Mail* article in 1944. "I wish to point out that there is a growing resentment among the people of the Six Nations," Powless wrote, "toward the Department of Indian Affairs in its deliberate attempt to antagonize us by curtailment of our rights and privileges operating under the cloak of the *Indian Act*." He then stressed that "such a state of affairs as [Indian Affairs] has deliberately created will not be a credit to it nor the Government it serves."[30] In light of anti-discrimination sentiment, First Nation peoples' charges of inequality would have certainly raised concerns in Ottawa's policy circles. A call to honour on-going treaty rights, however, fell largely on deaf ears.

At the federal level, members of opposition parties also advocated for substantial change. Dorise Winifred Nielsen (North Battleford), a member of the Unity Party, pronounced the conditions of First Nations peoples living in Northern Saskatchewan to be "one of the most appalling things" and described how many lived in "the most degrading conditions." In reaction, Nielsen offered a passionate plea to embrace the progressive spirit of the times. She observed,

> today many people are very much concerned not only with the immediate winning of the war but with the implementing of the Atlantic Charter in the years to come…perhaps Canadians, even before they begin thinking about Europe or any other part of the world, should begin to realize that it is necessary for them to do a little housecleaning so far as the Indian question in Canada is concerned. We are hoping at some time in the future to have the implementation of the Marsh report—at least, we are hoping to have some kind of new order in Canada, under which there shall be at least a basis for security for the people of our country. I submit that there is no time like the present for taking into consideration the need for thoroughly reviewing the whole status and position of the Indians.[31]

[30] William F. Powless, "Threat to Indians' Guaranteed Rights Resented." *Globe and Mail* (Toronto, Ontario) May 30, 1944, Page 6. ProQuest Historical Newspapers.
[31] Dorise Winifred Nielsen, House of Commons. Edited Hansard. 19th Parliament, 4th Session (July 23, 1943). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1325769/

In much the same way that Marsh and Beveridge had called on politicians to reimagine their duty to care for their citizens, Nielsen challenged the government to reconsider the position of "the Indian" as a ward of the federal government. In her view, the best way to care for First Nations peoples on an equal basis with Canadian citizens was to treat them as such. Nielsen was especially keen for First Nations peoples to be given citizenship's attendant advantages of Canadian education and health care.[32] She was far from alone in this belief. In addition to federal colleagues, a rising tide of criticism outside of government enhanced the political will for action at the federal level. Speaking to the 26th annual meeting of the Health League of Canada in 1945, Charles H. Hair of the Ontario Accident Prevention Association articulated a growing perspective that the treatment of First Nations populations in the far north was "a disgrace to civilization."[33]

The federal Liberals and their officials were by no means deaf to such calls. From the 1940s onward, federal policy makers had become wary of the failures of former assimilation policies. Studies in the immediate post-war period clearly indicated that far from being a success, former policies of assimilation had led to the "egregious living conditions of native peoples."[34] In early reconstruction efforts, the Committee on Postwar Reconstruction and Reestablishment created a platform to review the situation of First Nations veterans and, by extension, the experience of First

[32] Dorise Winifred Nielsen, House of Commons. Edited Hansard. 19th Parliament, 4th Session (July 23, 1943). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1325769/ Members of the Cooperative Commonwealth Federation were also frequent critics of the Liberal government's treatment of First Nations peoples, especially in the second half of the 1940s. In 1946, for example, George Hugh Castleden (CCF, Yorkton) argued that "the conditions which have been allowed to develop among the Indians with regard to their health, economic situation and training facilities are nothing less than a monument of disgrace to those who have been in power in Canada." George Hugh Castleden, House of Commons. Edited Hansard. 20th Parliament, 2nd Session (May 13, 1946). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1413058/

[33] "Treatment Given Canadian Indians Said Disgraceful." *Globe and Mail*, October 31, 1945, 4. ProQuest Historical Newspapers.

[34] Leslie, "Assimilation, Integration or Termination," 9.

Nations peoples in Canada more broadly.[35] In an address to the Committee on the 24th of May 1944, Secretary of the Indian Affairs Branch, T.R.L. MacInnes, who had worked in Indian Affairs since 1913, agreed with critics that past government policy regarding Indian Affairs was outdated. MacInnes explained that the separation of First Nations peoples on reserves was "retarding them" and argued that if segregation from White society continued, it would cause communities to "sicken and deteriorate."[36]

Such information and advocacy clearly demonstrated to Ottawa that the First Nations population in Canada constituted an "Indian problem"—a race-based segment of the Canadian population whose widespread suffering could easily provoke the charge of racial discrimination. Considering the growing ethos in the western world that citizen well-being was the purview of the nation-state—even more so for those deemed federal wards— such suffering could not be ignored. In an earlier era of Canadian policy, the federal government had chosen to place First Nations peoples in positions of federal wardship on reserves for their alleged protection. Now, this policy of social and political segregation was being called into question.

Opinions on how to improve the well-being of First Nations peoples were divided. In the arena of health, for example, while Indian Affairs officials such as Percy Moore, the superintendent of medical services, advocated for a strengthening of Indian health services within Indian Affairs, for others, such as MacInnes, the maintenance of a distinct Indian portfolio service would do little to

[35] Hugh Shewell, *'Enough to Keep Them Alive': Indian Welfare in Canada, 1873-1965* (Toronto: University of Toronto Press, 2004), 146.
[36] T.R.L. MacInnes testimony to the Joint Commission. Special Joint Committee, *Minutes of Proceedings and Evidence* 24 May 1944. Cited in Shewell, *'Enough to Keep Them Alive,'* 151.

improve First Nations well-being and, instead, would only further their isolation.[37] The answer for MacInnes was clear: "speed up…the process of making the Indians a regular part of the Canadian community, without any separate… substandard special status."[38] Many politicians agreed with his assessment. Given the many benefits of normal Canadian citizenship, improving the condition of First Nations peoples in Canada through equal citizenship status seemed the obvious choice. Thus, in 1945, jurisdiction for the health of First Nations peoples was transferred from its home in the Department of Mines and Resources to the newly created Department of National Health and Welfare (DNHW). This integration of Indian Health Services (IHS) into National Health and Welfare was emblematic of a larger revisiting and rhetorical reorientation of First Nations policy in the post-war period that promoted the removal of First Nations distinctiveness as federal wards to transform them into Canadian citizens.

To further understand the linkages between Canada's treatment of First Nations peoples as federal wards and their current living conditions, Minister of Mines and Resources James A. Glen appointed the *Joint House of Commons Senate Committee to Consider Amendments to the Indian Act and Indian Administration Generally* (hereafter Joint Committee) on the 13th of May 1946. The Committee was empowered to investigate a broad range of policy issues involving status Indians' distinctiveness within settler society including treaty rights, tax exemptions, the right to vote, and regulations for the consumption of liquor. While strong support for the creation of a joint

[37] Shewell, *'Enough to Keep Them Alive,'* 155. Such a reorientation was also facilitated by a change in personnel. In 1945, J.A. Glen replaced longstanding Minister of Mines and Resources T.A. Crerar and R. Hoey replaced Harold McGill as Branch Director. Both men had served in these roles for at least ten years. Thus, as John Leslie argued, "the previous hostile approach of D.C. Scott and Harold McGill to Indian political activity was gradually altered to cautious indulgence." Such an approach supported the concept that First Nations peoples could, and should, be trained in citizenship. Leslie, "Assimilation, Integration or Termination.", 102.

[38] T.R.L. MacInnes testimony to the Joint Commission. Special Joint Committee, *Minutes of Proceedings and Evidence* 24 May 1944. Cited in Shewell, *'Enough to Keep Them Alive,'* 155;152.

parliamentary committee existed, it is essential to note that many others had advocated for the creation of a royal commission. As MP J.H. Blackmore (Social Credit, Lethbridge) explained, "those in my territory who advocate a commission point to the fact that the members of a committee of parliament, no matter how wisely the committee may be chosen, will hardly have representatives of the Indians themselves on the personnel of the organization."[39] First Nations leaders such as Andrew Paull of the North American Indian Brotherhood denounced the endeavour as "a committee investigating yourselves."[40] The call for both a royal commission and First Nations representation, however, met strong resistance. Members of Parliament voiced reservations about whether First Nations peoples had the capacity to sit in a settler government, a perspective reflected and reinforced by the absence of Indigenous representatives in either the Senate or the House of Commons. Underscoring the view that to be Indigenous in Canada was to be a human of less capacity, MP Gladys Strum (CCF, Qu'Appelle) expressed herself to be "astonished" that there was international precedent for Indigenous peoples in parliament. Since 1867, the parliament of New Zealand had ensured the election of four Māori members.[41]

When the decision was made that a joint committee of the House of Commons and the Senate was the best tool the government had to consider the matter of First Nations in Canada, reticence to make significant space for First Nations voices in policy discussions continued. CCF MP G.H. Castleden, himself a member of the Joint Committee, entreated his colleagues to invite five

[39] John Horne Blackmore, Edited Hansard. 20th Parliament, 2nd Session (May 13, 1946). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1413045/
[40] Leslie, "Assimilation, Integration or Termination,", 125.
[41] Gladys Grace Mae Strum, Edited Hansard. 20th Parliament, 2nd Session (May 13, 1946). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1413072/; Twelve years later, shortly after the appointment of James Gladstone of the Blackfoot First Nation to the Senate, another MP again expressed surprise at "how many Indian people express valuable ideas." Alexander Malcolm Nicholson (CCF, Mackenzie), Edited Hansard. 23rd Parliament, 1st Session (January 31, 1958). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1936059/

representatives of First Nations communities to sit on the committee, a call that Rev. Peter Kelly, a member of the Native Brotherhood of British Columbia, and Andrew Paull actively endorsed.[42] After much consideration and debate, however, Castleden's colleagues deemed such an invitation inappropriate. As the chair of the committee Donald Brown explained, "this committee… is not of the opinion that at the present time the work of the committee should be facilitated, or expedited, by authorizing the constant attendance before it…of any number of Indians or other representatives."[43] Such strong resistance to First Nations perspectives is also borne out in scholar Jim McMurtry's revelation that when certain First Nations communities wanted to use their own band funds to send representatives to Joint Committee sessions, they were prevented from doing so.[44] As the work of the committee progressed, this kind of resistance to First Nations partnership continued. Social work scholar Hugh Shewell has demonstrated that even when First Nation's voices were invited to address the committee, "[their] submissions—especially those concerned with historical grievances were considered least relevant or not relevant at all." In contrast, however, "those from established Euro-Canadian organizations were given greater weight and were incorporated into the committee's four reports."[45] Settlers thus jealously guarded their power to define and manage the "Indian problem."

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[42] Shewell, *'Enough to Keep Them Alive,'* 175-177. Canada. Royal Commission on Aboriginal Peoples. *Report of the Royal Commission on Aboriginal Peoples.* Vol 1: Looking Forward, Looking Back. (Ottawa, Royal Commission on Aboriginal Peoples, 1996): 284.

[43] Donald Brown (Liberal, Essex West), Special Joint Committee, *Minutes of Proceedings and Evidence* No. 1 July 1946, 494. In the end, the only First Nations person directly associated with the work of the Committee was Six Nations Lawyer Norman E. Lickers who served a committee counsel and liaison officer.
Cited in Shewell, *'Enough to Keep Them Alive,'* 177.

[44] Jim McMurtry, "The 1946-1948 Special Joint Committee on the Indian Act and Education Policy" (M.A. Thesis, University of Alberta, 1985), 47.

[45] Shewell, *'Enough to Keep Them Alive,'* 174.

In his introduction of the Joint Committee in the House of Commons, Glen proposed that what had been traditionally known as "the Indian problem" was at a fork in the road. At the nation's current state of development, Glen argued, the Canadian government had two choices. One, purchase more lands for First Nations peoples and extend their hunting and trapping rights or, two, "decide on an educational and welfare program that will fit and equip the Indian to enter into competition with the white man."[46] While leaving the Committee to make its own assessment of whether First Nations' unique rights were to be respected, Glen's further comments reveal his own sense of what the path forward was to be.

> The Indian… is developing, slowly perhaps, but nevertheless developing toward a better acquaintance with the ways of the white race. His blood is becoming steadily more mixed, which, in fact, points toward ultimate assimilation. It is possible, in my judgement, to say that too much emphasis has been frequently placed upon the fancied injustice of requiring the Indian to conform to changing conditions. In the last analysis it is both just and expedient to help the Indian to adjust himself to these conditions. It is neither necessary nor merciful in the long run to encourage him perpetually to continue in a state of backwardness or semi-backwardness…Time, we are told, heals all wounds, and in this healing process the soars [sic] of race tension, conflict, and misunderstanding will, I feel sure, disappear.[47]

This framed inevitability suggested that politicians and government bureaucrats' role was not to decide if First Nations peoples should be assimilated into Canadian society but rather to determine how best to facilitate their transition from wards to citizens with access to an increasing range of welfare programs. Responding to a growing perception that outright racial discrimination was no longer palatable, however, Glen stressed that a policy of integration should allow "the Indian…[to] retain and develop many of his native characteristics."[48] Notably, Glen referred to the

[46] James Allison Glen, House of Commons. Edited Hansard. 20th Parliament, 2nd Session (May 13, 1946). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1413037/
[47] James Allison Glen, House of Commons. Edited Hansard. 20th Parliament, 2nd Session (May 13, 1946). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1413039/
[48] James Allison Glen, House of Commons. Edited Hansard. 20th Parliament, 2nd Session (May 13, 1946). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1413037/

characteristics of First Nations communities and not their rights. After a few hours of discussion, Glen's resolution for a Joint Committee received unanimous support.

The history of the Joint Committee has been well-documented by scholars.[49] In brief, the Committee's major influence on political discourse was its cross-partisan, multi-generational support of Glen's proposal to integrate First Nations peoples into Canadian citizenship.[50] After 128 meetings, hearing 122 witnesses, and a review of 411 written briefs, the Joint Committee published its final report on 22 June 1948. Recommendations such as the establishment of a claims commission to settle First Nations grievances or that First Nations peoples be given greater powers of self-government suggest a degree of respect for First Nations' autonomy. In truth, however, these recommendations were seen as a means to better facilitate First Nations integration into Canadian society. Perhaps more revealing of intent are the Committee's recommendations that the definition of the Indian be revised to limit those who had access to services on reserve, that First Nations exemption for the payment of certain taxes be reviewed, and that the integration of First Nations children into the regular—read as White— public school system be encouraged.[51] In sum, the overall conclusion of the Joint Committee was best articulated by the Committee members themselves who argued it was "the duty and responsibility of all officials dealing with Indians to assist them to attain the full rights and to assume the responsibilities of Canadian citizenship."[52]

[49] Leslie, "Assimilation, Integration or Termination;" Shewell, *'Enough to Keep Them Alive;'* Carisse, "Becoming Canadian;" and McMurtry, "The 1946-1948 Special Joint Committee."
[50] The committee was made up of eight Liberal senators, thirteen Liberal MPs, four Conservative senators, six Conservative MPs, two CCF MPs and one MP from the Social Credit Party. In 1947, one Conservative MP and two Senators, a Liberal and a Conservative, joined. Reflecting on the discussions of the Joint Committee, Conservative member W.G. Case (MP, Grey North) remembered that "closed deliberations were marked by consensus." McMurtry, "The 1946-1948 Special Joint Committee," 49.
[51] For a comprehensive list of the Committee's recommendations see Leslie, "Assimilation, Integration or Termination," 72, 177, 180.
[52] Final Report of the Joint Committee published 22 June 1948. Cited in Shewell, *'Enough to Keep Them Alive,'* 203.

With greater rights as citizens within the Canadian nation and more responsibilities, the Committee's co-Chair Donald Brown felt confident the whole theme of the committee could be realized, "to help the Indian to help himself."[53] Later, Minister of Citizenship and Immigration Jack Pickersgill would dub this policy approach to First Nations peoples in Canada as "the Gospel of Integration."[54]

Only a few months after the Joint Committee submitted its final report, Canadians witnessed the retirement of their long-standing Prime Minister, Mackenzie King. A policy of integration, however, was not to be interrupted. Within a year of his election, Liberal Prime Minister Louis St. Laurent exemplified his willingness to carry on a policy to integrate First Nations peoples into Canadian society as citizens when he approved the transfer of the Indian Affairs Branch from the Department of Mines and Resources to the newly created Department of Citizenship and Immigration. Notably, Indian Health Services remained within the purview of the Department of National Health and Welfare. In no uncertain terms, St. Laurent made the goal of the new Department clear: "having citizenship, immigration, and Indian affairs in the one department would indicate that the purpose of the activities of the department was to make Canadian citizens of those who were born here, of the original inhabitants of the territory, or those who migrated to this country."[55] First Nations peoples were to be integrated into Canadian citizenship and, as a

[53] Donald Ferguson Brown, House of Commons. Edited Hansard. 21st Parliament, 2nd Session (June 21, 1950). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1613913/

[54] Minister of Citizenship and Immigration Jack Pickersgill framed integration as a gospel in an address to the House of Commons regarding the Indian question on the 7th of August 1956. John Whitney Pickersgill, Edited Hansard. 22nd Parliament, 3rd Session (August 7, 1956). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1873416/

[55] Louis St. Laurent, House of Commons. Edited Hansard. 21st Parliament, 1st Session (November 26, 1949). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1579001/ ; See also Heidi Bohaker and Franca Iacovetta, "Making Aboriginal People 'Immigrants Too': A comparison of Citizenship Programs for Newcomers and Indigenous peoples in Postwar Canada, 1940s-1960s," *The Canadian Historical Review* 90, no. 3 (September 2009): 427-461.

result, they would be offered improved social services and their racial discrimination would end. As citizens, integration policy argued, First Nations peoples could better their standard of living without any perceived artificial separation from their fellow Canadians. Save for a few cultural characteristics, politicians hoped, integration would solve the "Indian problem" and end First Nations distinctiveness.

Settler Sovereignty and White Supremacy: The Continuities of Integration Policy

As the post-war period witnessed an increased willingness of the state to support social welfare programs and to end the race-based segregation of First Nations peoples, there were problematic continuities that warrant critical assessment. In practice, an invitation to Canadian citizenship through a policy of integration neither stopped the racialization of First Nations peoples as Indians nor ended efforts to secure uncontested settler sovereignty. Instead, integration policy was embraced because of its essential similarities to earlier assimilation policy and its failure to challenge the status quo. Both assimilation and integration policy were the creations of settler-colonial governments who sought to remove First Nations sovereignty from the land, maintain ultimate authority, and employed racialization to "justify" their incursion.

A key strategy of settler-colonialism is to maintain the power to define issues and the scope of the negotiations. Certainly, the reticence to include First Nations representatives on the ground floor of policy planning remained in the early 1950s. In the years following the final report of the Joint Committee, officials in the Indian Affairs Branch began drafting a new *Indian Act*. After delays that proved that Indian Affairs was not a pressing priority for the Liberal government, newly

appointed Minister of Citizenship and Immigration, Walter Harris, introduced Bill 267 to the House of Commons. The backlash was immediate. Douglas Scott Harkness, PC member for Calgary East, described the bill as a "regrettable mistake" and noted that the proposed changes "bore little resemblance in many important respects to the draft bill recommended by the [Joint] committee, nor did it follow out the recommendations made by the Indians as the kind of bill they wanted and the things that they thought were unjust and should be changed."[56] Beyond government, civil liberties organizations described the Bill as "draconian."[57] Not only does this comment point to the dismissal of First Nations perspectives, but also reveals the fits and starts with which Ottawa began to give up any control over First Nations' lives, even in the name of integration. Among its problems, Bill 267 maintained the significant powers of the Minister to make unilateral decisions for First Nations peoples and bands and dismissed the recommendation to create an Indian Claims Commission or Indian Advisory Boards.

In response, Harris withdrew the Bill on 22 June 1950 and agreed to more substantive consultation with First Nations representatives. Twenty First Nations leaders were thus invited to Ottawa on 28 February 1951.[58] Over four days of meetings, the First Nations representatives expressed their opposition to several sections of the proposed *Indian Act* that undermined their unique status. In particular, they challenged the belief that access to voting rights should be contingent on the denial of their tax exemptions. Moreover, representatives were strongly opposed to involuntary

[56] Douglas Scott Harkness (PC, Calgary Centre), Edited Hansard. 21st Parliament, 4th Session (February 27, 1951). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1624042/
[57] Leslie, "Assimilation, Integration or Termination," 184.
[58] The meeting consisted of eight federal government officials from the Indian Affairs Branch, twenty First Nations delegates, and thirteen First Nations observers. For a full list of attendees see Leslie, "Assimilation, Integration or Termination," 223.

enfranchisement and demonstrated significant hostility to the continued restrictions on intoxicants.[59]

Unfortunately, the meeting, the first between a minister of the crown and First Nations leadership, provides another example of how a rhetorical desire for consultation failed to produce any meaningful partnership. If First Nations peoples were to "help themselves," federal action and policy desired it to be only on terms acceptable to the settler state. In fact, historian John Leslie demonstrated how every phase of the consultation process was organized to strengthen the views of the government. Conference planners carefully selected who was invited, when participants were allowed to speak, and where they would sit to ensure those deemed more disruptive were farther away from the minister.[60] Furthermore, Harris and his officials made great efforts to ensure that the government controlled the narrative of the conference to the press. According to Leslie, "the official conference record is cryptic and, in some instances, when pensions, Indian education, and a claims commission were discussed, no record was kept. Instead, the minister's press release at the conclusion of the conference was crafted to minimize any suggestion of Indian discontent and criticism."[61] Moreover, Ottawa only prepared an official summary of discussions in lieu of official minutes. The operations of settler colonial authority were well on display.

After this consultation, Harris presented parliament with the amended legislation. Significantly, the revised *Indian Act* of 1951 in some respects did demonstrate a degree of government

[59] Robert G. Moore, "The Historical Development of the Indian Act," P.R.E. Group, Indian and Northern Affairs (Ottawa: Treaties and Historical Research Centre, 1978), 147. https://www.tfntreaty.ca/uploads/1/6/6/3/1663584/the_historical_development_of_the_indian_act_aug_1978.pdf
[60] Leslie, "Assimilation, Integration or Termination," 221-224.
[61] Leslie, "Assimilation, Integration or Termination," 224.

responsiveness to First Nations voices and a shift away from former practices. For example, a minister's ability to interfere in band affairs required approval from the band.[62] In addition, bans on particular cultural practices such as the potlach were removed. Unfortunately, despite claims that the new Act represented a "magna carta" for First Nations peoples, the basic nature of the relationship between the Canadian state and First Nations peoples remained intact. Both the *Indian Act* of 1951 and its original form in 1876, which had transformed the positionality of First Nations peoples with respect to the Canadian settler state from being a "nation in a tripartite imperial system to legal incompetent in the bilateral federal/provincial system," maintained that relationship.[63] Despite Harris' suggestion that a new level of openness to First Nations' perspectives on legislation existed, these similarities suggest that his sincerity was limited. So engrained was a settler-colonial desire for control that when politicians agreed to hear First Nations leaders they chose not to listen.

To understand why political leaders so readily turned away from First Nations' voices it is imperative to perceive the racialization that was alive and well during the early post-war period. Particularly tenacious was the valorization of White settler lifestyle along with the construction that White settler actors operated exclusively with honourable intent. Addressing the Joint Committee in March 1947, government anthropologist Diamond Jenness reflected on the goals of past government policy and described how

> we segregated [First Nations] from the white population for their own benefit. We thought that since they did not appear capable of taking care of themselves under modern conditions, we would protect them, we would train them and

[62] Moore, *The Historical Development of the Indian Act,* 150.
[63] RCAP described how the powers of the minister of Indians Affairs and the governor in council "remained formidable" in 1951 with "administration of more than half the act being at their discretion." Moreover, provision for compulsory enfranchisement remained in the Act until 1961. Canada. Royal Commission on Aboriginal Peoples. *Report of the Royal Commission on Aboriginal Peoples.* Vol 1, 255; 285-286.

> educate them until in time they would become useful citizens. Our intentions were excellent.

Jenness then went on to articulate how good intentions had not produced the desired results. He argued that "instead of educating and training them for citizenship and a free life that was just around the corner, we shut them up indefinitely where they would be out of the way of the white man. We have kept them from starving, it is true, but we have made them pariahs and outcasts."[64] Jenness' call was not to end assimilation but to assimilate better.

This positive framing of earlier efforts was echoed in the House of Commons. In particular, MP W.J. Browne (Progressive Conservative, St. John's West) offered listeners a romantic reflection. Calling forth a cultural narrative of the selfless missionary, Browne reminded his peers that "anyone who is familiar with the duties of missionaries knows of their self-sacrifice, their devotion, and the hardships that they suffer from the moment they enter upon their missions" and emphasized the need to "recognize the debt of gratitude that the Indians owe to these self-sacrificing and devoted missionaries."[65] Thus, while the failures of assimilation were to be criticized, especially by opposition parties, Browne's valorization of the work of missionaries offered politicians a noble settler heritage from which to draw. As missionaries understood themselves to bring salvation through religion, politicians in the post-war period could equally understand themselves to be offering salvation through citizenship. Such a framework likely inspired the contemporary politicians like Joint Committee chair Donald Ferguson Brown who believed that assimilation in the post-war period, would permit a First Nations individual "to be

[64] Diamond Jenness presentation to the Joint Commission, March 1947. Cited in Carisse, "Becoming Canadian," 37.
[65] William Joseph Browne, House of Commons. Edited Hansard. 21st Parliament, 4th Session (November 27, 1951). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1624066/

recognized as being a human being and subject to the attention of those seeking office."[66] By implication, to refuse the assistance governments offered through integration was, in the minds of politicians, to actively choose a second-class life in Canada.

To make integration more alluring, the merits of colonial Canadian society were repeatedly extolled in the House of Commons. In 1949, for example, Minister of National Defence Brooke Claxton (Liberal, St. Lawrence-St. George), described Canada's system of government as "the best form of government yet devised by man to regulate his affairs."[67] Similarly, Edward T. Applewhaite (Liberal, Skeena) framed the Department of National Health and Welfare's extension of Family Allowances to a greater number of First Nations peoples as "the extension of civilization westward and northward" in Canada.[68] In their efforts to bring First Nations people under the influence of the Canadian state, many politicians believed they were bequeathing the best of what their British-style system had to offer.

Equally praised in government circles was the White character of the country and its government. As José E. Igartua demonstrated, the valued qualities of Britishness were often framed within a language of biology. According to Major General G.R. Pearkes, (PC, Nanaimo), himself born and raised in England, "the British immigrant 'will have learned about Magna Carta, he will know of

[66] Donald Ferguson Brown, House of Commons. Edited Hansard. 20th Parliament, 4th Session (June 15, 1948). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1535107/
[67] Brooke Claxton, House of Commons. Edited Hansard. 21st Parliament, 1st Session (October 12, 1949). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1569213/
[68] Edward Turney Applewhaite, Edited Hansard. 21st Parliament, 7th Session (January 19, 1953). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1709012/. Unmentioned here is the fact that this "extension of civilization" often involved the forcible removal of children from their homes. The federal government used family allowances to compel residential school attendance as a condition of receipt. See J.R. Miller, *Shingwauk's Vision: A History of Native Residential Schools* (Toronto: University of Toronto Press, 1996): 170.

habeas corpus and the bill of rights…He is of the breed, and, being of the breed, he knows the breed; he is prepared to take the worth of the breed for granted.'"[69] Problematically, this conflation of biology with Britishness constricted the conceptual map of who and what was to be valued in Canada. To illustrate this reality further, MP Alexander Maxwell Campbell's (CCF, Battlefords) comments expose how racialized notions of civilized behaviour also found expression in particular perceptions of praiseworthy community life. Following his visit to the Six Nations Reserve, Campbell celebrated finding "very highly civilized, well-educated, cultured Indians" who with their agricultural society, orchestra, day schools, basketball courts and football fields "would average up pretty well as a farming community with any community of white people."[70] To be valued was to be a settler and the best settlers were seen to be White.

The practice of associating laudable qualities with Whiteness was supported among prominent circles of the Canadian public. In 1956, *The Globe and Mail* offered its perspective on Canadian immigration policy. Its journalist argued that "there must, by the nature of this country and its people, be restrictions. In particular, there must be restrictions where the non-White races are concerned."[71] While the article did suggest that policy makers "should not be harshly inflexible," the bottom line of the sentiment was clear; the strength of Canadian society lay in its adherence to the qualities of Whiteness. In addition, as education scholar Ken Montgomery has revealed, school textbooks of this period made explicit connections between a national heritage and a "racial kinship." Montgomery concluded that "since the spaces and populations of the UK, US, and

[69] José E. Igartua, *The Other Quiet Revolution: National Identities in English Canada, 1945-1971,* (Vancouver: University of British Columbia Press, 2006), 20.
[70] Alexander Maxwell (Max) Campbell, Edited Hansard. 20th Parliament, 2nd Session (May 13, 1946). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1413043/
[71] "After Three Years," *The Globe and Mail,* January 2nd, 1956, 6. ProQuest Historical Newspapers.

Europe were explicitly and frequently identified as 'white', the myths of blood and 'race' as skin colour intertwined to create an imagined community of Canada centred on whiteness."[72] In an explicit conflation of biology and behaviour, Montgomery also described how concepts of Whiteness were imbued with beliefs about conduct. Appropriate White behaviour was "marked… [in textbooks] through the repetitive ascription of traits such as leadership, compassion and intelligence to Europeans, and more explicitly, by describing European imperialism as the expansion of 'white man's civilization.'"[73]

The potency of this rhetoric was demonstrated when MP Joseph-Arthur Bradette (Liberal, Cochrane) described his criticism of White people who acted outside the bounds of what Bradette considered appropriate behaviour. Bradette acknowledged that many First Nations peoples have a reasonable sense of resentment due to the "hardships which have been caused them by a few so-called white people." He then went on to stress that such individuals could only be known as "white in name only, not in respect of their behaviour and conduct."[74] Thus, when an incident occurred which warranted chastisement, MPs felt the need to amputate the perpetrators from the White body politic. In so doing, the use of Whiteness proved its malleability; Whiteness was an ideal that could not be sullied by the behaviour of phenotypically White individuals. Instead, it was a concept imbued with notions of preference, and therefore, power. Those racialized as non-White were expected to remain at the margins.

[72] Ken Montgomery, "Banal Race-Thinking: Ties of Blood, Canadian History Textbooks and Ethnic Nationalism," *Paedagogica Historica* 41, no, 3 (June 2005): 322.
[73] Ken Montgomery, "Banal Race-Thinking," 319.
[74] Joseph-Arthur Bradette, Edited Hansard. 20th Parliament, 2nd Session (May 13, 1946). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1413044/ [Emphasis added]

In contrast to Whiteness, racialized government narratives of First Nations suggested these communities of people had little to offer. In the 1955 annual report of the Department of National Health and Welfare, the crux of First Nations' problems was described in no uncertain terms. The report stated that "the greatest problems facing [Indian Health Services] are racial rather than individual in scope…the depressed economic and educational level of most, the inadequate housing and poor nutritional status of many, the ignorance and superstition rife amongst some, all contribute to the high incidence of disease still found amongst native peoples."[75] Drawing again on racialized stereotypes the following year in his address to the House of Commons, MP John Harrison (Liberal, Meadow Lake) questioned the wisdom of extending Family Allowances to First Nations peoples without a guarantee they had been appropriately trained in Canadian ways. A failure to do so, Harrison argued, would be to "completely ignore the mentality of people of the Indian race. The moment they get a dollar in their hands they want to spend it…they live for today and let tomorrow take care of itself."[76] Such presentations of Indianness, and many others like it, framed First Nations peoples as a "backward race" and challenged settler society to end "its sheer neglect and indifference" of this othered population.[77] Consequently, politicians sought ways to encourage First Nations peoples to actively embrace a White colonial lifestyle in order to, as they understood it, save First Nations peoples from themselves.

[75] Department of National Health and Welfare, *Annual Report: For the Fiscal Year Ended March 31, 1955.* Edmond Cloutier (Ottawa: Queen's Printer and Controller of Stationery, 1955): 80.
[76] John Hornby Harrison, Edited Hansard. 22nd Parliament, 3rd Session (July 27, 1956). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1869558/ To emphasize the mistrust of First Nations' ability to manage their own finances, Hugh Shewell has demonstrated how Indian Affairs imposed stringent controls on First Nations use of Family Allowances. Shewell, *'Enough to Keep Them Alive,'* 233.
[77] David Arnold Croll (Liberal, Spadina), Edited Hansard. 20th Parliament, 4th Session (June 15, 1948). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1535123/

As with Whiteness, racialized perspectives of First Nations peoples were espoused in the press. When a young boy from Attawapiskat First Nation was sent to Sick Kids Hospital in Toronto for treatment in 1945, a newspaper article described the boy as speaking very little English and felt it was unsurprising that "he was filthy." To add insult to injury, doctors and nurses referred to this child as "young Mud." Tragically, this child died while in care at the hospital, a point which the journalist used to call for a hospital to be built closer to these northern communities in order to help "other little Muds."[78] The pathologization of First Nations peoples stemmed from such conflations of First Nations culture with unsanitary habits of living. Consequently, it reinforced the notion that Indian bodies and behaviours needed to be changed.[79]

The centrality of Whiteness and settler-colonial values to the constructions of Canadian citizenship is clear in debates over two of its basic tenets: the right to vote and the payment of tax. For decades, racialized First Nations peoples were denied the right to vote on the basis of race.[80] In 1948, the chair of the Joint Committee, Donald Brown (Liberal, Essex West), emphasized that this right should be extended to First Nations peoples for "it would train him in our democratic practices and make him realize that he has a place in the Canadian economy and the Canadian society." Brown explained that the committee strongly believed that such training would not only "help the

[78] Jack Hambleton, "No Favourites: All Efforts Made to Save Indian Boy," *Globe and Mail,* June 21st, 1945, 15. ProQuest Historical Newspapers.
[79] Mona Gleason's case study of school medical inspections reveals how this conceptual approach was formed and employed in the period of assimilation policy. Gleason noted how "First Nations children of the Inkameep Reserve in the early 1930s…learned that 'good health' meant conforming to the expectations of the dominant society'" and that "school medical inspectors 'disciplined children by pathologizing those whose race, class, and location, put them beyond the boundaries of White middle-class urban British Columbians." Mona Gleason, "Race, Class, and Health: School Medical Inspections and 'Health' Children in British Columbia 1890 to 1930," *Canadian Bulletin of Medical History* 19 (2002): 95-96. See also Robert Ross (Roy) Knight (CCF, Saskatoon), Edited Hansard. 21st Parliament, 4th Session (February 27, 1951). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1624061/
[80] A person racialized as Indian could gain the right to vote prior to this date if they sought enfranchisement to end their legal "Indian status", which included an end to their exemption from taxation.

Indian help himself," but would also "create in the Indian a sense of obligation to society."[81] Resistance to the proposition, however, was too strong. Not only did many politicians find the extension of a powerful privilege of White settler citizenship to those not understood to be White an uncomfortable prospect, many First Nations also pushed back against inclusion in a political system in which they had no desire to participate. Thus, the political will to make this change was limited.[82] Status First Nations people would be denied the right to vote in federal elections until 1960.[83]

Settler perspectives also challenged the extension of health and welfare services to First Nations peoples who resisted settler terms of land ownership and the payment of tax to settler governments. Reserve land set aside for First Nations communities were exempt from the payment of tax, as well as all income earned on reserve, as set forth in the *Indian Act*. This arrangement increasingly became the subject of derision among federal politicians in the post-war period. Instead of seeing reserve land as acknowledgement of First Nations' title and the result of treaty negotiations, politicians repeatedly viewed reserves as a source of First Nations' suffering and argued that reserves segregated them from the beneficial influence of White society.[84] Significantly, the reality of Canada's growing wealth since confederation did little to foster concern over settler land

[81] Donald Ferguson Brown, Edited Hansard. 20th Parliament, 4th Session (June 15, 1948). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1535107/

[82] After a fellow Liberal brought to Brown's attention that Chiefs in Saskatchewan created a petition that they not be granted the vote, Brown withdrew the amendment. Donald Ferguson Brown, Edited Hansard. 20th Parliament, 4th Session (June 15, 1948). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1535107/

[83] Colonialism brought a particular virulence to the racial discrimination that First Nations peoples experienced. For example, while the associations of citizenship and whiteness remained powerful, Asian Canadians received the right to vote twelve years earlier than First Nations peoples.

[84] See Hugh Alexander Bryson, (CCF Humbolt-Melfort), Edited Hansard. 22nd Parliament, 2nd Session (January 14, 1955). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1781744/ and Walter Gilbert Dinsdale, Edited Hansard. 22nd Parliament, 3rd Session (June 19, 1956). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1859443/

ownership or the capacity of market-based economies to create prosperity.[85] If First Nations peoples aligned themselves with White settler culture, however, politicians believed the wealth of all could be increased. As Independent MP John Gibson (Comox-Alberni) articulated, "it is the more advanced and more cultured Indians who will be paying most of the tax, because in ordinary circumstances the more cultured among them have the higher incomes."[86] Thus, settler colonial ideology dichotomized First Nations culture and wealth. White colonial lifestyle was seen as the best means to maximize financial contributions to Canadian society.

Such a framing certainly worked to devalue First Nations' relationships with the land and their communities. Specifically, these relationships were framed as isolating and "unproductive." The value of First Nations peoples in contradistinction to the value of a citizen was echoed in the House of Commons for many years. In 1955, Minister of Citizenship and Immigration Jack Pickersgill (Liberal, Bonavista-Twillingate) reflected the perceived value variance: "We do take the view in my department that those Indians who go off the reserve, who work off the reserve, who live off the reserve, who have their normal domicile somewhere else, should be treated like any other Canadian citizens…those Indians are taxpayers and wage earners and they contribute to the communities in which they live." Pickersgill argued, however, that the department "had never taken that view about the Indian on the reserve."[87] The Indian was a person apart, neither belonging

[85] According to historian Gerald Friesen, between 1870 and 1950, "each person's economic production (gross national product, or GNP, per capita) increased by a factor of five…each Canadian in 1950 on average produced five times more wealth—as measured in money terms—than his or her 1870 counterpart." Gerald Friesen, *Citizen and Nation: An Essay on History, Communication, and Canada* (Toronto: University of Toronto Press, 2000), 127.
[86] John Lambert Gibson, Edited Hansard. 20th Parliament, 4th Session (June 15, 1948). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1535108/
[87] John Whitney Pickersgill, Edited Hansard, 22nd Parliament, 2nd Session (July 16, 1955). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1817383/ [Emphasis added]

nor deserving of aid. The goal for the federal government then was to transform First Nations peoples into Canadian citizens with responsibilities to the Canadian state.

Indeed, MPs repeatedly problematized First Nations peoples' tax exemptions on reserve and expressed difficultly reconciling the extension of citizenship privileges to First Nations communities if they neither embraced Canadian society nor fully contributed to the country's economic well-being through taxation.[88] As historian Dorothy Porter has noted, the period's "welfarism struck a fine balance between collectivism and individualism. The right to benefits depended upon contributions made to social funds, so that social security was earned by individuals fulfilling their responsibility to the collective good."[89] The implication that First Nations peoples contributed very little to Canada because they paid limited taxes to the Canadian government suggested to politicians that First Nations peoples were undeserving of the welfare services extended to citizens who paid taxes. As historian Shirley Tillotson demonstrated in her examination of the "cultural vocabulary" of taxation, when the federal government committed to offering its citizens increased assistance, the post-war period needed, and witnessed, a growing acceptance of the economic *duty* of citizenship. With the rise of social welfare programs, particularly in the 1950s and 60s, even in the face of dissent, many Canadian citizens accepted an increased responsibility to contribute if their government accepted a responsibility to offer greater welfare support.[90]

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[88] Liberal MP for Vancouver North John Sinclair, expressed his confusion stating, "I cannot see how Indians who want to maintain their treaty rights as wards of the state living on reserves away from the great influence of Canadian life can expect at the same time to be able to vote as Canadian citizens in dominion elections." John Sinclair, Edited Hansard, 20th Parliament, 4th Session (June 15, 1948). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1535114/ [misattributed to John Ewen Sinclair on LiPad]

[89] Porter, *Health, Civilization and the State,* 235.

[90] Shirley Tillotson, *Give and Take: The Citizen-Taxpayer and the Rise of Canadian Democracy* (Vancouver: University of British Columbia Press, 2017), 12. Financial considerations, however, constrained the expectations

Politicians' efforts to remove racial discrimination with the extension of welfare services therefore required a strengthened policy commitment to integrate First Nations peoples into a colonial system as citizens rather than as wards. To maintain First Nations distinction as wards who did not pay tax, it was feared, would permit First Nations peoples to "become a charge on our people."[91] In his address to the House of Commons in 1953, Minister for Citizenship and Immigration Walter Harris (Grey-Bruce) reflected a growing sentiment when he called for amendments to the *Indian Act* that would "encourage the Indians to break up [their] lands and put them into production."[92] Put another way, to access the rights of Canadian citizenship, First Nations peoples could not be allowed to shirk their responsibilities to the Canadian economic community. Alternative and pre-existing relationships with First Nations peoples through treaties or the immense wealth Canadians had already taken from their access to Indigenous land were not entertained. The answer for the Liberal government was to strengthen integration efforts to remove difference and invite First Nations peoples to participate in the equal-opportunity and equal-responsibility citizenship Canada believed it offered.[93]

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and commitment of both citizens and the state. Tillotson demonstrated that while a "new breed of citizen" was willing to support social programs, they remained continuously "tax conscious;" Tillotson, *Give and Take*, 209.

[91] Alexander Maxwell (Max) Campbell, (CCF, Battlefords), Edited Hansard. 22nd Parliament, 2nd Session (May 6, 1955). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1799745/

[92] Walter Edward Harris, Edited Hansard, 21st Parliament, 7th Session (April 20, 1953). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1729291/

[93] Pickersgill explained that the government believed "the more closely the education of the Indians is integrated with the education of the rest of the population the sooner the Indians will be able to live with the rest of us on equal terms, compete on equal terms, and become indistinguishable from other Canadian citizens." John Whitney Pickersgill, Edited Hansard, 22nd Parliament, 2nd Session (May 6, 1955). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1799750/

Critical analysis of the language of post-war Canadian politics thus reveals that a policy of integration was pursued because colonial and racialized narratives placed Canadian and First Nations identities within a dichotomous framework, the product of a long history of racialization in Canada.[94] Whiteness in this historical context was associated with access to a healthy lifestyle, was valued in both the present and the future, and seen to contribute to the economic well-being of the nation. To be Indian, however, was to be pathologized, to have only historical value, and to be a burden on state finances. To support claims of cultural superiority, as John Lutz has argued, settlers had to employ negative racialized language, that "the Indian" as "other" was lazy. Therefore, even in the face of contrasting evidence, First Nations were often racialized as less worthy of respect or on-going aid than White citizens.[95] Despite assertions that a policy of integration would continue to respect the culture and rights of First Nations peoples, a dichotomous framework of identity became the Achilles heel of the policy's commitment to cultural respect. As Critical Race Theory scholars have demonstrated in contemporary and historical analysis, there has never been a neutral societal baseline in which a population is asked to integrate.[96] Post-war policy invited First Nations peoples to integrate into a White colonial citizenship which required the removal of First Nations "otherness" through assimilation into a purported "equal" settler society.[97] The settler-colonial state, infused with ideas about the value of Whiteness, espoused a

[94] Paige Raibmon demonstrated in her work *Authentic Indians* that colonialists in late-nineteenth century on the Northwest coast understood white settlers and 'Indian' identities in a binary framework. 'Indians,' Raibmon wrote "were traditional, uncivilized, cultural, impoverished, feminine, static, part of nature and of the past." 'Whites,' however, "were modern, civilized, political, prosperous, masculine, dynamic, part of society, and of the future." Paige Raibmon, *Authentic Indians: Episodes of Encounter from the Late-Nineteenth Century Northwest Coast* (Durham and London: Duke University Press, 2005), 7.

[95] Lutz, *Makúk: A New History of Aboriginal-White Relations* (Vancouver: University of British Columbia press, 2009), 33-34.

[96] Kimberlé Crenshaw, Neil Gotanda, Gary Peller, and Kendall Thomas, "Introduction" in *Critical Race Theory: The Key Writings That Formed the Movement* (New York: The New York Press, 1995), xxv.

[97] As John Lutz shows, when First Nations peoples were asked to participate in capitalist wage work, they became engaged in a form of "peaceable subordination." Lutz explains, "when Aboriginal Peoples entered the capitalist workplace, they entered a foreign cultural framework. And the longer they spent within their foreign cultural framework, the more their original framework had to adjust." Note Lutz's use of the word adjust rather than

rhetoric of universalism to extend the reach of its sovereignty. But the use of racialization to achieve such a goal in turn only offered First Nations peoples a second-class citizenship as the "White man's burden."

If the fundamental nature of assimilation policy remained embedded in the post-war political push for integration, why had the rhetoric begun to change? One reason is that many politicians grasped a new demographic reality. Canadian politicians, and society more broadly, had once believed in the inevitable disappearance of First Nations peoples through assimilation or disease, as Glen himself had articulated in his introduction of the Joint Committee in 1946. Statistics, however, began to tell a different story. Between 1949 and 1950, over 6,000 First Nations children had been born while only 310 First Nations individuals had become enfranchised.[98] Discussed repeatedly in the House of Commons in the 1940s and 1950s, MP William Scottie Bryce (CCF, Selkirk) most succinctly articulated politicians' concerns about this trend. Addressing his peers, Bryce argued "you have a bigger problem on your hands now than you ever had before because the Indians are not dying in such numbers."[99] For those who had a stake in the status quo maintenance of White colonial power, assimilation into Canadian society had to be pursued with a renewed vigour lest "there gradually becom[e] more of them."[100] A new government policy of integration could suggest a strengthened effort to assimilate First Nations peoples into the body politic while at the same time implying a policy break with a perspective that framed this absorption as a physical and

disappear. Foundational to Lutz's argument is that neither capitalism specifically nor settler-colonialism broadly ever succeeding in "vanishing" Indigenous peoples. John Lutz, *Makúk: A New History of Aboriginal-White Relations* (Vancouver: University of British Columbia press, 2009): 25.

[98] Walter Edward Harris, House of Commons. Edited Hansard. 21st Parliament, 2nd Session (June 16, 1950). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1611488/

[99] William Scottie Bryce, House of Commons. Edited Hansard. 22nd Parliament, 2nd Session (May 6, 1955). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1799746/

[100] William Scottie Bryce, House of Commons. Edited Hansard. 22nd Parliament, 2nd Session (May 6, 1955). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1799746/

cultural inevitability. Instead, given the tenor of the times, a policy of integration offered a more politically palatable policy framework that presented absorption to be in First Nations' best interests and invited them to *choose* the rights and responsibilities of Canadian citizenship.[101]

The Federal Government Turns to the Provinces

The complete integration of First Nations peoples into Canadian society, able to access services "as any other citizen" could not be accomplished through federal will alone. While the federal government may have been reticent to see First Nations peoples as partners, they actively courted partnership with the provinces. In the federal government's efforts to transform First Nations peoples from federal wards to citizens, they stressed First Nations' positions as eventual citizens not just of Canada but also of the provinces in which they resided. In their final recommendations, members of the Joint Committee advocated for the federal and provincial governments to establish financial agreements that would allow for the extension of certain provincial responsibilities, such as health and welfare services, to First Nations peoples. Through such arrangements, the Committee hoped, "there [would] be mutual and coordinated assistance to facilitate the Indians to become, in every respect, citizens proud of Canada and of the provinces in which they reside."[102]

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[101] This growing acceptance among Canadian politicians for a degree of cultural diversity under the umbrella of white British, and to a lesser degree French, political and cultural dominance was also extended to recent immigrants to Canada. Liberal MP Arthur Roebuck (Trinity) best encapsulated this perspective when he argued "It is not necessary that men who come from other countries should forget the country of their origin…Canada has been the gainer by the culture, the language, the knowledge and the diversity that these people have brought to our shores. Canada will be a great nation when finally we unite all these nationalities and groups into one great united homogenous people." Arthur Wentworth Roebuck, House of Commons. Edited Hansard. 19th Parliament, 5th Session (April 27, 1944). LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1343107/

[102] Canada, Special Joint Committee on the Indian Act, *Minutes and Proceedings of Evidence.* Fourth Report, 22 June 1948, 187. Cited in Shewell, *'Enough to Keep Them Alive,'* 204.

In fact, the Committee advocated for revisions to the *Indian Act* that would allow for the gradual transformation of band councils into municipalities within provincial jurisdictions.[103]

In complete alignment with the federal government's policy of integration, these provincial recommendations were enthusiastically embraced. As Hugh Shewell demonstrated, the synergy between the Joint Committee and the federal government manifested itself in Section 87 of the revised *Indian Act* of 1951. Section 87 stated that "subject to the terms of any treaty and any other Act of Parliament of Canada, all laws of general application from time to time in force in any province are applicable to and in respect of Indians in the province." Although the section did leave room for certain exceptions, in Shewell's words, this revision to the *Indian Act* effectively "served notice" to the provinces that they needed to prepare themselves to accept a new level of responsibility for First Nations peoples living within their provincial borders.[104]

Throughout the early discussions of post-war social policy in Canada, Mackenzie King had stressed his government's desire not to infringe on the jurisdictional privileges of the provinces. Accordingly, King's cabinet was territorial about its own areas of responsibility. In 1945, Glen had reminded members of the House of Commons that "the welfare of the Indian is the sole responsibility of the federal government [and] not a responsibility shared by the government with the provinces."[105] As the integration impulse strengthened, however, and the reality of the high price of cost-sharing social services such as health insurance was investigated, hard lines softened.

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[103] Shewell, *'Enough to Keep Them Alive,'* 203.
[104] The remainder of Section 87 stated, "Except to the extent that such laws are inconsistent with this Act or any order, rule, regulation, or by-law made thereunder, and except to the extent that such laws make provision for any matter for which provision is made by or under this Act." Shewell, *'Enough to Keep Them Alive,'* 204-5.
[105] James Allison Glen, (Liberal, Marquette), Edited Hansard. 20th Parliament, 1st Session (October 24, 1945). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1386966/

Certain reports began to obfuscate the historical relationship of First Nations peoples and the federal government. In contrast to earlier legislation and policy, the 1955 annual report of DNHW suggested that "the Indians have never been made wards of the Crown." [106] While the report went on to echo the long-standing policy perspective that DNHW had some level of responsibility for First Nations peoples, the outright denial of First Nations wardship reveals an intensification of integration efforts. Department officials were likely keen to sow the rhetorical seeds of provincial involvement before the federal-provincial conference set to take place that October. Given that the focus of the meeting was to be on federal-provincial fiscal relations and health and welfare services, such a statement may have been used to alert provincial readers to prepare for a shift in federal policy. As the 1955 annual report continued, the DNHW stood ready "to hand back [health care provision] functions to the home, the local community and the province when these agencies exhibit the will and the resources to take them over."[107] While a dedicated federal-provincial conference on "Indian Affairs" would not occur for almost another ten years, here was a sign that Ottawa clearly wanted out of the field of First Nations health care.

For centuries, First Nations peoples have resisted the government's attempts to dispossess them of their lands, to challenge their sovereignty, and to forget treaty obligations. The post-war period proved no different. In their written brief to the Joint committee, members of the Mohawk Nation of the St. Regis Reserve reminded the Committee that Mohawk people swore their allegiance not to the Canadian state but "to the Six Nations Confederacy, as the only true government of our

[106] Department of National Health and Welfare, *Annual Report: For the Fiscal Year Ended March 31 1955*. Edmond Cloutier (Ottawa: Queen's Printer and Controller of Stationery): 1955.
[107] Department of National Health and Welfare, *Annual Report: For the Fiscal Year Ended March 31 1955*. Edmond Cloutier (Ottawa: Queen's Printer and Controller of Stationery): 1955. The following January, Percy Moore wrote to Deputy Minister of Health G.D.W. Cameron seeking approval for a "plan designed to relive Indian Health Services of at least some of the costs of hospitalization and medical and surgical care in hospital." Letter from Percy Moore to G.D.W. Cameron, (30 January 1956), RG 29 Vol 2884 File 851-1-23 Pt. 1 [B], LAC.

people."[108] They further articulated their title to their land and issued direct challenges to the legitimacy of colonial state power on it. Likewise, members of the Wahnapitae First Nation objected to the federal government's policy of integration. In their submission to the Committee, members explained that "we think it better to remain a good Indian than a poor imitation of a white man!"[109] Even when First Nations leaders did not challenge the extension of citizenship privileges to First Nations peoples, the principle that First Nations peoples had inalienable rights as First Nations and unceded title to their land remained a central feature of leaders' arguments.[110]

As time went on, government rhetoric and action did little to convince many First Nations that integration was in their best interests. In fact, far from uncertain about government policy, many First Nations leaders articulated profound disagreement with the very premise of government plans. When the federal government shared their proposed revisions to the *Indian Act* in 1950 with First Nations peoples, the Alberta Indian Association expressed grave concern. The Association argued:

> the provisions of the bill fail to provide for the logical second step in the progress of the treaty Indian, gradual extension of self-government and administration of the reserve affairs. The bill admits the existence of only two grades of Indians—the incapable old-fashioned Indians who in mind and mode of life has made no real progress since the coming of the white man, and the Indian whom your government, in spite of all agreements and treaties of any kind at any time, proposes to catapult into the responsibilities of full citizenship.[111]

[108] Written statement to the Joint Committee to Investigate the Indian Act, from the Mohawk Nation, St-Regis Reserve, 11 May 1948, 209. Cited in Shewell, *'Enough to Keep Them Alive,'* 193.
[109] SJC, Minutes and Proceedings no. 33, 12 June 1947, 1945. Cited in Sheffield and Riseman, *Indigenous People and the Second World War,* 277.
[110] Wahnapitae First Nation's Brief to the Joint Commission. Cited in Carisse, "Becoming Canadian," 29.
[111] Statement from Alberta Indian Association read into Hansard by John Horne Blackmore. Edited Hansard. 21st Parliament, 4th Session (February 27, 1951). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1624240/

Likewise, members of the Kahnawake community wrote a letter of complaint. The letter, read aloud in the House of Commons, argued that Bill 267 "is an entirely negative one and apparently designed to govern an inferior and subordinate people and to keep them inferior and subordinate. It also tends to destroy the racial identity of the Indian and submerge it out of sight." The authors concluded that if such a bill was to pass, "the new *Indian Act* will be the most bureaucratic and dictatorial legislation ever imposed on mankind." In direct contrast to government policy, the letter articulated that its authors had no desire to become Canadian citizens.[112] Even for those First Nations communities who accepted the extension of citizenship status to First Nations peoples, their leaders "continually referred to the treaties when advancing an alternative vision of Indian peoples' enhanced civic status in post-war Canadian society."[113] From multiple perspectives, Canada's invitation to equal citizenship status remained unwanted.

First Nations leaders were by no means alone in their challenge to federal policy. While politicians repeatedly fell short of acknowledging First Nations' sovereignty on the land on which Canada was built, several MPs contested the notion that the Canadian government had operated in the best interests of First Nations peoples. In particular, members of the CCF critiqued former Liberal and Conservative policies. MP Max Campbell (CCF, Battlefords), for example, argued that "the whole story of the treatment of Indians by the white men has been one of exploitation all the way through."[114] Other MPs employed comparative examples to make a critical point. With a particularly provocative argument in the context of the most recent world war, John Blackmore

[112] Statement from Kahnawake community read into Hansard by John Horne Blackmore. Edited Hansard. 21st Parliament, 4th Session (February 27, 1951). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1624059/
[113] Leslie, "Assimilation, Integration or Termination," 144.
[114] Alexander Maxwell (Max) Campbell, Edited Hansard. 20th Parliament, 2nd Session (May 13, 1946). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1413043/

(Social Credit, Lethbridge) reminded his colleagues that Canada had gone to war against Germany in the First World War because "the Kaiser of Germany…dealt with a sacred treaty as a scrap of paper, when he invaded Belgium." He then reminded members of the House that "since 1867…Canada had been consistently and progressively breaking solemn treaties with great people, the Indians, dealing with them not only as scraps of paper in word but in act and in fact."[115] Such calls to do better may have been heard but their impact soon faded away.

Attention to the resistance which arose to the government's attempts to integrate First Nations peoples is useful for it both highlights competing perspectives and reveals with greater precision the nature of federal policy and its blind spots. Ottawa's growing commitment to a policy of integration in the post-war period certainly drew on a wider ethos of White settler colonial superiority but such a view was by no means universally accepted. Thus, in framing its integration policy, politicians and bureaucrats had to ignore the reality of dissenting voices and alternative viewpoints. Despite many First Nations leaders' repeated declaration of their sovereignty as nations distinct from Canada, federal ministers continued to see treaties as land surrenders that carried, it was hoped, temporary special rights. Such a belief was so ingrained that when the *Indian Act* was revised in 1950 and 1951, Harris noted that this piece of legislation—the keystone of the federal government's paternalistic control over First Nations peoples—did not deal with treaties beyond "guaranteeing their continued existence in one respect or another."[116] The peripheral place

[115] John Horne Blackmore, Edited Hansard. 21st Parliament, 4th Session (February 27, 1951). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1624053/
[116] Walter Edward Harris, (Liberal, Grey Bruce), House of Commons. Edited Hansard. 21st Parliament, 4th Session (February 27, 1951). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1624279/

of treaties in the legislation did little to support First Nations leaders' call for a nation-to-nation relationship.

Instead, the government's policy of integration maintained the systems of privilege and power that had characterized the era of assimilation. The rhetoric of equality that promised to extend access to services and support First Nations on the same basis as Canadian citizens masked a more sinister reality. Equality was conditional. As in the period of assimilation policy, integration policy required First Nations peoples to deny any claim to sovereignty or special status.[117] Thus, while the Canadian government agreed to aid the well-being of their citizens as never before, and in so doing created a new societal baseline of support, integration policy failed to profoundly expand the criteria for who was "deserving" of care. To be Indian was to be a problem, but to be a citizen was to be cared for.

Consequently, parliamentarians and their officials could argue that they sought to remove the stain of racial discrimination from the country's legislation and improve the horrendous living conditions of First Nations peoples that had been so prominently criticized, while at the same time delegitimize in the eyes of the state challenges to the sovereignty of the Canadian government on this land. In essence, the position of the federal government was that First Nations peoples could receive greater federal support if they chose to acknowledge the legitimacy of the settler state and become Canadian citizens.

[117] Canada was by no means alone in their efforts to "qualify" equality. As political scientist Peter Russell notes, "While the Charter of the United Nations begins by affirming 'the equal rights of men and women and of nations large and small, and its first article sets out as one of the UN's purposes 'to develop friendly relations among nations based on the principle of equal rights and self-determination of peoples,' the founding states of the United Nations were no more willing to apply those principles to Indigenous nations or peoples than was the League of Nations when it slammed the door on the Haudenosaunee in 1923 and on the Māori in 1925." Peter H. Russell, *Sovereignty: Biography of a Claim* (Toronto: University of Toronto Press, 2021), 59.

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"This word 'integrate,'" MP John Horne Blackmore (Social Credit, Lethbridge) argued, "is one of those chameleon-like words. It can mean anything you want it to mean, according to the way you use it."[118] This chapter's examination of post-war discourse of Canadian citizenship and the Indian, has revealed the particular nature of integration for many politicians in the post-war period. While there was no universally accepted definition, integration on the whole was presented as a concept and action plan in First Nations' best interests. In reality, the interests best served by the policy were those of the settler-colonial state. Integration not only positioned Whiteness as superior, but it also sought to foster the legitimacy of settler presence on the land and strove to maintain its attendant systems of governance.

In many ways, the federal government's protection of treaty rights in the immediate post-war period can be seen simply as a concession that assimilation without force—integration— would take a long time. Jack Pickersgill's address to the House of Commons on August 7th, 1956, best summarizes this view. Pickersgill and his colleagues hoped that it would be "the desire of practically everyone in this parliament to see the day come when every Indian in this country will feel that his rights as a Canadian citizen are so much more valuable than any treaty rights he has that he will not be concerned at all about the treaty rights, and…reservations, treaties and all these

[118] John Horne Blackmore, (Social Credit, Lethbridge), Edited Hansard. 21st Parliament, 4th Session (February 27, 1951). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1624053/

concepts of segregation and discrimination will have disappeared."[119] Once again, the end of racial discrimination in Canadian citizenship was premised on the denial of First Nations sovereignty. For the sake of the settler-colonial project competing claims of sovereignty—understood as a dangerous threat to Canadian legitimacy—had to be erased. Thus, federal politicians drew on well-worn racialized tropes to demonstrate healthy, sovereign First Nations peoples were to have no place in Canada.

[119] John Whitney Pickersgill (Liberal, Bonavista-Twillingate), Edited Hansard. 22nd Parliament, 3rd Session (August 7, 1956). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1873416/

Chapter 2

"There are many areas yet where the job is colossal": Policy in Practice[1]

"Ministerial pronouncements," a journalist for *The Globe and Mail* wrote in 1946, "mean nothing unless they are followed by departmental action."[2] Indeed, the political project of integration may have been espoused in the House of Commons and formed on the vision of an equal society but before such equality could be realized, federal departments needed to manage the devastating consequences of racial discrimination and, although not identified as such, of colonial incursion. Moreover, the Indian Affairs Branch of the Department of Citizenship and Immigration and the Indian Health Service of the Department of National Health and Welfare (DNHW) had to prepare both their staff and First Nations peoples to meet integration's call. Simply put, integration required new arrangements. To realize the great promises of the post-war period to improve life for all those in Canada, Health Minister Brooke Claxton tasked Percy E. Moore with the bureaucratic leadership of DNHW's Indian Health Service (IHS).[3] Already familiar with government services for First Nations health, Moore approached the management of IHS with an "outgoing and aggressive manner."[4]

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[1] Paul Martin, Minister of National Health and Welfare, in reference to the work of Indian Health Services. Edited Hansard. 21st Parliament, 2nd Sessions (June 20, 1950). Retrieved from LiPaD: The Linked Parliamentary Data Project https://www.lipad.ca/full/permalink/1613520/ [Misidentified on LiPaD as Mr. Marlin).

[2] "Still Pleading," *The Globe and Mail,* August 8, 1946, 6.

[3] Percy E. Moore was born in Oxford Mills, Ontario in 1899. He pursued an interest in medicine at the University of Manitoba after which he spent seven years as medical superintendent of the Fish River Indian Agency in Hodgson, Manitoba. After receiving a diploma in public health from the University of Toronto in 1938, Moore joined the Indian Affairs Branch as assistant superintendent of medical services. When the then director E.L. Stone joined Canada's war effort in 1939, Moore became acting superintendent of the medical service, a position that was made permanent when Stone chose not to return to Ottawa. P.G. Nixon, "Percy Elmer Moore," *Arctic* 42, no. 2 (June 1989): 166.

[4] G.J. Wherrett, *The Miracle of Empty Beds: A History of Tuberculosis in Canada* (Toronto: University of Toronto Press, 1977), 114.

This chapter will explore how the integration ethos informed the early conceptual and practical development of Indian Health Services in the Department of National Health and Welfare during the policy's first ten years. First, it will consider how and why department leadership felt entitled to define the scope and the terms of health service provision to First Nations individuals. In particular, it will examine how settler-colonial and racialized frameworks shaped the discourses of First Nations health care access in the post-war period and the nature of federal-First Nations relationships. Second, it will explore how the IHS sought to remedy the previous neglect of First Nations' health.

As this chapter will reveal, despite IHS efforts to expand its Service, the accessibility and quality of settler-offered health care exhibited substantial limitations. Thus, the third section of this chapter will examine the ideological and material obstacles to the creation of an adequate program of service provision. Part of this critical analysis will be to consider the ways in which education scholars Eve Tuck and K. Wayne Yang's concept of "settler moves to innocence," played a key role in mitigating political or bureaucratic will among the DNHW's leadership either to enhance the services offered or to ground service extension in a discussion of treaty rights.[5]

Finally, because integration policy called for the equal treatment of all Canadian citizens in Canada, the long-term existence of a separate health care service for First Nations peoples required attention; the DNHW had to determine the rationale, scope, and pace of its eventual elimination. How IHS began this process, is the subject of the fourth section.

[5] Eve Tuck and K. Wayne Yang, "Decolonization is not a metaphor," *Decolonization: Indigeneity, Education and Society* 1, no. 1 (2012): 1-40.

No Law or Treaty

In 1944, Canada established its new Department of National Health and Welfare and within a year the mandate for Indian Health Services (IHS) was transferred to the new Department. In 1946, its first minister, Brooke Claxton, was invited to offer his assessment of the current state of IHS to the Joint House of Commons Senate Committee on Indian Administration. Early in his remarks, Claxton ruminated on settler-Canadians' long relationship with First Nations peoples regarding health and healing, placing its start at the very arrival of Jacques Cartier. With the use of H.P Briggar's account in *The Voyages of Jacques Cartier,* Claxton told the Committee members of Cartier's meeting with Chief Agouhanna. Its content is worth quoting at length:

> This [Chief] Agouhanna, who was some fifty years of age, was in no way better dressed than the other Indians except that he wore about his head for a crown a sort of red band made of hedgehog's skin. This chief was completely paralyzed and deprived of the use of his limbs. When he had saluted the Captain and his men, by making signs which clearly meant that they were very welcome, he showed his arms and his legs to the Captain, motioning to him to be good enough to touch them, as if he thereby expected to be cured and healed. On this the Captain set about rubbing his arms and legs with his hands. Thereupon this Agouhanna took the band of cloth he was wearing as a crown and presented it to the Captain. And at once many sick persons, some blind, other [sic] with but one eye, others lame or impotent and others again so extremely old that their eyelids hung down to their cheeks, were brought in and set down or laid out near the Captain, in order that he might lay his hands upon them, so that one would have thought Christ had come down to earth to heal them.[6]

Claxton's choice of account which likened the arrival of Jacques Cartier to the healing power of Christ would likely have been well-received by the members of the Joint Committee. As the previous chapter discussed, a kind of saviour ethos infused post-war integration policy and while

[6] Brooke Claxton address to the Joint House of Commons-Senate Committee on Indian Administration, RG 26 Vol 71, Library and Archives Canada, Ottawa, Ontario, [hereafter cited as LAC].

religious allusions decreased with time, the belief that politicians could draw on the same noble heritage as Canada's early explorers and missionaries held significant moral sway.[7] Certainly, the settler belief that post-war integration policy would "save" First Nations peoples from their suffering informed the outlook and efforts of the Indian Health Services' top political and bureaucratic leadership.[8] In addition, the account's description of a First Nation's leader giving up his crown to Cartier, clearly harmonized with the settler belief that Indigenous sovereignty had been exchanged for settler services.

Perhaps most telling of all is what Claxton chose not to mention. When Jacques Cartier had arrived in what is now known as Canada for the second time, it was the medical knowledge of local First Nations individuals that saved Cartier and his men from scurvy and widespread death.[9] This omission in the health narrative was to become emblematic of settler government discourse on health and health services in Canada; First Nations peoples were understood as passive recipients of settler aid with little, it was believed, to contribute themselves. Thus, while politicians had presented integration as a break from past colonial policy, namely the earlier neglect of First Nations communities, it nevertheless failed to destabilize the state's interest and investment in a unilateral exercise of power by the colonizer over the colonized. To a large degree, the story of

[7] As highlighted in the previous chapter, Department of National Health and Welfare officials described how "Indian and Eskimo Health Services carries the spirit of the crusader into modern medical practice." Letter to H.A. Procter, Assistant Director Indian Health Services from Eric J. Preston of Department of National Health and Welfare (10 November 1949), RG 29 Vol 2866 File 851-1-1 Part 1B, Medical Services Operations, LAC.
[8] Brooke Claxton's biographer described him as a "true party man" with an "overriding…desire to be useful to his country." No doubt he believed "saving" the First Nations population would contribute to that goal. David Bercuson, *True Patriot: The Life of Brooke Claxton, 1898-1960* (Toronto: University of Toronto Press, 1993), 121, 287.
[9] Micah True, "'Un remedie contre toutes maladies': travel writing and the scurvy incident in Cartier's second voyage," *Quebec Studies* 54 (2012): *Gale Academic OneFile.* https://link.gale.com/apps/doc/A329066287/AONE?u=anon~de01483&sid=googleScholar&xid=6589f104; Martini E. Jacques, "Cartier witnesses a treatment for scurvy." *Vesalius*. 8: (June 2002) :2-6. PMID: 12422875.

settler health narratives had not changed. This continuity would have a profound impact on post-war health care services.

The belief that the Canadian government represented a superior society to which First Nations peoples were invited to join, undermined the principle that services rendered to First Nations communities were the fulfilment of treaty obligations. DNHW officials asserted "no treaty and no law places the responsibility for the medical care of Indians and Eskimos upon the Dominion government. The service is a development of the fundamental principle that if we are to remain healthy, our neighbours must be healthy also."[10] Part of the belief that settler life was superior was the notion that it was healthier than First Nations' lifestyles. Moreover, this dichotomous framing also positioned First Nations as a threat to Canadians' well-being.[11] An invitation to join Canadian medical systems as citizens was therefore understood to be everyone's best chance for improved health care. Thus, as outlined in the DNHW's 1948 annual report, the position of IHS in the immediate post-war period was to provide "a health service for native Indians and Eskimos…as a voluntarily assumed moral obligation on the part of the government, to provide assistance to a more primitive people and to protect the new inhabitants."[12] Both Preston's letter and the

[10] Letter to H.A. Procter, Assistant Director Indian Health Services from Eric J. Preston of Department of National Health and Welfare, (10 November 1949), RG 29 Vol 2866 File 851-1-1 Part 1B, Medical Services Operations, LAC.

[11] Historians Mary Ellen Kelm and Maureen Lux articulate how this fear *of* First Nations entrenched itself in the 1930s. This positioning catalyzed efforts to remove dying Indigenous bodies and to colonize their land in order to maintain claims of superiority. See Maureen Lux, *Medicine that Walks: Disease, Medicine and Canadian Plains Native People 1880-1940* (Toronto: University of Toronto Press, 2001); Mary-Ellen Kelm, "Diagnosing the Discursive Indian: Medicine, Gender, and the 'Dying Race." *Ethnohistory* 52:2 (2005): 371-406. Similarly, gender studies scholar Sherene Razack argues that First Nations bodies continued to be framed as "wasted." Sherene Razack, *Dying from Improvement: Inquests and Inquires into Indigenous Deaths in Custody* (Toronto: University of Toronto Press, 2015).

[12] Department of National Health and Welfare, *Annual Report: Fiscal Year ended March 31 1948.* Edmond Cloutier, (Ottawa: King's Printer and Controller of Stationery, 1948): 40.

Department's annual report in 1948 expose how racialized perspectives of who mattered most to the federal government continued to inform policy.

Yet, alternative interpretations to this position have existed from the earliest days of treaty negotiations. For example, historian J.R. Miller has described how "ritualized gift exchanges" between First Nations and trader newcomers represented a form of treaty-making from the earliest days of Indigenous-European contact. Later Peace and Friendship treaties, such as the Covenant Chain and the Two Row Wampum, acknowledged that the nature of First Nations-newcomer relationships was *reciprocal*.[13] Mohawk anthropologist Audra Simpson articulates how this historical consciousness of a diplomatic history of negotiation rather than charity continued for generations, right to the present.[14] Additionally, numerous studies have revealed the ways in which the written content of many treaties made between First Nations and successive settler states did not match the oral promises that treaty negotiators had articulated.[15] In fact, according to Métis legal scholars Yvonne Boyer and Sheyenne Spence, "through oral promises made in the negotiations of all numbered treaties there exist treaty rights to health."[16] Furthermore, Boyer has also argued that because written versions of the various numbered treaties repeatedly referenced

[13] J.R. Miller, *Compact, Contract, Covenant: Aboriginal Treaty Making in Canada* (Toronto: University of Toronto Press), 22, 49-50.
[14] Audra Simpson, *Mohawk Interruptus: Political Life Across the Borders of Settler State* (Durham: Duke University Press, 2014), 32.
[15] Grand Council Treaty #3, *'We Have Kept our Part of the Treaty': The Anishinaabe Understanding of Treaty #3.* (2011) https://manitoumounds.com/wp-content/uploads/2020/10/We-Have-Kept-Our-Part-Of-The-Treaty-Booklet.pdf; Yvonne Boyer and Sheyenne Spence, "Identifying and Advancing the Treaty Right to Health…Signed from 1871 and 1906 in Manitoba," *Revue francaise d'études américaines,*144, no. 3 (2015): 95-108; Treaty 7 Tribal Council et al., *The True Spirit and Original Intent of Treaty 7* (Kingston-Montreal: McGill-Queen's Press, 1996); John S. Long, *Treaty No, 9: Making the Agreement to Share the Land in Far Northern Ontario in 1905* (Kingston-Montreal: McGill-Queen's Press, 2010); Brittany Luby, "The Department is Going Back on These Promises": An Examination of Anishinaabe and Crown Understandings of Treaty," *The Canadian Journal of Native Studies* XXX, no. 2 (2010): 203-228; Wayne Daugherty, "Treaty Research Report: Treaty Three (1873)" Treaties and Historical Research Centre, Indian and Northern Affairs, 1986).
[16] Yvonne Boyer and Sheyenne Spence, "Identifying and Advancing the Treaty Right to Health…Signed from 1871 and 1906 in Manitoba," *Revue francaise d'études américaines* 144, no. 3 (2015): 98.

the federal government's duty to protect, and not to interfere with First Nations peoples, those provisions contain an implied treaty right to health in both Indigenous and Western forms. As Boyer states "a limitation of Aboriginal rights to health would violate the sovereign's promise of protection."[17] Such a covenant was far more than an expression of a moral duty. In their submissions to the Joint Committee, many First Nations in Ontario discussed the need for improved health care as part of their call for the federal government to better respect treaty rights.

It is important to note that an expectation that treaty signing would include the protection of First Nations physical health and overall wellbeing could not have been seen as an unrealistic expectation. In his history of the 1905 Treaty 9 agreement, historian John S. Long elucidated that "after two centuries of fur trade experience, the northern Ojibwe and Cree would have now expected the Crown to protect them, helping them in times of need for an indefinite period—indeed, forever."[18] Moreover, according to historians Mary Jane Logan McCallum and Maureen Lux, settler patterns of practice, namely the offering of medical care and vaccinations during annual treaty ceremonies, "no doubt confirmed the link between the two."[19] But a fundamental challenge to this expectation came from the federal government's own priorities. Long goes on to explain how Frank Pedley, the recently appointed deputy superintendent general of Indian Affairs

[17] Yvonne Boyer, "Aboriginal Health: A Constitutional Rights Analysis, "Discussion Paper Series in Aboriginal Health U*niversity of Saskatchewan Native Law Centre*, (June 2003): p. 9-10. Boyer's argument can also be easily extended to treaty-making that pre-dated the numbered treaties period. Sir Francis Bond Head, for example, at an 1836 treaty-making session with Odawa and Ojibwa stated, "it has become necessary that new arrangements should be entered into for the purpose of protecting you from the encroachments of the whites." Cited in J.R. Miller, *Compact, Contract, Covenant,* 107.

[18] Long, *Treaty No. 9,* 23.

[19] Mary Jane Logan McCallum and Maureen Lux, "Medicare versus Medicine Chest: Court Challenges and Treaty Rights to Health Care," in *Medicare's Histories: Origins, Omissions, and Opportunities in Canada*, ed. Esyllt W. Jones et al. (Winnipeg: University of Manitoba Press, 2022), 104. Elsewhere, Lux argued that a similar connection held true for Indian hospitals. She explained, "Indian hospitals, particularly those situated close to reserves and increasingly staffed by Aboriginal workers, became tangible manifestations of a treaty or legal right, and community leaders took propriety interest in their operations." Lux, *Separate Beds,* 103.

during the Treaty 9 negotiations, desired "not to respond to the Indigenous peoples' pleas for support and protection" but to ensure "'an extinguishment of the Indian title to lands…which [he felt] may be considered to be necessary in view of railway construction, advancing settlement etc.'"[20] Written acknowledgement of a treaty right to care was thus not impossible, but merely unwanted, or at least not a priority for Pedley and his government. Crucially, despite Pedley's aims and later government rhetoric, the land encompassed in Treaty 9 was never surrendered. As Long explains, "Indigenous peoples agreed to accept presents [treaty annuities and services] that to them signified a renewal of their commitment to the fur trade's middle ground of compromise and coexistence."[21] For First Nations, medical care was a privilege born from resource sharing, not an act of moral charity.

In the many decades that followed, this interpretation remained ostracized from federal discourse. Scholars such as historian Brittany Luby have demonstrated the early and complete misrepresentation of treaties as land surrender rather than land-sharing agreements and the marshalling of that myth as a tool of colonialism. In her study of the Anishinaabe and Crown understandings of Treaty 3, Luby outlined the destructive attacks on Anishinaabe well-being through denial of access to the best farmland, the loss of guaranteed mineral rights, and the domineering presence of the Crown through the work of the Canadian state.[22] Such efforts not only facilitated multifaceted suffering but also limited the resources that First Nations peoples could marshal to assert their treaty rights. The power of the Canadian state to generate support for

[20] Long, *Treaty No. 9,* 52. Memorandum to Clifton Sifton, 17 August 1903. Cited in Long, *Treaty No. 9,* 52.
[21] Long, *Treaty No. 9,* 352.
[22] Brittany Luby, "The Department is Going Back on These Promises": An Examination of Anishinaabe and Crown Understandings of Treaty," *The Canadian Journal of Native Studies* XXX, no. 2 (2010): 203-228.

their interpretation ensured the dominance of settler-perspectives despite on-going calls for a different kind of relationship.

Furthermore, to establish a service based on benevolence rather than obligation, settlers framed "the Indian" as primitive and incapable on their own, and thereby "justified" White settler paternalism and control. For example, Claxton in his address to the joint committee criticized the "Indian mode of life." Significantly, Claxton offered little definition of what he understood the "Indian mode of life" to be beyond the acknowledgement that while some individuals lived in "settled parts of the country" most lived nomadic, or semi-nomadic, lives by trapping, hunting, and fishing. It was this mode of life, Claxton believed, that had caused individuals and communities to endure a low standard of living. He went on to explain that as a result, many families were unable to secure "suitable food for their children" and attributed Indians' high infant mortality rate to this perceived cultural inability to secure sufficient nutrition for their children. In addition, Claxton also echoed the racialized belief that "Indians… have little idea of hygienic methods of preparing or caring for food" which too was felt to cause ill-health in children.[23] Thus, while earlier ideas about First Nations as a race that was more biologically susceptible to disease had begun to lose favour in scientific and government circles, the pathologization of the "Indian race" continued in an altered form. Instead of framing Indigenous peoples as possessing bodies that were biologically weaker than White bodies, now criticism focused on Indigenous cultural behaviour.[24] Hence, the post-war period was not the period of profound transformation that calls

[23] Brooke Claxton address to the Joint House of Commons-Senate Committee on Indian Administration, RG 26 Vol 71, LAC.

[24] Such race-focused prescriptions were echoed in the period's medical journals. The published findings of a 1947 nutrition study in James Bay, in which Percy Moore participated, commented that "The Indian must be taught in a simple and practical way the elementary rules of sanitation and health, and the need for better preservation, preparation and choice of food." R. P. Vivian, et al., "The Nutrition and Health of the James Bay Indian," *Canadian Medical Association Journal* 59, no. 6 (December 1948): 518.

in political circles to turn away from overt racism might suggest. Rather, racism was simply reconfigured.[25]

In juxtaposition to Indians, White settlers were presented as modern, healthy, and capable, even when such descriptors were not borne out in fact. Part of the rationale for integration was the notion that First Nations peoples had to be trained to properly feed their children or create sanitary living conditions fit for the "modern age." Ironically, the children forcibly removed from their families and made to live in residential schools experienced the very conditions purportedly created through First Nations' "mode of life". In a personal letter to Percy Moore from the medical superintendent of the Sioux Lookout District, Cameron Corrigan expressed significant worry about the health of the children at the Pelican Lake Residential School. Not only did the children live in crowded quarters, Corrigan explained, but many also spent up to six weeks in such conditions before any form of physical examination was made. As a result, some children who had arrived at the school with negative tuberculin tests contracted tuberculosis while in residence.[26] The nutrition standards were little better than the living conditions. After admitting a child for scurvy, Corrigan conducted

[25] Critical Race Scholar Kimberlé Crenshaw warns against race discourse that centres around "big eventism," the use of "big events around which people say the nature of our racial society had been completely transformed." Using the example of the Civil War, Crenshaw argued that such interpretations can obscure the racial antecedents of a period's racism and present post-war racial segregation as "just something to do with our cultural habits" rather than a continuation of the race-based slavery rhetoric and practice. Kimberlé Crenshaw "Race, Gender, Inequality and Intersectionality" at Symposium-- "Race Today: A Symposium on Race in America." Brown University, 2015, https://www.youtube.com/watch?v=KNKbGFoYC1Q

[26] In addition to concern over the spread of contagious disease, IHS officials also reported on infrastructure problems. Writing to P.E. Moore about the Bishop Horden Residential School on Moose Factory Island, B.H. Harper explained that "the septic tank was in such a mess that the fluid contents were seeping through the grounds in the immediate vicinity of the back door of the school and the odour caused thereby both outside and inside the building was most repulsive." Even though the school had experienced an outbreak of typhoid from contaminated water three years prior, efforts to fix the issue did not last long. Harper stressed that unless more was done the health of the children would suffer. Letter from. B.H. Harper, Acting Medical Superintendent at Moose Factory Indian Hospital, to P.E. Moore, (11 December 1950), RG 29 Vol 2907 File 851-1-A486 Pt. 5, Indian and Northern Health Services, James Bay District, Moose Factory, ON, LAC. For more on the 1947 typhoid outbreak see, RG 29 Vol 2906 File 851-1-A486 Pt. 3, LAC

a nutrition survey of the students. He found that many of the children had mild scurvy and a general state of vitamin deprivation. When Corrigan advised the principal about the importance of oranges and fresh vegetables, the principal responded he could not afford them. Instead, children were fed meals that visiting IHS workers refused to eat themselves.[27] Absent from the report were any comments regarding the inabilities of the White race to raise healthy children in their care. In contrast, racialized tropes of the "primitive" and "incapable Indian" were repeatedly employed to defend the incursion of White settlers into the lives and lifestyles of First Nations communities, the people so many settlers viewed as the "most helpless of all Canadians."[28]

Integration may have been born from a sincere desire to improve the health of First Nations peoples, but settler investment in the exclusive power to define the terms of health, healthy living, and health care access, tainted the intentions of integration policy makers. By assigning a "good life" to the prescriptions of White settler society, settler leadership both actively devalued and dismissed First Nations own knowledge, their bodies, and their communities. For many settlers, Indians were not ready to reflect the behaviours of White citizenship, including the ability to meet its responsibilities. Instead, the state viewed First Nations individuals as citizens of the future—a Citizen* — a kind of in-between citizen, absorbed but unwanted by the settler state as the dangerous other.[29] While the term itself was not used in contemporary documents, I use the term

[27] Despite a general rule against the use of lard in residential schools, Corrigan discovered its evident use at the school. Letter from Cameron Corrigan to P.E. Moore, (6 April 1951), RG 29 Vol 2911, File 851-1-A494 Pt. 3, Indian and Northern Health Services, Sioux Lookout District, LAC.

[28] James Y. Nicol, "Epidemic Hits Trappers, Dog Trip Saves Woman," *Toronto Evening Telegram, February 28, 1949*. Filed in RG 29 Vol 2907 File 851-1-A486 Pt. 5 Indian and Northern Health Services, James Bay District, Moose Factory, Ont, LAC. Likewise, Wilfrid Case (Progressive Conservative) reminded his colleagues in the House of Commons of the difficulty of the problem to "help those who apparently cannot help themselves." Wilfrid Garfield Case (Grey North), Edited Hansard. 20th Parliament, 3rd Session (June 20, 1947). Retrieved from LiPaD: The Linked Parliamentary Data Project. Lipad.ca/full/permalink/1478721

[29] Eve Tuck and K. Wayne Yang describe the association of an asterisk with an Indigenous population in a settler colonial state as a "settler move to innocence." The use of the asterisk highlights racialized difference while at the

Citizen* to encapsulate a process of symbolic asterisking that must be revealed to understand the enactment of settler colonialism and systemic racism. For the majority of setter governments and officials of the period, the Indian otherness of specific individuals was a difference to be identified, used, managed, and ultimately removed when First Nations peoples learned to abandon their desires for cultural and political sovereignty.

Thus, political plans for integration were complicated. To integrate First Nations individuals into Canadian society and citizenship, the DHNW first called for the expansion of a separate service. While at first glance, such an approach seems contradictory, department leadership viewed this action as a necessary step to the integration process. Department officials needed to manage the conceptual and material consequences of racialized settler-colonialism. Settler-colonial racism had framed "the Indian" as a diseased menace unable to care for themselves; land theft had placed many First Nations peoples in conditions of poverty and deprivation.[30] Ottawa thus believed it was required of them to commit to a period of transitional preparation and training. Notably, because the IHS and most settler society viewed First Nations suffering as the product of a primitive community left to their own devices, the focus of change was placed on the shoulders of First

same time obscures Indigenous sovereignty by placing Indigenous peoples within a group, confined to the margins. Here, I build on this argument in using the term citizen* to focus specifically on the marginalization of First Nations individuals within citizenship discourses. Eve Tuck and K. Wayne Yang, "Decolonization is not a metaphor," *Decolonization: Indigeneity, Education and Society* 1, no. 1 (2012): 22.

[30] Nishaabeg scholar Leanne Betasamosake Simpson clarifies the destructive influence of settler-colonialism in her community, an experience emblematic of many First Nations. Simpson explains that "over the past two-hundred years, without our permission and without our consent, we have been systematically removed and dispossessed from most of our territory. We have fought back as our homeland has been stolen, clear-cut, subdivided, and sold to settlers from Europe and later cottagers from Toronto." Simpson also highlighted the specific consequences of settler-interpreted treaty-making, explaining that through the Williams Treaty (1923), communities "had lost their hunting and fishing rights through the fraudulent processes of signing the treaty (which wasn't negotiated), in the midst of a century of environmental destruction (of wild rice beds and fish populations through the construction of the Trent-Severn Waterway), settler encroachment and dispossession…destroyed the foundation of our economy." Leanne Betasamosake Simpson, *As We Have Always Done: Indigenous Freedom Through Radical Resistance* (Minneapolis: University of Minnesota Press, 2017), 4, 106.

Nations peoples. While IHS would intensify assistance to extend health care services, the goal was to assist First Nations so that "they can *themselves* gain a better living as the basis for good health, greater welfare and a better life" on settler terms.[31] The prescription was self-help, not sovereignty.

The Early Days of Integration at IHS

In his address to the joint committee, Claxton used a portion of his time to describe a long history of settler generosity and benevolence. From as early as 1639, when the Hotel Dieu of Quebec offered "some 200 Indians…relief at the hands of the nursing sisters," to the expansion of health services for First Nations peoples in the first half of the 20th century, Claxton argued that settlers had repeatedly demonstrated a willingness to help those they deemed in need.[32] Indeed, many annual reports of IHS in the early years of integration devoted significant space to recount the narrative of settler aid to First Nations communities. In the post-war period, the federal government was ready to maintain both its pattern of service extension and its rationales. In fact, Ottawa sought to increase its authority over the Churches who too had a long history of service extension to First Nations peoples.[33]

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[31] Brooke Claxton address to the Joint House of Commons-Senate Committee on Indian Administration, RG 26 Vol 71, LAC. Emphasis added. The reality that First Nations individuals were offered equality with White Canadians is also evident in the presumed need in government reports to justify extra-ordinary efforts in TB management. For example, when late 1940 IHS reports explained that on an annual basis approximately 50% of "the Indian population" receives chest x-rays, the report immediately added that "this…more intensive program than is carried out in the white population," but argued such inequality in treatment was necessary due to the three times higher rate of incidence in First Nation populations. RG 29 Vol 2866 File 851-1-1, Medical Services Operations, LAC.

[32] The Dominion government's first official attempt at an organized health service for First Nations peoples came with the appointment of Dr. Peter H. Bryce as General Medical Superintendent in 1905. As a result of his criticism of government inaction in the face of devastating TB rates at residential schools, Bryce was relieved of his duties concerning First Nations peoples in 1910. The position of Medical Superintendent remained vacant until E.L. Stone was appointed in 1927. Between 1880 and 1945 the parliamentary vote for First Nations health services increased almost 600-fold. Brooke Claxton address to the Joint House of Commons-Senate Committee on Indian Administration, RG 26 Vol 71, LAC.

[33] In 1945, the Minister of Mines and Resources, Thomas Crerar received a letter from the Bishop M. Lajeunesse of The Pas Manitoba, which suggested the Roman Catholic Church felt it ought to be consulted on matters related to

Claxton, however, was willing to admit that the efforts of the Canadian government in the past had failed to sufficiently improve First Nations health, a reality borne out in department statistics. In 1944, First Nations suffered from tuberculosis on average at a rate of 708.2 deaths per 100,000, a staggeringly high number in comparison to the rate among those listed as "Whites," which was 41.6. Examination of other causes of death such as pneumonia, measles, and accidental or violent deaths revealed disproportionate realities equally damning for the government.[34] Moreover, Claxton expressed concern that the very health profiles of each community demonstrated a division along racial lines. Whereas First Nations peoples were known to die most frequently from tuberculosis, pneumonia, and diseases of the first years of life, the causes of death for Whites were largely diseases of the heart, cancer, and stroke, diseases more often associated with middle or old age. Within the post-war spirit of improved standards of living and a desire to end overt racial discrimination, Claxton committed the new DNHW to the belief that "it is impossible to segregate the Indians for the sake of protecting their health…they should be welcomed and treated as Canadians as they have every right to so regard themselves. This will mean that they must be given full opportunity…for the maintenance of sound health."[35] As the previous chapter explored,

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First Nations policy. In his response, Crerar was emphatic. He began, this letter "appears to raise the question as to who has the primary responsibility for welfare of the Indians, the State or the Church," and then explained that "the Indians are definitely wards of the state, and I am certain that, in any public discussion of an issue of this kind, public opinion would indubitably affirm the primary responsibility of the state in the care of Indians." Shortly after this letter was sent, IHS' new home department would again confirm the federal government's belief that First Nations were wards of the government. Letter from Thomas Crerar, Minister of Mines and Resources, to Bishop M. Lajeunesse, 1945, LAC RG 29 Vol 2866 File 851-1-1 Part 1, Medical Services Operations, LAC.

[34] The cause of death rates for pneumonia among "Indians" and "whites" in 1944 was 357.2 and 46.7 respectively; for measles 64.5 and 1.4; for accidental and violent deaths 223.8 and 63.7. Such rates are even more staggering given the staggering difference in population size. In 1944, the Canadian census counted 11, 946,000 Canadians whereas First Nations and Inuit collectively amounted to 1% of that population (125, 686 and 7700 respectively). Brooke Claxton address to the Joint House of Commons-Senate Committee on Indian Administration, RG 26 Vol 71, LAC.

[35] Brooke Claxton address to the Joint House of Commons-Senate Committee on Indian Administration, RG 26 Vol 71, LAC.

politicians believed that the solution to Canada's "Indian problem" lay in the equalizing efforts of the state.[36] Certainly, Percy Moore, who had served IHS under the previous policy of assimilation and segregation, admitted that the IHS needed a new level of attention and investment in First Nations health care. While Moore believed that "anything approaching adequate medical services" would be costly, he was convinced that the improvement in health conditions would "pay dividends."[37]

On November 1, 1945, Moore sent a memorandum to his new deputy minister, Brock Chisholm to introduce the current state of government efforts to extend health services to First Nations communities. Chisholm, who had joined DNHW immediately following its creation in 1944, had also played a key role in the development of the Green Book proposals. This background gave Moore reason to hope that his new DM would be open to greater investment in First Nations health and welfare. At the start of the integration period, Moore explained to Chisholm that IHS had a sizeable complement of hardworking staff ready to meet the challenges of the time.[38] But by the

[36] Maureen Lux's work reveals that the embrace of the integration ethos was not limited to the federal government. At a 1945 meeting of the Advisory Committee for the Control and Prevention of Tuberculosis among Indians, Lux demonstrated that provincial health bureaucrats and sanatorium directors joined the federal government to discuss the "need for Aboriginal people to embrace the values of Christian capitalist workers…[and] to 'raise up the Indian' to embrace the advantages and especially the responsibilities of citizenship. Maureen Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s* (Toronto: University of Toronto Press, 2016), 39.

[37] Letter from P.E. Moore to Brock Chisholm, (1 November 1945), RG 29 Vol 2866 File 851-1-1 Pt. 1, Medical Services Operations, LAC.

[38] Moore wrote, "our field officials are as follows: 11 full time permanent medical officers, 3 full-time temporary officers, 2 permanent full time medical officers whose salaries are paid from Band funds, 33 permanent, part-time medical officers, 39 temporary part time medical officers, [and] thirteen field nurses full time." In addition, Moore added "there is a variety of positions that are filled part time on a basis of payment for services rendered. These positions include, doctors, nurses, field matrons, drug dispensers, and others who give some assistance in medical care to natives in remote areas." Percy Moore Letter to Brock Chisholm, (November 1945), RG 29 Vol 2866 Vol 851-1-1 Part 1, Medical Services Operations, LAC. In the early stages of integration, there remained some overlap with the Indian Affairs Branch, the former home of Indian Health Services. For example, certain IHS had no business offices or office staffs, and therefore remained dependent on the Indian Agent's office for these services. In addition, in some locations, the Indian Agent also served in the role of Health Officer, who under direction of a medical attendant, served as a representative for IHS decision-making. Letter from Percy Moore to Brock Chisholm, (November 1945), RG 29 Vol 2866 File 851-1-1 Pt. 1, Medical Service Operations, LAC.

following July, Chisholm left the federal service to take up a position at the World Health Organization. Moore was thus forced once again to make the case that the current provision of health care services to First Nations peoples needed further investment. In no uncertain terms, Moore admitted to Chisholm's successor, G.D.W. Cameron, that in certain areas, medical facilities were "hopelessly inadequate."[39] In the Sioux Lookout Agency, for example, the community was serviced by only a part-time physician and an overcrowded small municipal hospital. In addition, three mining companies had physicians on staff but, as we shall see, IHS policy made access to these services difficult. Apart from these services, the community was neglected save for the annual visits of the treaty party and the occasional mercy flight.[40] For an administrative region that contained 14 administrative "bands" and a population of 4,634 individuals, such arrangements were hardly sufficient. In what department officials referred to as the more "settled" areas of the province, the limitations were less institutional, and more personnel related. The most urgent need of these areas was for an increase in public health nurses who could extend the reach of the Service beyond an institutional focus on cure to a settler-defined program of illness prevention training.

At the next meeting of the Dominion Council of Health the following May, Moore was ready to outline a program for a marked expansion of services.[41] Given Moore's careful attempts to avoid any suggestion that the IHS sought to duplicate existing services in the provinces, he was granted the authority to oversee the appointment of eight regional superintendents who would have "full

[39] Memorandum from P.E. Moore to G.D.W. Cameron, Deputy Minster, Health and Welfare, 10 April 1946), RG 29 Vol 2866 File 851-1-1 Pt. 1 Medical Services Operations, LAC. Cameron, a contemporary of Chisholm, joined the DNHW in 1945 as the Director of Health Services. He served as Deputy Minister of Health from 1946-1965.
[40] Memorandum from P.E. Moore to G.D.W. Cameron, Deputy Minster, Health and Welfare (10 April 1946), RG 29 Vol 2866 File 851-1-1 Pt. 1, Medical Services Operations, LAC.
[41] The Dominion Council of Health was a permanent body of ministers and deputy ministers of health at the federal and provincial level. Their role was to coordinate and correlate the activities of the federal and provincial Departments of Health.

authority to deal with health problems", the opening of new Department hospitals and the building of 60 nursing stations.[42] With the blessing of the new minister, Paul Martin, to "provide and complete a health service to all Indians and Eskimos who are wards of the dominion government," Moore's vision saw success.[43] Between 1946 and 1949, Indian Health Services tripled their personnel and in one fiscal year, added 291 institutional beds, opened 11 new nursing stations and twelve dispensaries.[44] Growth in departmental facilities continued over the years so that by 1956 IHS institutions counted 18 hospitals, 40 nursing stations, 59 health centres, and 27 clinics.[45] Overall, the budget of IHS had increased almost sevenfold.[46]

Table 1: Allotment Statement of Expenditures of the DNHW

Fiscal Year Ended	IHS Expenditure	Total Department Expenditure	Percentage of Total
1946	$2,344,082.45	$212, 494,970.52	1.1
1947	$3,857,744,34	$289,684,737.64	1.3
1948	$5,467,857.79	$332,069,388.90	1.6
1949	$8,016,896.78	$359,582,689.11	2.2
1950	$9, 924,124.00	--	--
1951	$10, 285, 667.75	$448, 852, 907.05	2.3

Data collected from Department of National Health and Welfare, Annual Report for the Fiscal Year Ended March 1946-1949, Ottawa: Queen's Printer, 1949. Accessed, Internet Archive, September 2021, and Treasury Office, DNHW, Allotment State of Expenditures as of March 31, 1951, RG 29 Vol 1846, File R120/1000-1/90-4, Library and Archives Canada, Ottawa, Ontario.

[42] Minutes of the 49th Meeting of the Dominion Council of Health, May 13-15 1946, Microfilm Reel C-9816, LAC.
[43] Paul Martin (Essex East), Edited Hansard. 20th Parliament, 3rd Session (June 20, 1947). Retrieved from LiPaD: The Linked Parliamentary Data Project. Lipad.ca/full/permalink/1478711
[44] Of the 291 institutional beds added, 118 beds were lost in fires at the Coqualeetza Indian Hospital at Sardis, BC and the Hobbema Indian Hospital, Alberta.
Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1949,* Ottawa: Queen's Printer, 1949. Accessed, *Internet Archive*, September 2021.
[45] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1956,* Ottawa: Queen's Printer, 1956. Accessed, *Internet Archive*, September 2021. It is worthwhile to note that the spread of institutions did not correlate with population. Ontario, which had the largest population of First Nations peoples (37,249) contained only three of the department's hospitals and seven nursing stations. In contrast, Manitoba with a population of 19,684 contained six hospitals and eight nursing stations; Claxton described nursing stations to the joint committee as "about the size of a small bungalow and contain quarters for a nurse, Indian maid or housekeeper, and possibly one or two one-bed rooms for emergency cases. They are not hospitals in the ordinary sense of the word but will be centres to which the Indians may go for medical advice and help." Brooke Claxton address to the Joint House of Commons-Senate Committee on Indian Administration, RG 26 Vol 71, LAC.
[46] By the 1950-1951 fiscal year, "Medical Services for Indians and Eskimos" accounted for 2.3 percent of the DNHW's Health Administration funds, a total of $10,285,667.75 out $448, 862, 907.05. Treasury Office, DNHW, Allotment State of Expenditures as of March 31, 1951, RG 29 Vol 1846, File R120/1000-1/90-4. LAC. See also Appendix A.

Among the annual reports of the DNHW, there emerge two very clear areas of IHS interest: the control of infectious disease and health education. Given Moore's background in TB and nutrition studies, it is not surprising to see the clear focus of the department on these issues. More significantly, such topics aligned with the government's priorities to limit the spread of infectious disease to neighbouring communities and, with health education, to help First Nations individuals to help themselves.[47] As Maureen Lux has revealed, the Department's growing cadre of Indian Hospitals focused predominately on the treatment of tuberculosis.[48] Beyond hospital walls, the officials of the IHS and their partners in Indian Affairs, the provincial departments of health, and volunteers conducted x-ray and immunization campaigns, printed booklets, posters and calendars and made "every effort…to improve the standard of living by demonstration, example, and gentle pressure."[49] As early as 1948, such efforts had produced results. The mortality rate among First Nations had declined by 17% and by 1956, tuberculosis, the once chief killer, had fallen to eighth position. Members of the House of Commons took notice. William Scottie Bryce (CCF) celebrated the recent work of IHS, reminding his colleagues that "The Indians of Canada for the last forty or fifty years have been a neglected people, and anybody who had the welfare of the Indian at heart welcomes this new approach."[50] But was it really the best of all possible worlds?

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[47] A federal nutrition division had been created in 1941 and in 1947, the DNHW established the Division of Epidemiology. For more on nutrition see: P.E. Moore, "Tuberculosis Control in the Indian Population of Canada," *Canadian Public Health Journal* 32, no.1 (January 1941): 13-17; R. P. Vivian, et al., "The Nutrition and Health of the James Bay Indian," *Canadian Medical Association Journal* 59, no. 6 (December 1948): 505-518.

[48] Lux, *Separate Beds.*

[49] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1949,* Ottawa: Queen's Printer, 1949. Accessed, *Internet Archive*, September 2021. Recent scholarship has revealed that the focus on health education and improved standards of living were pursued not only for First Nations benefit but at their expense as well. Ian Mosby explores this reality in his investigation of nutrition experimentation using First Nations children in Indian Residential Schools. See Ian Mosby, "Administering Colonial Science: Nutrition Research and Human Biomedical Experimentation in Aboriginal Communities and Residential Schools, 1942-1952," *Histoire sociale/Social History* 46, no. 9 (May 2013): 145-172.

[50] William Scottie Bryce (Selkirk, Manitoba), Edited Hansard. 20th Parliament, 3rd Session (June 20, 1947). Retrieved from LiPaD: The Linked Parliamentary Data Project. Lipad.ca/full/permalink/1478713

For all that the IHS endeavoured "to provide prompt modern active treatment to the sick," its chief focus on the actualization of "aggressive" public health programs created problematic circumstances.[51] Such a goal made little space for the fears and priorities of First Nations communities. Instead, concerns both for and of the rate of infectious disease in First Nations communities facilitated a framework of thinking in which coercion was considered a public health imperative.

Even before the vigorous public health campaign against tuberculosis in the early years of the IHS, Percy Moore, still at Indian Affairs, advised his officials of the value of compulsory treatment. On July 21st, 1944, Dr. G.L. Bell, a surgeon in Sioux Lookout, wrote with apparent concern to Sioux Lookout Indian Agent Mr. G. Swartman. Bell explained that a member from the Lac Seul Band and patient at the Dynevor Sanatorium in Selkirk, Manitoba, insisted on leaving the sanatorium to return home. The letter failed to mention the reasons this individual wanted to leave the institution and, instead, focused on the fear that an open case of tuberculosis would become "a source from which this disease will spread to other members of the bands." Avoiding any discussion of the kinds of economic and environmental conditions that facilitated tuberculosis in the first place, Bell was distressed that the government's case finding efforts would be "rendered null and void if Indians are permitted to return from sanatorium and circulate among the general Indian population."[52] Swartman took swift action. While he did not know the particulars of the case, in

[51] The Work of the Directorate of Indian Health Services, in letter from Eric J. Preston to H.A. Procter, Assistant Director, Indian Health Services, (10 November 1949), RG 29 Vol 2866 File 8510101 Part 1 [B], Medical Services Operations, LAC.
[52] Gordon L. Bell to Gifford Swartman, RG 29 Vol 2911 File 851-1-A494 Pt. 2 Indian and Northern Health Services, Sioux Lookout District, Sioux Lookout, ON, LAC.

accordance with Dr. Bell's wishes, he instructed the physicians at Dynevor to hold the individual in question. The following day, he wrote to his superiors at the Indian Affairs Branch. Within four days, Percy Moore advised Swartman that "the department is willing to use any moral or legal suasion to prevent Indians who are infectious from leaving hospital against advice." He went on to say that should the First Nation individual insist on leaving the institution, the police would be sent to return him. To reassure Swartman that the rule of law was on his side, Moore outlined the various legal tools at his disposal, including the Regulations for Medical Services and the Manitoba Act, to compel the individual to return to treatment at Dynevor.[53]

The following year, Swartman wrote again to Moore with a somewhat more empathetic description of the situation on the ground. Swartman highlighted the feelings of antagonism among First Nations communities who were forced to send their members far away for treatment. This situation made it almost impossible for family members to visit loved ones in care and caused many to say goodbye to their friends and family with "a fatalistic feeling comparable to a condemned man approaching the gallows." Swartman ended his letter by stating, more often than not, such a feeling was fully justified.[54]

First Nations agitation and Swartman's appeal to Department officials had some influence. An Indian hospital was opened at Sioux Lookout in the summer of 1949. Unfortunately, the limitations of the facility with respect to surgery and the persistent distrust of First Nations decision-making

[53] P.E. Moore to Gifford Swartman, RG 29 Vol 2911 File 851-1-A494 Pt. 2, Indian and Northern Health Services, Sioux Lookout District, Sioux Lookout, ON, LAC.
[54] Gifford Swartman to P.E. Moore (December 1945), RG 29 Vol 2911 File 851-1-A494 Pt. 2 Indian and Northern Health Services, Sioux Lookout District, Sioux Lookout, ON, LAC.

resulted in the maintenance of earlier patterns.[55] In the summer of 1951, Cameron Corrigan, the medical superintendent appointed for the Sioux Lookout Agency, wrote to Moore to defend himself against Swartman's criticisms that IHS continued to send First Nations patients out of province. Corrigan argued that Swartman's promise to community members that they could be treated in the Sioux Lookout Indian Hospital was impossible to achieve because "practically no surgical treatment was carried on here." Moreover, while Corrigan stressed that he always requested individuals come to hospital of their own volition for treatment, he admitted that when an individual "absolutely refused" to come, he invited the police to take over.[56] IHS public health imperatives overshadowed viewpoints and priorities of First Nations individuals.

Corrigan's actions were emblematic of similar efforts to compel treatment across the service. In 1953, Percy Moore circulated copies of the new Indian Health Regulations to members of the Dominion Council of Health. The Regulations had been recently enacted in the *Indian Act* for the purpose of requiring compulsory examination or treatment of infectious diseases in First Nations individuals. As part of the federal government's wider efforts to integrate First Nations peoples

[55] Maureen Lux explores the continued commitment of medical professionals and government staff to use institutional treatment for First Nations populations, even after the emergence of effective chemotherapy. She explains that the preference for confinement was "directed at those who through ignorance or social position had not yet acquired the knowledge and understanding to be rational healthy citizens." Maureen Lux, "Care for the 'Racially Careless': Indian Hospitals in the Canadian West, 1920-1950s," *The Canadian Historical Review* 91, no. 3 (September 2010): 420.

[56] Cameron Corrigan to P.E. Moore, (8 August 1951) RG 29 Vol 2911 File 851-1-A494 Pt. 3, Indian and Northern Health Services, Sioux Lookout District, Sioux Lookout, ON, LAC. It is difficult to ascertain a complete picture of the frequency of such unauthorized departures and subsequent apprehensions. The records accessible to this study, however, do contain many references to IHS calls for police intervention. For example, in November of 1948, O. Leroux, Assistant Director of Indian Health Services noted that five individuals had departed from sanatorium care against authorities' advice. In addition, we know that in the Zone Monthly Report for the Sioux Lookout Agency in March 1962, it was noted that there was an AWOL problem every month at the Fort William Sanatorium. See Letter from O. Leroux to Mr. J.G. Burk, Superintendent, Indian Agency Port Arthur, (2 November 1948), RG 29 Vol 2911 File 851-1-A492 Pt. 2. Indian and Northern Health Services, Lakehead District, Thunder Bay, ON, LAC; Canadian Mounted Police Report—Moose Factory Detachment, (12 April 1948) and Indian—Rupert's House, P.Q. Assistance to IHS, DNHW, (2 April 1948), RG 29 Vol 2907 File 851-1-A486 Pt. 4, Indian and Northern Health Services, James Bay District, Moose Factory, ON, LAC.

into Canadian society, the Regulations, which applied to every person residing on a reserve or "every Indian who follows the Indian mode of life whether or not he ordinarily resides on a reserve," subjected First Nations individuals "to all laws and regulations in force within a province relating to health and sanitation."[57] In effect, the addition of provincial legislation to the tools available for the federal compulsion of First Nations treatment revealed, as historian Maureen Lux has argued, "the limits of Canada's liberalism;" the Regulations of 1953 continued to target a specific population and, "made clear the association of Aboriginal illness with criminality and subsequent incarceration."[58]

Even for those Department officials who claimed to avoid the use of force, the regulations offered a renewed interest in this possibility. Writing to Percy Moore in 1955, Dr. J.H. Wiebe, medical superintendent at Six Nations, informed his superior that he had, for the first time, drawn on the legal tools available to him and employed Form 7018B of the Indian Health Regulations, an order of apprehension for a Six Nations man who had elected to leave treatment at the Brant Sanatorium.[59] The move put no small amount of pressure on this individual to return to settler care. The regulations stated that any person who refused to comply with the orders faced the threat of a hundred dollar fine, three-month imprisonment, or both.[60] Moreover, when the patient in question was a child, IHS invested authority in the local Indian agent with power to consent to treatment,

[57] Minutes of the 64th Meeting of the Dominion Council of Health, (October 1953), Microfilm Reel C-9816, LAC.
[58] Lux explained that "most provincial jurisdictions did not infringe on civil liberties of the tuberculous through compulsory detention, but the sweeping powers of the Indian Health Regulations were another reminder that Aboriginal people remained wards of the state without the liberties of citizens." Lux, *Separate Beds*, 117-118. The Indian Health Regulations stated that "a superintendent or medical office may enter, in the daytime, any dwelling or other premises situated on the reserve under his charge, to inquire as to the state of health of any person therein or to examine the hygienic condition of the dwelling or other premises." Minutes of the 64th Meeting of the Dominion Council of Health, October 1953, Microfilm Reel C-9816, LAC.
[59] Letter from Dr. J.H. Wiebe to P.E. Moore, (1955), RG 29 Vol 2904 File 851-1-A479 Pt. 1, Indian and Northern Health Service, Brantford District, LAC.
[60] Minutes of the 64th Meeting of the Dominion Council of Health, (October 1953), Microfilm Reel C-9816, LAC.

including surgery, without the need to consult the parents. Thus, rhetoric and reality did not seem to match. As much as politicians had championed the invitation to citizenship for First Nations peoples that promised equality in treatment, settler priorities and racialized perspectives facilitated a differential experience.

Once returned to IHS or partner institutions, settler-colonial anxieties made little space for First Nations presence beyond a desire to see them as passive patients. When First Nations individuals refused to operate within the confines of this artificial representation, the ire of department officials was clear. In 1953, the medical superintendent of the Freeport Sanatorium in Kitchener, Ontario sent a letter to Dr. Barkley McKone (Moose Factory), in which he explained that one of his First Nations patients was eager to return to treatment at the Moose Factory Indian Hospital. McKone wrote back with obvious displeasure. He explained that the staff at the hospital were quite familiar with the individual in question and "found him most incorrigible." In fact, it is likely the patient in question had initially been sent away from Moose Factory for that very reason. McKone grumbled to his colleague that "when one gets an incorrigible type of person who understands more about the treatment of tuberculosis than the Doctors, nearly our whole Indian patient population prefer to believe and follow that type, instead of one problem, when he was here before we had ten on our hands."[61] Nevertheless, McKone accepted the transfer.

In other scenarios, IHS officials were less flexible. When the wife of a First Nations employee at the Moose Factory Hospital left the facility without being released, McKone suggested to the local

[61] Letter from Dr. Barkley McKone to S.J. Hawkins, Medical Superintendent of the Freeport Sanatorium, Kitchener, ON, (February 26, 1953), RG 29, Vol 2907, File 851-1-A486 Pt. 4, Indian and Northern Health Services, James Bay District, Moose Factory, ON, LAC.

Indian Agent that the employee in question be considered for termination. Steeped in the belief that a husband should be in control of his wife's actions, McKone warned the agent of the dangerous precedent it would create if a hospital employee was partly responsible for discharges against advice. Moreover, given that the employee was himself an ex-patient, McKone took the opportunity to reassert the desirability of hiring only former patients who could be trusted to cooperate.[62] Dissension was not acceptable. It is worthwhile to note that while the DNHW operated a work environment in which criticism from any quarter was not readily accepted, IHS personnel had the highest turnover rate in the department. Although it is not clear what percentage of departures were First Nations peoples, department reports repeatedly acknowledged that Indigenous employees left at a high rate of frequency.[63] It is thus reasonable to conclude that IHS was a work environment unwelcoming for First Nations staff who did not fully embrace the White-settler-colonial status quo. It is crucial to remember that many communities demonstrated a sincere willingness to accept the appearance of and participation within settler health care services as part of their negotiated land sharing agreements.[64] Long challenged, however, was the paternalistic power differentials manifested in settler management.

Indeed, many individuals chose to reject IHS services altogether. In 1953, for example, eight members of the Albany and Attawapiskat communities wrote directly to the Service to request they or their children remain under treatment at the private Catholic-run Assumption Hospital in Moosonee, instead of being transferred to the Moose Factory Indian Hospital as the IHS

[62] Letter from B. McKone to J.S. Allen, Indian Agent, James Bay Region, (6 November 1953), RG 29 Vol 2907 File 851-1-A486 Pt. 4, James Bay District, Moose Factory, LAC.
[63] For more on Indigenous labour in the IHS see Laurie Mejer Drees, *Healing Histories: Stories from Canada's Indian Hospitals* (Edmonton: University of Alberta Press, 2013); Mary Jane Logan McCallum, *Indigenous Women, Work and History: 1940-1980* (Winnipeg: University of Manitoba Press, 2014).
[64] Band funds contributed to the payment of medical services in 13 communities in Ontario. In nine of these communities, they accounted for one hundred percent payment for the cost of physicians' services. See Table 1

Superintendent had requested.[65] Furthermore, the records of the Department of National Health and Welfare contain many case records of First Nations patients who left IHS hospitals and allied settler institutions to return to their home communities or to seek treatment from traditional healers.[66] As other historians of health have argued, settler colonialism is a powerful, but never totalizing force.[67] First Nations individuals did not access settler-provided health care services as their only hope for survival but, instead, as one resource available to them to support their own well-being.

First Nations agency could also readily be found in the advocacy of organized leadership. In 1951 Andrew Paull, President of the North American Indian Brotherhood, wrote a letter to W.E. Harris, Minister of Citizenship and Immigration, to express concern over the federal government's unbalanced interest in case finding and control at the expense of increased attention to the amelioration of poor living conditions that exacerbated ill health. Paull had been contacted by individuals working in the James Bay area who described "the tragic poverty among these Indians" and asked Paull if he could "do something to alleviate this in-human suffering." In response, Paull contacted the director of the Indian Affairs Branch, Major D.M. McKay. As Paull conveyed to

[65] Letters to Dr. B.McKone, (5 January 1953), RG 29 Vol 2930 File 851-1-X184 Pt. 1, Indian and Northern Health Services, James Bay District, Moose Factory Indian Hospital, LAC.
[66] On September 8th, 1954, J.H. Wiebe wrote to the Tuberculosis Division of the Department of Health to inform them that the patient in question had "put himself under the care of a local Indian 'Medicine Man,' and it is doubtful whether we shall be able to get much co-operation from him." RG 29 Vol 2904 File 851-1-A479 Pt. 1 Indian and Northern Health Services, Brantford District, LAC. Examples of patients fleeing from settler health institutions can be found in RG 29 Vol 2907 File 851-1-A486 Pt. 4 Indian and Northern Health Services, James Bay District, Moose Factory, ON. LAC and RG 29 Vol 2907 File 800-1-X184 Pt. 1 Organization and Administration Moose Factory Hospital, Moose Factory, ON, LAC.
[67] Select examples include Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950* (Vancouver: University of British Columbia Press, 1998); Maureen Lux, *Medicine That Walks: Disease, Medicine and Canadian Plains Native People, 1880-1940* (Toronto: University of Toronto Press, 2001); Drees, *Healing Histories;* McCallum, *Indigenous Women, Work and History*; Luby *Dammed*; Lianne Leddy, *Serpent River Resurgence: Confronting Uranium Mining at Elliot Lake* (Toronto: University of Toronto Press, 2022).

Harris, McKay had simply articulated his confidence in the Indian Agent at James Bay who, he believed, would improve the situation, "if such conditions existed."[68] Disheartened but not discouraged, Paull sent of copy of his letter to Paul Martin, Minister of National Health and Welfare, to raise awareness across government departments.

P.E. Moore's response to Paull's letter on behalf of IHS reinforced the Services' commitment to case-finding and treatment over broader forms of prevention beyond public health training. Moore stressed to Paull that IHS had recently opened a new Indian Hospital at Moose Factory, at the cost of two million dollars, as well as a travelling clinic for tuberculosis surveys. Moore also reminded him that when IHS had sent a plane to the Attawapiskat First Nation to collect known cases of tuberculosis, community members had refused treatment.[69] As a service of the state, the IHS continued to define its priorities and evaluate its concerns within the scope of its own interests. First Nations individuals and communities were invited to accept what was on offer or endure the consequences. Significantly, Moore's comments also highlight integration's problematic division of IHS from the Indian Affairs Branch; attempts to improve First Nations' well-being rarely saw a sufficiently co-ordinated approach to improve the social determinants of health. Instead, tight federal budgets for First Nations communities facilitated a watchful partition of departmental mandates in which the discourses of health often became segregated from the work of the Indian Affairs Branch.

[68] Letter from Andy Paull, President of the North American Indian Brotherhood, to W.E. Harris, Minister of Citizenship and Immigration, (21 November 1950), RG 29 Vol 2907 File 851-1-A486 Pt. 5 Indian and Northern Health Service, James Bay District, Moose Factory, ON, LAC.
[69] Letter from P.E. Moore to Andy Paull, (30 November 1950), RG 29 Vol 2907 File 851-1-A486 Pt. 5 Indian and Northern Health Service, James Bay District, Moose Factory, ON, LAC.

Possibilities Constrained: The Discourse of Distance, Bottom Lines, and Low Standards

In the face of the profound dislocation, damage, and injustice that settler colonialism has and continues to cause for Indigenous peoples in Canada, scholars Eve Tuck and K. Wayne Yang have drawn attention to a series of strategies that settlers use to absolve themselves of connection to such destruction. Termed "settler moves to innocence," Tuck and Yang explain how settlers position themselves to "attempt to relieve the settler feelings of guilt or responsibility without [actually] giving up land or power or privilege, without having to change much at all." For example, settlers have repeatedly located or invented an ancestor from their past to give them access to an "Indian bloodline" and then "use this claim to mark themselves as blameless in the attempted eradication of Indigenous peoples."[70] As alluded to earlier, Tuck and Yang suggest a key settler move to innocence is the Asterisking of Indigenous peoples. This move is focused on the ways the identification of Indigenous difference (through an asterisk/or other signs of separation) is used to highlight racialization while also obscuring Indigenous sovereignty; the asterisk subsumes Indigenous peoples into the settler group and then constrains them to the margins as a racialized other. Such a positioning serves to maintain settler positions of authority and strives to invalidate accusations of genocide.[71] These insights provide useful frameworks to understand how the federal government failed either to establish a complete health service for citizens* or to accept responsibilities for its inadequacies.

In 1946, Percy Moore wrote to his deputy minister to explain that Indian Health Services strove to create "the best possible arrangements" for First Nations health care. He cautioned, however, that

[70] Tuck and Yang, "Decolonization is not a metaphor," 10.
[71] Tuck and Yang, "Decolonization is not a metaphor," 22-23.

what was truly achievable was "dependent upon conditions and circumstances."[72] The establishment of full treatment services for First Nations communities, Moore explained, had in the past been hampered for three principal factors: The first two, lack of funds and a shortage of medical personnel had been somewhat ameliorated by recent IHS expansion efforts. But the third reason remained a profound matter of concern for settlers. The challenge for IHS, Moore explained, was that many bands were "located in remote areas and [did not live] in sufficient concentration to justify the full time services of the doctor."[73] This focus on First Nations peoples' location and patterns of organization remained a major conceptual obstacle for the IHS. If First Nations' individuals *chose* to live differently than White settler society, how could the DNHW, operating under the banner of citizen equality, justify the extraordinary financial expenditure required to extend health care services to all First Nations peoples wherever they may be?

The IHS chose two rhetorical roads to rationalize the scope of their service provision. The first was to focus on First Nations' choices. In much the same way that settler discourse had long focused on the inability of First Nations to care for themselves, discussions around the capacity of the IHS drew on rhetoric of First Nations blame. Namely their desire to live in, by settler standards, dispersed and isolated environments in order to account for the limitations of the Service. In the words of the Department itself, it was believed that "the inaccessibility of a large proportion of the native population is the greatest handicap to active treatment."[74] Likewise, it described

[72] Memorandum from P.E. Moore to Brock Chisholm, (10 April 1946), RG 29 Vol 2866 File 851-1-1 Pt. 1, Medical Services Operations, LAC.
[73] Letter from P.E. Moore to Brock Chisholm, (6 December 1945), RG 29 Vol 2866 File 851-1-1 Pt. 1, Medical Services Operations, LAC.
[74] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1948,* Ottawa: Queen's Printer, 1948. Accessed, *Internet Archive*, September 2021; Mentioned far less frequently was the reality that the reach of surveys was occasionally geared to the number of free beds available. Given the frequent shortage of sanatorium beds during this period, the management of TB was hindered significantly by this fact.

immunization campaigns to nomadic and semi-nomadic groups as a "herculean task."[75] Mentioned far less frequently was the reality that the reach of TB surveys, for example, was occasionally geared only to the number of free beds available, which given the frequent shortage of such beds during this period, hindered the management of TB significantly. Nevertheless, the choices of First Nations peoples remained the key priority for change within the IHS.

Notwithstanding the real material challenges that come with the establishment of a health service responsible for large geographic areas, the frequency of government reference to the isolation, dispersal, and "nomadic habits" of First Nations warrants critical analysis because the discourse served settler aims. As historian Mary Jane Logan McCallum has argued, "'isolation' is not a naturally occurring geographical feature but is made historically through relations of power."[76] To focus discussion of the challenges of health service extension on the First Nations communities who lived far away from "civilization" or who continued the "Indian mode of life" through nomadic habits, IHS officials maintained their pathologization of Indigenous ways of life. In so doing, IHS officials hoped to encourage the dispossession of First Nations peoples from their lands with the argument that health care was best achieved within spaces of large settler concentrations. In McCallum's words, "the location of Aboriginal health on the outer reaches of the nation ultimately served the broader project of colonization…in mapping a healthy Canadian state."[77] Once again, the offer of substantial settler government assistance was conditional on First Nations'

SeeDepartment of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1947,* Ottawa: Queen's Printer, 1947. Accessed, *Internet Archive*, September 2021.
[75] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1953,* Ottawa: Queen's Printer, 1953. Accessed, *Internet Archive*, September 2021.
[76] Mary Jane McCallum, "This Last Frontier: Isolation and Aboriginal Health," *Canadian Bulletin of Medical History* 21, no. 1 (2005): 109.
[77] McCallum, "This Last Frontier," 104.

acceptance of the power [presence] of the settler-state. Significantly, this focus on lifestyle choice worked to bolster settler claims to innocence for the harms of colonial displacement.

Nearly ten years into the IHS mandate, the script had not changed. In its 1955 annual report, the Department explained to readers that "it is not too difficult nowadays to plan and operate a health service for the typical North American city of 160,000 people." The report then went on to stress, however, that First Nations peoples were far from 'normal':

> If the education of its inhabitants happened to be well below average, if their traditions and outlook on life differed from those of the remainder of the country, and their level of prosperity was so low that only a handful could meet their medical expenses in full, the situation would become much more difficult. If, in addition, they were divided into more than 2,000 groups, some nomadic and many isolated, and scattered over 3,500,000 square miles of territory, the task of providing a health service for them would become enormous. That is the task with which Indian Health Services is faced.[78]

Reading between the lines, the message of the IHS is clear: so long as First Nations peoples remained on the physical and conceptual margins of settler society (citizens*), unwilling to accept the authority of the settler state and contribute to its financial well-being through means like property taxes, they would continue to be perceived as a problematic population for whom only so much would be offered. To further illustrate this point, in contrast to the negative view of First Nations peoples who remained in 'isolation,' IHS staff stationed in areas seen as 'remote' were praised for their loyalty and devotion for remaining there.[79] Thus, place did offer material challenges to health service extension, but the race of those found in 'isolation' produced particular anxieties for the IHS and the government at large.

[78] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1955,* Ottawa: Queen's Printer, 1955. Accessed, *Internet Archive*, September 2021.
[79] Letter from Percy Moore to Brock Chisholm, (November 1945), RG 29 Vol 2866 File 851-1-1 Pt. 1, Medical Service Operations, LAC.

Even as IHS expanded its service and institutional presence to new locations, reference to the nomadic habits, dispersal, and isolation of First Nations peoples remained. Over the period under study, such descriptors were employed forty-three times in annual reports. As a service born of charity rather than obligation, the IHS stressed that, even if enough funds could be found to expand services to such populations, the cost itself would be prodigal.[80] Thus, the second rhetorical tool that the IHS used was to emphasize that because no law or treaty bound the Service to provide care, their acts of charity had already given far more than they were required. Additional funds would be difficult to obtain.

For those locations that were not too distant to provide treatment, the services offered were always bound to the constraints of settler charity and budgets. The notion that the Canadian state operated in the best interests of First Nations peoples and that care was not a legal obligation but an expression of charitable intent of temporary duration kept standards notoriously low. MP J.A. Bradette (Liberal, Cochrane) argued in the House of Commons that "while Canada may not have done for Indians all we could have wished to do…at least we consider them as human beings."[81] The reality that a recognition of First Nations people's basic humanity was seen as a laudable quality demonstrates the depth of racism prevalent at the time and offers a window into the kind of thinking that framed government efforts as 'better than nothing.'

To avoid criticism that IHS was wasteful with public monies, department leadership made significant efforts to stress to both their political masters and the public at large that their efforts

[80] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1950,* Ottawa: Queen's Printer, 1950. Accessed, *Internet Archive*, September 2021.
[81] Joseph-Arthur Bradette, Edited Hansard. 20th Parliament, 2nd Session (May 13, 1946). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1413044/

were as economical as possible. Minister Martin expressed concern for instance that an article in *The Globe and Mail* about the recent opening of the Moose Factory Indian Hospital would give the impression that the hospital was "an extravagant expenditure by the government." In response, Martin wrote to an individual who had long worked in the James Bay area to address the article's misrepresentations, particularly the comparison of the Moose Factory Indian Hospital to the Department of Veterans' Affairs Hospital at Sunnybrook. Martin clarified that "there is little basis of fact in this comparison." In contrast to the southern Veterans' hospital, Martin explained that wherever possible the DNHW had chosen to use the most economical type of construction. Martin hoped that his contact would "help…to correct mis-understanding [sic] and unfortunate rumours which are bound to arise with a large undertaking of this kind."[82] As Percy Moore had reminded the Treasury Board in 1949, IHS may frequently be known as miserly, but it had never been accused of being profligate.[83]

The truth of Moore's claim came with a review of the conditions of the Moose Factory Indian Hospital two years into its operation. Barclay McKone, medical superintendent at the hospital, described the 200-bed institution as lacking space, services, and equitable standards of care compared with non-IHS institutions.[84] For example, despite ninety percent of patients suffering from tuberculosis, the pneumothorax room had been turned into the matron's office. In addition,

[82] Letter from Minister of National Health and Welfare Paul Martin to Rt. Rev. R.J. Renison, (30 November 1950), RG 29 Vol 2907 File 800-1-X184 Pt 1, Organization and Administration Moose Factory Hospital, Moose Factory Ont. LAC.
[83] Letter from P.E. Moore to Mr. A.L. Wickwire, Treasury Board, (24 September 1949), RG 29 Vol 2866 File 851-1-1 Pt 1[B] Medical Services Operations, LAC.
[84] Katherine McCuaig explained that "by 1925…. every properly equipped sanatorium had laboratory, x-ray, dental, surgical and heliotherapy facilities administered under separate departments, and they were staffed by surgeons, pathologists, radiologists, ear, eye, nose, and throat specialists, dentists, and technicians, as well as chest physicians and nurses." Katherine McCuaig, *The Weariness, the Fever, and the Fret: The Campaign Against Tuberculosis in Canada, 1900-1950* (Kingston-Montreal: McGill-Queens Press, 1999), 93.

against the expectation that an IHS hospital on James Bay would mitigate the need to send patients further away from their home, McKone reported to Moore that the lack of beds and the inability of the hospital to conduct chest surgeries meant that many patients had to be sent to sanatoria in Hamilton or Weston, almost 900 kilometers away.[85] When patients did remain at Moose Factory, they lived in an institution where the x-ray department was too small, there was only one doctor's office and examination room, and bedridden patients could not even be guaranteed a bedside table. McKone also stressed that the overcrowding of patients only worsened the already low morale of nurses who suffered from the constant shortage of staff. Such conditions were a far cry from what patients in non-IHS institutions had come to expect.

The following year's report on the hospital showed little improvement. H.A. Procter Deputy/Assistant Superintendent for IHS wrote to Moore after his visit to the hospital, and described how "the grounds, building and equipment are showing gross signs of neglect with the result that the appearance must create a very unfavourable impression on any visitors and be an extremely poor example to the Indians who either visit or are there under treatment and presumably instruction."[86] Procter was also convinced that the hospital continued to suffer from a severe nursing shortage. Staff felt overworked and one nurse feared a nervous breakdown. Despite a tradition among Department leadership to feel a sense of pride at the "economically efficient" management of IHS, the non-economic costs reveal little to celebrate.[87] Despite the rhetoric of

[85] B. McKone, Medical Superintendent Moose Factory Indian Hospital to P.E. Moore, (31 July 1952), RG 29 Vol 2907 File 851-1-A486 Pt. 6 Medical Services, Indian and Northern Health Services, James Bay District, Moose Factory, ON, LAC.
[86] Letter from Dr. H.A. Procter to P.E. Moore, (21 July 1953), RG 29 Vol 2907 File 800-1-X184 Pt. 1, Organization and Administration Moose Factory Hospital, Moose Factory, ON, LAC.
[87] A Statement Regarding the Hospitalization of Indians published prior to the transfer of IHS to DNHW, noted that, "it has been found that the Department can operate Departmental Indian Hospitals efficiently and economically. Our per diem rate of costs is established by complete audit by auditors from the Treasury Branch and no non-

integration and the clear willingness to increase investment in the IHS, the earlier parsimony with which federally provided health care services to First Nations peoples operated continued into the post-war period.

Not only did insufficient financial investment in First Nations health challenge the quality of care provided, a close examination of the government's unwritten policy of low-cost bottom lines also reveals its tendency to foster division among IHS staff. On an August afternoon in 1956, a young infant was climbing on his bed when he suddenly fell to the floor. Within half an hour, the child began convulsing, vomiting, and bleeding from the nose and mouth before he became unconscious and hemiplegic. In an abundance of caution and after a full staff consultation at the Moose Factory Indian Hospital, those involved decided to send the infant to Toronto where he would have access to the brain surgeon that was unavailable to him in Moose Factory, if such a recourse was needed. A flight was chartered. Three months later, the staff at the Moose Factory Indian Hospital received a letter of chastisement from their superior Percy Moore. While Moore had paid the bill, he conveyed his conclusion that the flight was ill-advised for he felt it to be "both a very poor medical judgement and more especially poor financial judgement."[88] Consequently, the IHS staff were reminded of the priorities of the Services' leadership, its hierarchical structure, and the resultant willingness to undermine medical consensus of those on the ground.

Significantly, the IHS restrained financial expenditure for First Nations health limited First Nations' access to non-departmental health services. In Northern Ontario, the manager of the

governmental hospital has ever been willing to accept rates anywhere near the figures at which we have been able to provide efficient hospital services." RG 29 Vol 2866 File 851-1- Pt. 1, Medical Services Operations, LAC.

[88] Letter from P.E. Moore to Moose Factory Indian Hospital, (6 November 1956), RG 29 Vol 2930 File 851-1-X184 Pt. 1 Indian and Northern Health Services, Moose Factory Hospital, Moose Factory, ON, LAC.

Central Patricia Gold Mine, whose company hospital had on occasion treated First Nations individuals, wrote to Dr. W.J. Wood, Regional Superintendent for IHS to inform the Service of the company's intention to cease its treatment services. The manager complained that whenever the company submitted accounts for the care of First Nations individuals, the department had "invariably…. paid on a reduced basis." The Central Patricia Gold Mine therefore determined it could no longer spend shareholder money on the care of First Nations individuals who were not in the company's employ.[89] Moreover, resentment was found not only in the corporate sector but in Church-run facilities as well. In 1953 for instance, Rev. Canon G.R. Stanley, Rector of St. Mark's Anglican Church in Kapuskasing Ontario wrote to F. Matters, Regional Supervisor for Indian Agencies of the Indian Affairs Branch. Stanley explained to Matters the great concern he felt about the payment policies of IHS for treaty Indians in private hospitals, noting that on multiple occasions the Service had paid only half of the patients' bill, leaving the rest to be covered by the referring physician. Stanley explained to Matters that "the doctors have been hooked for the hospital bill so often they are wary about admitting them and often direct them to Hearst or Cochrane."[90] In a subsequent letter the following year, Stanley again impressed upon Matters the problematic nature of this situation. To receive medical treatment, such patients would have to "come down the private railway line getting in here at 10am, [then] the train for Cochrane means a wait of 5 hours, the train for Hearst means a wait of 10 hours. In cases of emergency this is not good." Stanley reminded Matters that at least two Treaty Indians had died preventable deaths

[89] Letter from Richard E. Barrett to W.J. Wood, (22 March 1947), RG 29 Vol 2911 File 851-1-A494 Pt. 2 Indian and Northern Health Services, Sioux Lookout District, Sioux Lookout, ON, LAC.
[90] Letter from Rev. Canon G.R. Stanley to F. Matters, December 15, 1953, RG 29 Vol 2907 File 851-1-A486 Pt.4, Indian and Northern Health Services, James Bay District, Moose Factory, ON. LAC. That Stanley chose to direct his correspondence to a staff member of the Indian Affairs Branch rather than Indian Health Services likely speaks to the continued confusion over responsibility on the ground. It is also possible, however, that Stanley was aware of the long chain of bureaucracy and, therefore, directed a letter to as many people as possible.

because they were not admitted to the local hospital.[91] The parsimonious financial policy of the IHS created an environment where service providers at best resented, and at worst feared, to offer treatment to First Nations individuals in need.

Such barriers to care reveal the tangible health consequences of the settler belief that First Nations peoples were wards of the state who had surrendered their land. Neither public nor private enterprises acknowledged First Nations' title to the land from which settlers had gained so much. Instead, the settler-colonial objective to exclusively own land and the dismissal of treaty relationship reciprocity facilitated the understanding among many settlers that the care of First Nations peoples was a burden for the settler-government and its citizens. Certainly, the Patricia Gold Mine was not willing to concede that the very resources it mined in Northern Ontario were the unceded territory of Anishinaabe Nations. As a result, investment in the care of First Nations peoples was resisted. Furthermore, as Brittany Luby and Lianne Leddy have shown, settler land control and industrial development not only exploited the land and impacted treaty relationships, but such projects were also responsible for direct harm to First Nations bodies and land stewardship.[92] Without attention to the sovereignty of First Nations, to treaties as land sharing agreements, or the need for harms compensation, the myth persisted that aid to First Nations peoples was provided from a settler system in which "the majority contribute nothing."[93] Even without a consideration of resources taken from First Nations' land, this myth masked a different

[91] Letter from Rev. Canon G.R. Stanley to F. Matters, (4 February 1954), RG 29 Vol 2907 File 851-1-A486 Pt.4, Indian and Northern Health Services, James Bay District, Moose Factory, ON, LAC.
[92] See Brittany Luby, *Dammed: The Politics of Loss and Survival in Anishinaabe Territory* (Winnipeg: University of Manitoba Press, 2020); and Lianne Leddy, *Serpent River Resurgence: Confronting Uranium Mining at Elliot Lake* (Toronto: University of Toronto Press, 2022).
[93] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1948,* Ottawa: Queen's Printer, 1948. Accessed, *Internet Archive*, September 2021.

reality. The table below demonstrates that 13 of the 24 Indian Agencies in Ontario contributed to the cost of their medical care directly from band funds.

Table 2: List of physicians paid in whole or part from Band Funds (Ontario)— 1945

			Total	Band Funds
Cape Croker	Dr. F.M. Williamson	P.T.	1,800.00	180.00 (10%)
Caradoc	Dr. T.R. McLeod	F.T.	3,420.00	1,000.00 (29%)
Christian Island	Dr. G.E. Tanner	F.T.	1, 200.00	1,200.00 (100%)
Manitoulin Island	Dr. R.B. McQuay	P.T.	1,000.00	1,000.00 (100%)
Manitoulin Island	Dr. C.K. Young	P.T.	700.00	700.00 (100%)
Moravian	Dr. G.M. Soper	P.T.	900.00	900.00 (100%)
Parry Sound	Dr. K.A. Denholm	P.T.	2,100.00	900.00 (43%)
Port Arthur	Dr. J.C. Gillie	P.T.	600.00	500.00 (83%)
Rama	Dr. W.E. Brown	P.T.	1,000.00	1,000.00 (100%)
Sarnia	Dr. M. McDonald	P.T.	700.00	700.00 (100%)
Sarnia	Dr. J.F. Badler	P.T.	800.00	800.00 (100%)
Sault Ste. Marie	Dr. W.B. Sproule	P.T.	225.00	225.00 (100%)
Six Nations	Dr. W. Davis	F.T.	3,420.00	3,420.00 (100%)

RG 29 Vol 2866 File 851-1-1 Pt 1 Medical Services Operations, Library and Archives Canada

Significantly, a willingness to allow the maintenance of sub-standard services was not isolated to the north of the province. To fill the gaps in staffing, IHS had agreed to hire physicians who had not passed the examinations set by the College of Physicians and Surgeons, including at the Lady Willingdon Hospital at Six Nations. In May of 1954, a patient from the Six Nations community was sent to the Lady Willingdon Hospital to undergo surgery. Unfortunately, the patient suffered cardiac arrest and died while at the hospital. The anesthetist in this case was one of the unlicensed physicians hired on staff at the Lady Willingdon. Medical Superintendent J.H. Wiebe used the occasion to remind Percy Moore of the importance of hiring qualified medical staff. Wiebe stressed that in this instance, the Service was fortunate to have a coroner "with an unbiased mind," without whom they risked "an inquest [which] might have resulted in undesirable publicity concerning an

unqualified anesthetist."[94] Perhaps in an effort to further push away any blame onto IHS staff, the report on the patient's death noted that the patient had "made it known to various nurses and her ward mates that she did not intend to survive the operation."[95] As in other instances, IHS staff used descriptions of patients' behaviour to "contextualize" the negative outcome.[96]

In the end Wiebe's call went unheeded. While Hospital Staff Medical By-laws in 1958 included an article that medical staff should be appointed from duly qualified members of the medical profession, the physician in question remained on staff. By 1960, the Six Nations Council passed a resolution to censure the hospital medical staff. Moved by Richard Isaac and seconded by Carson Martin, the motion called for the removal of the unqualified doctor due to complaints from residents of the reserve regarding his "negligent medical attention to out-patients, and that the other staff Doctors at the Lady Willingdon Hospital, be warned of removal likewise, who are found to be neglecting their duty to give attentive and proper medical attention to patients patronizing Lady Willingdon Hospital."[97] In response, J.H. Wiebe, who by now had become Regional Superintendent wrote to Moore to argue that "the Six Nations people in general are somewhat unreasonable" and stressed that neither the Six Nations peoples nor the Service would benefit if the Council were permitted to "hold our medical and hospital staff under threat." Wiebe suggested that when this resolution came to the Department through the appropriate channels, "the Council

[94] Letter from J.H. Wiebe to P.E. Moore, (May 1954), RG29 Vol 3399 File 822-1-D173, Medical and Dental Arrangements, Lady Willingdon, ON, LAC.
[95] Letter from J.H. Wiebe to County of Brant Coroner, (12 May 1954), RG 29 Vol 3399 File 822-1-D173, Medical and Dental Arrangements, Lady Willingdon, ON, LAC.
[96] Before reporting to his superiors that a young girl from the Attawapiskat First Nation had died from eating her blanket, a physician in Moose Factory described the girl as "an extremely bad-tempered girl, very hyperactive, mischievous and occasionally violent." Letter from F.E. Fournier to G.W.J. Fiddes, Medical Superintendent Moose Factory Indian Hospital, (11 January 1956), RG 29 Vol 2907 File 851-1-A486 Pt. 6, Medical Services, Indian and Northern Health Services, James Bay District, Moose Factory, ON, LAC.
[97] Six Nations Council Resolution passed 20 June 1960, RG 29 Vol 3399 File 822-1-D173, Medical and Dental Arrangements, Lady Willingdon, ON, LAC.

be advised of its responsibility to foster a sense of responsibility among its peoples."[98] Now in his new position within IHS, closer to the centres of decision making, Wiebe seemed more willing to accept the reality of unqualified medical staff at IHS institutions and less sympathetic to the resistance of First Nations communities. Instead, Wiebe relied on the IHS ethos that communities needed to be trained to accept settler authority and to turn their attention away from criticism of the IHS and towards the presumed irrationality of First Nations patients.

Such positionings help us to understand why the settler state sought to offer First Nations people citizenship rather than acknowledge their distinct nationhood and adapt systems to end discrimination based on systemic colonial racism. In rationalizing limited-service extension and funding through the identification of difference, seeing citizens* above all else, IHS practice penalized individuals and communities who rejected settler-colonial claims to dominion over their bodies and land. The underlying message was clear: First Nations peoples could be better cared for as citizens (without an asterisk) if they only chose to reject their culture and sovereignty. Given such an offer, how possible could a claim to innocence truly be?

Moving Integration Along: Federal Withdrawal

As IHS personnel charted their success in infectious disease management and health education, political and bureaucratic leadership remained keenly aware of two issues of concern. The

[98] J.H. Wiebe, Regional Superintendent, Eastern Region IHS, to P.E. Moore, (11 July 1960), RG 29 Vol 3399 File 822-1-D173, Medical and Dental Arrangements, Lady Willingdon, ON, LAC. Ontario. Maureen Lux also offers an account of this incident in *Separate Beds.* She highlights that despite continued calls for accountability from the Six Nations Council and continued criticism regarding medical negligence, IHS officials did not break ranks. Instead, internal investigations determined that members of the Council were both "unreasonable and irresponsible." Lux, *Separate Beds,* 92.

extension of the reach of IHS had necessitated a steady increase in the financial expenditure of the Service. In 1946, the IHS annual expenditure amounted to approximately $2.3 million. By 1953, it had risen to $11.8 million. Intimately connected with concerns of cost, were anxieties about the rise in the birth rate in First Nations communities. Despite the high mortality rates for infectious diseases such as tuberculosis and the individual loss of Indian status through enfranchisement, in 1949, the First Nation population in Canada recorded a population growth rate of 1.5 percent.[99] A growing First Nations population with Indian status destined IHS to higher costs. Already in 1951, the Service had been forced to re-organize its personnel partly in response to population growth.[100] Given the recent and significant strain of other programs on the department's budget, namely the National Health Grants introduced in 1949, interest in actualizing the policy of integration intensified.[101]

Certainly, integration had never left the purview of the IHS mandate. First, the Service had maintained a largely temporary staff base. When challenged in the House of Commons about the disproportionate number of temporary staff in the Service, Minister Martin replied that the IHS had a quota of permanent positions that rested at 30 percent. In practice, however, the Service had no need to implement their quota when the proportion of permanent staff in 1950 was only eight

[99] The Department noted in 1949 that 500 individuals had been lost that year "by absorption into the general population by enfranchisement." By 1954, that number had risen to 1,000. Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1949,* Ottawa: Queen's Printer, 1949. Accessed, *Internet Archive*, September 2021; Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1954,* Ottawa: Queen's Printer, 1954. Accessed, *Internet Archive*, September 2021.
[100] The IHS created four regional offices: Pacific, Foothill, Central and Eastern, that while remaining under the authority of the head office in Ottawa, would oversee the work of smaller units, known as zones, within their geographical purview.
[101] As Appendix B demonstrates, the introduction did not have an immediate consequence for the IHS share of the department budget in comparison to previous years. Notably, none of the grants were used to fund research into integration policy in the field of health research.

percent, down from 24 percent two years prior.[102] Second, the Service had indeed expanded the number of IHS institutions, but the number of non-department health care workers who treated First Nations patients far outstripped those in the government's employ. In 1950, the field staff of the IHS, counted 23 full-time medical officers, five dental surgeons and 43 graduate nurses on a full-time basis, and 64 physicians and 16 dispensers in part-time positions. Comparatively, the IHS regularly paid the fee-for-service rate for 1,250 physicians, 125 dentists, and 600 hospitals.[103] From such statistics, the Service emerges as much a manager of financial accounts as it was a health care provider. Indeed, in the same year, the number of First Nations and Inuit patients under treatment in non-departmental hospitals was 23,500 in contrast to the 8,500 cared for in departmental establishments.[104] The aim of the IHS to "get out of the business" of First Nations health care, seemed well underway.[105]

In line with a broader policy of integration, politicians and bureaucrats alike maintained that such services were to be of finite duration. Reminiscent of Duncan Campbell Scott's 1920 statement that Indian Affair's objective was to continue until "there was no Indian question and no Indian Department," Dr. H.A. Procter pointed out in 1954 that "our business is really to get out of the business by seeing that the health services to communities is organized either on a voluntary basis

[102] Paul Martin (Essex East), Edited Hansard. 21st Parliament, 2nd Session (June 20, 1950). Retrieved from LiPaD: The Linked Parliamentary Data Project. Lipad.ca/full/permalink/1613546. It is worthwhile to note that the number of permanent and temporary staff is not recorded in the annual reports of the DNHW after 1948.
[103] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1950,* Ottawa: Queen's Printer, 1950. Accessed, *Internet Archive*, September 2021; for more on the nature of IHS dental service see Catherine Carstairs and Ian Mosby, "Colonial Extractions: Oral Health Care and Indigenous Peoples in Canada, 1945-79," *Canadian Historical Review* 101, no. 2 (June 2020): 192-216.
[104] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1950,* Ottawa: Queen's Printer, 1950. Accessed, *Internet Archive*, September 2021.
[105] IHS Associate Director H.A. Procter conveyed the aim of the IHS at a Department Seminar in 1954 as follows, "our business is really to get out of the business by seeing that the health services to communities is organized either on a voluntary basis by the Indians themselves or under the auspices of provincial or other health authorities." H.A. Procter, (27 January 1954), RG 29 Vol 2866 File 851-1-1 Pt 1 [B] Medical Services Operations, LAC.

by the Indians themselves or under the auspices of provincial or other health authorities."[106] In fact, a DNHW Annual Report could hardly contain its enthusiasm when describing what "will undoubtedly prove to be one of the most outstanding advances in the history of native health care." The report was referring to a recent announcement that First Nations in British Columbia were to be included in its Hospital Insurance Plan.[107]

To limit both federal responsibility and expenditure, the early 1950s witnessed a re-working of IHS policy. Striving to eliminate what Jack Pickersgill would refer to as "concepts of segregation," bureaucrats at IHS increasingly strove to disassociate the extension of health services from Indian status.[108] As an alternative, the letters of government officials reveal a desire to anchor government-sponsored health care to conditions of poverty and reserve residency. In 1952, Percy Moore apologized to Col. E.P. Randle, the Indian Superintendent at Brantford, for IHS' past negligence in providing instructions on how to handle financial arrangements for medical care and explained to Randel that "the basic principle is that anyone able to pay his way should do so."[109] In another letter to Mrs. Joseph, a member of the Six Nations community, Moore was more emphatic about the conditions of IHS payment: "free medical attendance and hospitalization is not a treaty right but has been supplied to indigent Indians living on their reserve by the Government as a means of improving public health and sanitation on the reserves." Moore also added that an

[106] H.A. Procter, Assistant Director Indian Health Services, (1954), RG 29 Vol 2966 File 851-1-1 Part 1B, LAC. Like its provincial counterparts who would establish their own hospital insurance programs over the next decade, First Nations inclusion in provincial plans did not necessarily imply provincial financial coverage. All provinces continued to turn to Ottawa for, at the very least, payment for on-reserve status-First Nations individuals.
[107] Department of National Health and Welfare, *Annual Report: For the Fiscal Year Ended March 31, 1949*. Edmond Cloutier (Ottawa: King's Printer and Controller of Stationery, 1949):10.
[108] John Whitney Pickersgill (Liberal-Bonavista-Twillingate), Edited Hansard. 22nd Parliament, 3rd Session (August 7, 1956). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1873416/
[109] P.E. Moore to Col. E.P. Randle, Indian Superintendent, Brantford, ON, (2 July 1952), RG 29 Vol 2670 File 822-1-A479 Pt. 1, LAC.

individual with Indian status who left their reserve for a period of 18-months or more would no longer be eligible for treatment.[110] Shortly after, the eligibility time frame was reduced to 12 months.

Given the Service's aim to not only improve health but its ultimate objective to develop First Nations' self-sufficiency, the staff of IHS argued that such an approach was "a fair policy toward the Indians and towards the white people of our country."[111] White settlers, they felt, could not be expected to carry the "burden" of the Indian indefinitely. As Moore reminded the Departmental Secretary in the Spring of 1953, "No act of Parliament has intimated such intentions [to provide a comprehensive plan of medical care] and no treaty has promised more than a chest of medicines." In light of the fact that the federal government already felt it had offered far more than it was obliged, Moore explained that "the only logical basis upon which the Federal Government can make and continue to make the substantial payments…is that the recipients of these benefits are needy people who would be unable to obtain the medical care they require."[112] Over the years, the federal government continued to stress their restricted interpretation of acceptable IHS accounts. In brief, eligibility for medical care was determined by three conditions: "First, he must be an Indian within the meaning of the *Indian Act*; next, he must be following the Indian way of life, which for practical purposes in most parts of the country means that he must be living on an Indian reserve or have been away from the reserve for a period of less than a year; finally, it must be established that the individual is financially unable to arrange appropriate care for himself. If he is

[110] P.E. Moore to Mrs. Joseph, (7 January 1952), RG 29 Vol 2904 File 851-1-A479 Pt. 1, Indian and Northern Health Services, Brantford District, LAC.
[111] Paul Martin (Essex East), Edited Hansard. 21st Parliament, 7th Session (May 8, 1953). Retrieved from LiPaD: The Linked Parliamentary Data Project. Lipad.ca/full/permalink/1735651 [Misattributed on LiPad to Murdo William Martin]
[112] Letter from P.E. Moore to O.J. Waters, Departmental Secretary, (5 April 1954), RG 29 Vol 851-1- Part 1[B], Medical Services Operations, LAC.

able to, he is expected to do so." The IHS thus restricted legitimate expressions of treaty relationships to the confines of reservations, penalized economic success, and reinforced the patriarchal policies of the *Indian Act*.[113]

In eschewing a legislative commitment based on treaty negotiations, the federal government allowed itself the power to unilaterally reform or withdraw its health policy as it deemed fit. The language trajectory of DNHW leadership reaffirms this position. In 1947, then Minister of Health and Welfare, Paul Martin, declared to the House of Commons that the "aim of Indian Health Services is to provide and complete a health service to all Indians and Eskimos who are wards of the Dominion government."[114] By 1953, as integration policy became more entrenched, DNHW only sought to create a service that "augment[ed] the care normally provided by the home, the community, and provincial agencies," and went on to note that it stood "ready to hand back the charge."[115] No doubt, the rise of studies on the potential for hospital and health insurance programs contributed to such a rhetorical shift. Then, in 1955, the Department began to obfuscate its own historical interpretation of their relationship with First Nations peoples. In direct contrast to earlier statements, the annual report of that year strove to inform its readers that "the Indians have never

[113] In a 1948 memorandum from J. Allan, Superintendent, Reserve and Trusts in the Department of Mines and Resources, Allan reminded Moore that to be "'Indian' means 1) Everyone who, or whose ancestors in the male line, has not acquired the white status by process of law, who can trace descent through the male line- a) to an aboriginal native of the North American continent who was resident in British territory on or prior to the 1st day of July, 1867 b) to a male person who had the legal status of an Indians on the 1st day of July 1867, c) to a male person who, at the date of the respective Indian Treaties or Adherences thereto, was recognized as a member of the Band or Group subscribing to or adhering to the said Treaties; or 2) to a person whose name appears on any Band membership list or general list established and confirmed in accordance with the procedure provided in the *Indian Act*; 2. Any woman lawfully married to such a person; or 3) Any child or unmarried Indian woman, except where it can be proven or reasonably assumed from evidence satisfactory to the Minister, whose decision shall be final, that the father of such child is a person of white status." RG 29 Vol 2866 File 851-1-1 Pt. 1, Medical Services Operations, LAC.

[114] Paul Martin (Essex East), Edited Hansard. 20th Parliament, 3rd Session (June 20, 1947). Retrieved from LiPaD: The Linked Parliamentary Data Project. Lipad.ca/full/permalink/1478711

[115] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1953,* Ottawa: Queen's Printer, 1953. Accessed, *Internet Archive*, September 2021.

been made wards of the Crown nor has the Crown assumed a legal obligation to provide an all-embracing health and treatment service for them."[116] Policy, unlike treaty obligation, was a tool of the government. It was neither a commitment to relationship nor a token of reciprocity for First Nations land sharing.

The consequences were both wide-reaching and in direct contrast to the expectations of many First Nations individuals and communities. In 1955, a war veteran and member of the Couchiching First Nation wrote to the Indian Affairs Branch with respect to his treaty rights. He explained to the Branch his confusion over the IHS' rejection of financial assistance to cover the costs of his children's medical treatment due to the fact that while he had been forced to leave his reserve to find work, he had "never come out of treaty.' In fact, he had received his annual treaty money of five dollars only two months prior. To add to the concern, this individual described the repeated indifference of IHS staff to his daughter's plight when they failed to inform him that an eye specialist had come and gone three times from Fort Frances over the past year. Instead, the child and her mother had been forced to travel to Winnipeg to seek the proper treatment.[117] In response, the Director of the Indian Affairs Branch simply informed the individual that the Indian Health Services' policy is not to provide health services "to Indians who become established off their reserve for a period of twelve months."[118]As the previous chapter discussed, most politicians saw the maintenance of the reserve system as one of the sources of First Nations' suffering. The federal government accordingly put minimal effort into ensuring that reserve communities had viable

[116] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1955,* Ottawa: Queen's Printer, 1955. Accessed, *Internet Archive*, September 2021.
[117] Letter from member of Couchiching First Nation to H.M. Jones, Director, Indian Affairs Branch, (N.D), RG 29 Vol 2905 File 851-1-A485 Pt 1, Indian and Northern Health Services, Fort Frances District, LAC.
[118] Letter from H.M. Jones, Director, Indian Affairs Branch to member of Couchiching First Nation, (16 August 1955), RG 29 Vol 2905 File 851-1-A485 Pt 1, Indian and Northern Health Services, Fort Frances District, LAC.

means of employment. As a result, many individuals were forced to leave their reserves to seek an income. In doing so, however, such individuals risked a loss of status benefits. Both the Indian Affairs Branch and the IHS therefore actively facilitated the conditions from which they could force integration. IHS leadership and staff continued to embrace the end of First Nations legal distinctiveness and spatial segregation.

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By the end of 1956, the first decade of the post-war Indian Health Services had come to an end. The annual report of that year happily noted that "these have been the most fruitful years."[119] The IHS had rapidly expanded its budget, increased its institutional presence and the size of its personnel, conducted vigorous public health campaigns, and raised interest in the plight of 'the Indian.' In particular, staff of the IHS had enthusiastically charted the decline of tuberculosis amongst First Nations peoples, a key measure of success for a Service committed to public health and made tangible progress towards the gradual withdrawal of federal management of First Nations health. Nevertheless, challenges remained.

Only three months into his tenure as Deputy Minister of Health, G.D.W. Cameron had written to his colleague in 1946, and reflected that "I have not been in the service very long, but long enough to appreciate the difficulties in getting things done; especially when dealing with such a terrific problem as the health of the Eskimo and the Indian."[120] As this chapter has revealed, many of the

[119] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1956,* Ottawa: Queen's Printer, 1956. Accessed, *Internet Archive*, September 2021.
[120] Letter from G.D.W. Cameron to R.A. Gibson, Director, Lands, Parks and Forests Branch, Department of Mines and Resources, (9 October 1946), RG 29 Vol 2866 File 851-1-1 Pt 1, Medical Services Operations, LAC.

problems that IHS encountered were products of their own making. The rhetoric of integration that had been employed to justify the presence and power of White settlers rested on the identification of difference and its management. Significant effort thus had to be exerted to remedy both the disproportionate suffering of First Nations peoples and to train 'the Indian' to behave in ways that would make them healthy "social and economic assets" to Canada.[121] Crucially, the race-based belief that First Nations could not achieve healthy living on their own was the keystone of the IHS efforts and the tool to defend both paternalistic control and White settler incursion.

In contrast, IHS remained willfully blind to other rationales for investment in First Nations health. Treaties, according to IHS, may have made First Nations peoples wards of the government of Canada, but they did not bind it to provide a health service beyond what was "obliged on ordinary grounds of common decency" and a sense of fear that failure to contain disease among First Nations communities would endanger the well-being of settler Canadians.[122] The Service born as a result therefore reveals far more about the priorities of the White settler state than about the myriad and complex causes of health challenges in First Nations communities. Indian Health Service remained a tool to manage the 'Indian problem;' In time, it was hoped both would disappear.

The view that IHS was a separate service of finite duration had real material consequences for the health care provided. Specifically, their parsimonious financial policy created conditions in which the quality of care at department institutions deteriorated, First Nations' access to non-department

[121] Department of National Health and Welfare Report, "Indian and Eskimo Health Services," circa late 1940s. RG 29 Vol 2866 File 851-1-1 Pt. 1[B], LAC.
[122] Brooke Claxton address to the Joint House of Commons-Senate Committee on Indian Administration, RG 26 Vol 71, LAC.

facilities was limited, and staff experienced both division and profound exhaustion. The great promises of the post-war optimism thus failed to be realized. Far from a post-war period of profound change, settlers merely adapted their rhetoric to achieve their goals and to maintain the powerful position of White settler citizen status in Canada. As this chapter has revealed, racialized beliefs and settler colonial rhetoric not only circumscribed enthusiasm for changes to the status quo, but they also became the very tools that IHS drew on to 'excuse' insufficient efforts.

As the Indian Health Service, and the government that sponsored it, negotiated the "Indian problem" of difference in the immediate post-war years, they remained ever cognisant of their end goal. While the IHS may have actively discouraged the meaningful partnership of First Nations communities in the organization of health services, as historian John S. Long reminds us, "the *BNA Act* gave [the] Crown two heads."[123] Health services for First Nations peoples could not be offered on the same basis as citizens through federal will alone; it needed the partnership of the provinces. How would Ontario respond to such a request?

[123] Long, *Treaty No. 9,* 361.

Chapter 3

Citizen* in Ontario: "Earning" The Right to Health Care

Like the federal government, the province of Ontario had also been caught in the post-war spirit that eschewed overt racial discrimination and accepted an increased role of the state to improve the well-being of its citizens. Addressing the Provincial legislature in 1951, Conservative Premier Leslie Frost asserted that "some day historians will record these days in which we live as days of great and fundamental changes in the thinking of mankind."[1] But how would Ontario respond to the federal government's rhetoric about "the Indian," its policy of integration, and the eventual transfer of responsibility to the provinces that it implied? In the same address, Frost expressed his desire to "see our Indians…on equal footing with others in the province, with more equality with our people in this province."[2] Moreover, Ontario had been the first province to enact a *Racial Discrimination Act* in 1944 and seemed poised to challenge violators of its ethos. But, when tangible commitments were required, how sincere was Frost and his government? The extension of legal equality to First Nations residents in Ontario was a matter of no small concern for provincial governments already dissatisfied with the federal government's share of the tax wealth. For a settler government blind to the sovereignty of First Nations peoples and the value of the pre-existing land sharing agreements, to provide First Nations residents with the status of citizenship—the rights and responsibilities bound to every resident of Ontario— would come with a high price tag.

[1] Ontario, Legislative Assembly, Hansard, 13 March 1951 (Mr. Leslie Frost, PC): 10. https://archive.org/details/mar13hansard1951ontauoft/page/4/mode/2up?q=Indian
[2] Ontario, Legislative Assembly, Hansard, 13 March 1951 (Mr. Leslie Frost): 161. https://archive.org/details/mar13hansard1951ontauoft/page/4/mode/2up?q=Indian

This chapter will examine the ideas and structures that informed Ontario's response to the federal government's desire for a complete integration of First Nations peoples as citizens of Canada and of the provinces in which they resided. First, it will consider how Ontario's political leaders perceived the post-war period's rhetoric of universalism and human betterment and assess its influence on the place of First Nations peoples in the province. In this analysis the concept of Citizen* is useful to focus attention on the precarious position of First Nations individuals due to jurisdictional debate and uncertainty. While the federal and Ontario governments committed to improving the lot of the Indian, both engaged in a rhetorical game of badminton to question the degree to which each was responsible to achieve that end. Equality was all well and good, but who would pay for it? So effectively framed as an "othered burden,"— a Citizen*— what would compel Ontario to find a place for First Nations peoples within their "imagined" and material community?

Next, this chapter will focus on the investigative efforts of Ontario's Select Committee appointed to investigate the current realities that First Nations individuals faced and to inform Ontario's future program of action. With attention to the voices of many of the First Nations communities consulted, the discrepancy between settler-colonial priorities and those of many First Nations peoples will become clear. Moreover, the work of the Select Committee and its final recommendations, the subject of the third section, will argue that despite Ontario's perceived embrace of a rhetoric intended to remove race as a tool for discrimination, this settler government refused to relinquish its use of race. Instead, race—the 'Indian problem'—became a topic for investigation; a problem to uncover and to train away. Once First Nations peoples could be trained to behave as White and accept the settler colonial contract of Canadian and provincial citizenship,

Ontario would begin to feel that First Nations peoples as individuals had 'earned' their right to state assistance. Finally, this chapter ends with a case study that highlights the limits of Ottawa and Ontario's willingness to improve the living conditions of First Nations individuals. As Ottawa began its implementation of integration policy and called on provinces to take over care of "their" citizens, Ontario continued to resist jurisdictional responsibility for a population long racialized as primitive and as burdens.

Ontario's Post-War Priorities and the Contract of Settler-Colonial Citizenship

"The basic question is this: shall the reserve Indians be perpetually a ward or shall the aim be to help all Indians to become full citizens?" So asked the editor of the *Ottawa Citizen* in May 1947.[3] As the first chapter discussed, this question was the central concern animating post-war federal Indian policy in Canada. While much energy had been exerted to solve the "Indian problem" in the immediate post-war period, in many ways politicians' efforts had failed to remove a potent sense of ambiguity about what it meant to be an 'Indian' in Canada, including their relationship to the settler state. The *Indian Act*, revised in 1951, had re-established specific requirements to determine who was, and was not, entitled to be registered as an Indian with final authority for decisions resting in settler institutions.[4] But whether a status Indian was a citizen or not was left

[3] Editorial, "Indians: Wards or Citizens?" *The Ottawa Citizen*, May 31, 1947, 32.
[4] The 1952 annual report of the Indian Affairs Branch noted: "Provision is made for an Indian register in which persons of Indian status shall be listed. A registrar has charge of the Indian register, and administrative action taken by him in adding to or deleting from band lists may be protested by the Indians and referred to a judge of a county, district, or superior court for final determination." Department of Citizenship and Immigration, *Report of the Indian Affairs Branch for the Fiscal Year Ended March 31, 1952.* Ottawa: Queen's Printer, 1952. LAC. https://recherche-collection-search.bac-lac.gc.ca/eng/home/record?app=indaffannrep&IdNumber=33887&new=-8585511379307708273

as a matter of policy, not legislation.[5] This approach left significant space for the federal government to distance themselves from the care of First Nations peoples, despite the fact that the British North America Act had assigned them jurisdiction over "Indians and lands reserved for Indians." As Karl Carrise explained, the federal government increasingly relied on the legal fact that "the *BNA Act*, though authorizing the federal government to provide [First Nations] with services that were not otherwise mandated to the provinces, did not *require* it to do so."[6] Thus, as the first chapter highlighted, the federal government began to obscure jurisdictional lines when they refused to continue their long-standing policy that status First Nations peoples were wards of the Federal government. Instead, the term "ward" began to be associated with confinement and exclusion instead of a relationship based on fiduciary duty. As the Regional Supervisor on Indian Agencies for Southern Ontario, J.E. Morris, explained to members of the Ontario legislature and First Nations representatives, "we do not believe there is such a word as 'ward' among the Indians. It is not a word to be used in a democracy. The Canadian Indians move freely, wherever they want to go."[7] Furthermore, to add legislative weight to the policy of integration, the federal government established Section 87 of the *Indian Act* in 1951 to permit the application of provincial legislation to First Nations peoples unless such laws conflicted with the *Indian Act* or treaty rights. For politicians and civil servants at the federal level, the devolution of responsibility for First Nations peoples, citizens*, had already begun.

[5] It was not until 1956, "that the Citizenship Act was amended to make it clear that 'citizen' should include 'Indians'" See J.R. Miller, "The Slow Evolution of Indian Policy during the St. Laurent Years," in *The Unexpected Louis St. Laurent: Politics and Policies for a Modern Canada,* ed. Patrice Dutil (Vancouver: University of British Columbia Press, 2020), 439, footnote 26.
[6] Karl Carisse, "Becoming Canadian: Federal-Provincial Indian Policy and the Integration of Natives, 1946-1969: The Case of Ontario" (MA Thesis, University of Ottawa, 2000), 60. [my emphasis]
[7] J.E. Morris, Regional Supervisor on Indian Agencies for Southern Ontario at Manitou Rapids 1953, Testimony to Select Committee on the Civil Liberties and Rights of Indians in Ontario, (1953), RG49-132 Container B234948 File Proceedings, 29 August 1953- 2 September 1953), *Archives of Ontario, Toronto, Ontario.* [Hereafter AO]

To effectively consider how Ontario's provincial government responded to Ottawa's policy of integration, it is essential to consider Ontario's engagement with the wider social and political currents of the period. Like the federal government, leadership in Ontario demonstrated a willingness to embrace a new contract of social citizenship that compelled governments to provide for its citizens a basic standard of living. The responsibility to actualize these social rights was not only accepted in Ontario but already well underway. For example, under the leadership of Conservative Premier Leslie Frost, in 1953 the Ontario government committed to a health expenditure in the realm of $50 million per year and by 1954, it had increased its maintenance grants to its hospitals nine-fold.[8] In addition, there is evidence to suggest that Ontario's political leadership accepted that a commitment to an expansion of citizens' social rights came with the increasingly popular notion of universalism. As a result, political attention quickened to the reality of racial discrimination in Ontario. By the early 1950s, the Ontario government under the leadership of George Drew had passed the *Racial Discrimination Act* (1944) and in 1951 Frost oversaw the passage of the Act to Promote Fair Employment Practices to target race-based employment discrimination. Such efforts illustrate an agreement on the part of Ontario's leaders to participate in the international rhetoric of universalism. As Frost reminded his peers, "we in the western world have undertaken in the United Nations Charter to promote universal respect for and observance of human rights and freedom for all without distinction."[9] Significantly, such sentiments crossed partisan lines. The Leader of the Opposition, Mr. E.B. Jolliffe (CCF, York South) proclaimed to the legislature, "I think it is incumbent upon us to make this place a

[8] Ontario, Legislative Assembly, Hansard, 12 February 1953 (Mr. R. Connell, Hamilton Wentworth): p. 336. https://archive.org/details/feb12hansard1953ontauoft/page/336/mode/2up?q=%2450+million+a+year&view=theater; Ontario, Legislative Assembly, Hansard, 16 February 1954 (Speech from the Throne): p. 53. https://archive.org/details/hansard1954ontauoft/page/52/mode/2up?q=%22I+have+dwelt+perhaps+longer+than+I+intended%22

[9] Ontario, Legislative Assembly, Hansard, 13 March 1951 (Mr. Leslie Frost, PC): 10. https://archive.org/details/mar13hansard1951ontauoft/page/4/mode/2up?q=Indian

democratic society in which strangers will be welcomed…I cannot think of anything we can do to make more certain that they will become good citizens in our midst than the steps we take to provide that their [sic] should be no discrimination against them."[10] The dual calls for social citizenship and universalism had found another home.

To encourage popular support for this endeavour, Frost went on to stress that such tasks were not merely the product of altruism but foundational to the reputation of democracy in the 20th century among the millions of people currently engaged "in the racial and political revolutions of our century."[11] Given the socio-political anxieties of the Cold War, such matters were of no small concern. Within these parameters, human rights rhetoric in Ontario morphed into a new discursive tool that combined the language of universal human well-being with the exercise of citizenship rights and responsibilities to promote the offerings of a democratic system of government. With expanded access to social services based in a sense of inalienable human-citizen rights, it was hoped that residents would be drawn to, and grateful for, such a citizen-state relationship. As a result, it was again hoped, individuals would strive to be "good citizens" through the exercise of their concurrent democratic responsibilities to pay taxes and to vote. With acceptance of this approach, Ontario could expand the list of residents of the province who actively participated in its chosen form of political and economic organization, reaping both the financial and ideological benefits. In the context of powerful ideological pressures to maintain Canada's status-quo political and economic systems as well as calls for universalism, the extension of state-sponsored support to First Nations peoples in the province would appear to have been a foregone conclusion.

[10] Ontario, Legislative Assembly, Hansard, 13 March 1951 (Mr. E.B. Jolliffe, York South, CCF): H1. https://archive.org/details/mar13hansard1951ontauoft/page/124/mode/2up?q=Jolliffe
[11] Ontario, Legislative Assembly, Hansard, 13 March 1951 (Mr. Leslie Frost, PC): 10. https://archive.org/details/mar13hansard1951ontauoft/page/4/mode/2up?q=Indian

Ideals in practice are rarely so simple. Like their federal counterparts, Ontario politicians believed the benevolence of the welfare state needed to have its limits. As the 1954 Speech from the Throne articulated, "We do not expect the state to do everything for us. Far from it. We are not that kind of people. The Canadian people find little to attract them in the serfdom of Socialism or the slavery of Communism."[12] Like many federal politicians, including C.D. Howe, many provincial politicians nurtured a strong belief that access to financial prosperity would alleviate other social concerns.[13] Frost and his government were much more comfortable pursuing programs and priorities that would facilitate a healthy economy in which all could thrive financially and thereby support their own well-being. As a newspaper described, "Frost's programme 'can be summed up in one word—development…development of Ontario's population, of its power resources, its highway system, its forests and mineral wealth, and its industrial strength.'"[14] Given this focus on economic development through resource extraction, Frost joined with other political and business leaders in his apprehension to create costly programs for wide-reaching social assistance when economic growth could hold less costly solutions for the state.[15] Significantly, the reality of

[12] Ontario, Legislative Assembly, Hansard, 16 February 1954 (Speech from the Throne): p. 53. https://archive.org/details/hansard1954ontauoft/page/52/mode/2up?q=%22I+have+dwelt+perhaps+longer+than+I+intended%22

[13] As Minister of Munitions and Supply, Howe had ramped up Canada's war-time production capacity and became "the most important public entrepreneur in Canadian history." Michael Bliss, *Northern Enterprise: Five Centuries of Canadian Business* (Toronto: McClelland and Stewart, 1990), 443. In 1943, Howe beckoned members of the Toronto Canadian Club to rally around his vision for post-war Canada: "Let's build our post-war plans, not on the narrow base of public works and the dole but rather on the broad base of private industry, agriculture and forests, mines and fisheries." "Cabinet Ministers Differ on Need for Big Works Program." *The Toronto Telegraph,* (Toronto, Ontario) December 17th, 1943. https://www.warmuseum.ca/cwm/exhibitions/newspapers/canadawar/postwar_e.html

[14] Cited in Randall White, *Ontario: 1610-1985: A Political and Economic History* (Toronto: Dundurn Press, 1985), 273.

[15] Both Prime Ministers William Lyon Mackenzie King and Louis St. Laurent likewise expressed deep concern about the high financial cost of universal social welfare programs and unease about the impact of such programs on the work ethic of individuals. Gregory Marchildon, "The Cautious Liberal: St. Laurent and National Hospitalization," in *Louis St. Laurent: Politics and Policies for a Modern Canada,* ed. Patrice Dutil (Vancouver: University of British Columbia Press, 2020), 281.

Canada's growing wealth since confederation did little to foster concern over the capacity of market-based economies to create prosperity. In such a context, the extension of health and welfare programs was viewed by some as only *a* way to human wellbeing, not *the* way.

Thus, for all the espousal of the principle of universalism, critical analysis reveals that the belief that citizenship should include both political and social rights to a basic standard of living, proved to be a threatening perspective to states whose economies embraced a capitalist economic order. As historian of citizenship Derek Heater explained, citizenship and capitalism were, and are, uncomfortable bedmates:

> Capitalism generates economic inequalities, exacerbates class differences and encourages selfish acquisitiveness—all antithesis of the citizenship idea…. As citizenship has taken on social coloration, it has demanded its principle of equal status and dignity be supported by an amelioration of the effects of unbridled market forces. Some of the wealth from profits must be diverted, via taxation, to welfare and educational provision for the less fortunate. Thus, in the name of social citizenship the state intrudes on the liberty of the capitalist to enjoy all the profits he accrues from the operation of the free market.[16]

Acceptance of the universalism of social rights in Ontario thus abutted against the individualistic pursuit that capitalism encouraged. Under capitalism individuals were expected to work hard, succeed, and contribute to their society. A principle of universalism fostered a stereotype of "free loaders" and dampened enthusiasm to support those individuals who were seen to have failed either to succeed or to contribute. This tension between the idea of the individual in free market capitalism and the accepted responsibility of the state to actualize the social rights of citizens without prejudice remained a persistent current in policy decisions. In practical terms, it entrenched the stance that if citizens had the right to social welfare, they were expected, at least, to honour

[16] Derek Heater, *Citizenship: The Civic Ideal in World History, Politics and Education 3rd Ed.* (Manchester: Manchester University Press, 2004), 272-273.

their concomitant responsibility to make financial contributions to the government's efforts. Amidst this context, social citizenship rights appear to remain largely within a field of rhetorical idealism. When it came to the practicalities of implementing social programs, the discourse around access appeared to be at least, if not far more, about a quid pro quo for contributions to GDP than about an inalienable right to wellbeing. Like his federal counterparts, Frost found himself walking the line between two visions of human wellbeing.

The wariness around the extension of universal citizen rights based on an economic contract, held a particular potency in discussions of First Nations peoples. Once again like settler politicians at the federal level, provincial political leadership drew on similar race-based frameworks that viewed First Nations as less capable of living healthy productive lives. In 1950, for example, the Ontario government authorized the use of Donalda Dickie's *The Great Adventure: An Illustrated History of Canada for Young Canadians* in its middle schools: the book succinctly illustrates this widespread perspective. In her comparison of the "red man" and the "white man," Dickie wrote that "because of being uncivilized, our Indians could not make use of Canada's good farm land, nor of the other rich resources that nature had given her. To use these gifts, Canada needed civilized people, and they were already at her door."[17] That such a description of First Nations peoples as both uncivilized and unproductive received government sanction in a school textbook reveals the depth of its penetration into settler society. Racialized frameworks of First Nations peoples' perceived incapacity and their implied "unworthiness" to remain sovereign nations on the land did little to end the widespread "othering" of the First Nations peoples from White citizens in Ontario.

[17] Donalda Dickie, *The Great Adventure: An Illustrated History of Canada for Young Canadians* (Toronto: J.M. Dent and Sons, 1950) cited in José I. Igartua, *The Other Quiet Revolution: National Identities in English Canada, 1945-1971* (Vancouver, University of British Columbia Press), 66.

Closer to the centres of political discussion, despite the push against race-based discrimination, provincial politicians did not shy away from the use of racialized analysis. In contrast to Premier Frost's suggestion that contraventions of the Racial Discrimination Act and the Act to Promote Fair Employment practices would be few and far between, racialized portrayals of First Nations were endorsed by the provincial government itself. In 1951, MPP Mr. Robert Desmond (CCF, Hamilton Centre) challenged the Minister of Health Mackinnon Phillips to consider that the high rates of tuberculosis found in First Nations communities in Ontario were the product, not of a biological susceptibility, but the consequence of a people "who are obviously living under very poor conditions [and] not getting proper food."[18] In response, Phillips suggested the matter was more complicated; "You cannot change the whole habitat of a race…they want to live and be left alone and live as their fathers and grandfathers lived. It is more than just food, and so on."[19] Thus, even when alternative interpretations to the disproportionate suffering of First Nations communities were brought into the provincial legislature, settler politicians in power refused to dismiss the perspective that First Nations suffering was, to a certain degree, the product of racial choice. This perspective neither challenged the status quo nor compelled a significant internal review of policy and practice. In fact, when the province passed the *Act to Promote Fair Employment Practices* no provision was made for educating the public about prejudice. Consequently, instead of an anti-discrimination policy that focused change inwards, Frost's

[18] Ontario, Legislative Assembly, Hansard, 21 March 1951 (R. Thorneerry, Hamilton, Centre): p 100-102 https://archive.org/details/mar21hansard1951ontauoft/page/100/mode/2up?q=Thorneerry&view=theater
[19] Ontario, Legislative Assembly, Hansard, 21 March 1951 (MacKinnon Phillips, Minister of Health): p. 102. https://archive.org/details/mar21hansard1951ontauoft/page/100/mode/2up?q=Thorneerry&view=theater

government stressed the belief that settler society at its core was good, and that racial discrimination existed only among a few bad apples.[20]

Thus, Premier Frost's early engagement with integration was tepid. When MPPs in the provincial legislature asked Frost in March of 1951 whether he would support a resolution to the Federal Government asking that First Nations people be given full citizenship, his response was negative. Instead, he relied on the jurisdictional divisions of the *BNA Act* and reminded his colleagues that "we have enough trouble minding our own business."[21] Certainly, the management of an additional population was not a priority for the Frost government, given the high profile of public expenditures already in his government. In Ontario, the monies allotted for highway construction alone in 1953 would have made up the entire operations budget for the province prior to the war.[22] Compounding provincial concern about expenditures, many Ontario politicians expressed unease about the federal share of tax revenue. Ontario had already done battle with Ottawa in 1947 when Mackenzie King's government proposed to maintain the war-time practice of renting provincial taxing powers. Along with Quebec, Ontario under the leadership of George Drew, had staunchly refused.[23] By the 1950s unease remained. In 1952, MPP William H. Collings (PC, Beaches) proclaimed to the legislature that "if the design of Ottawa is to reduce our provinces and our

[20] Frost argued that violations of the new Act to Promote Fair Employment Practices, would "seldom if ever happen in this province of ours." Ontario, Legislative Assembly, Hansard, 13 March 1951 (Mr. Leslie Frost): 18. https://archive.org/details/mar13hansard1951ontauoft/page/4/mode/2up?q=Indian. Likewise, MPP J.B. Salsberg (PC, St. Andrew) believed discrimination was only practised by a minority of people. Ontario, Legislative Assembly, Hansard, 13 March 1951 (J.B Salsberg, St. Andrew): 46. https://archive.org/details/mar13hansard1951ontauoft/page/4/mode/2up?q=Indian

[21] Ontario, Legislative Assembly, Hansard, 13 March 1951 (Mr. Leslie Frost): 164. https://archive.org/details/mar13hansard1951ontauoft/page/4/mode/2up?q=Indian

[22] Ontario, Legislative Assembly, Hansard, 19 March 1953 (Mr. P.T. Kelly, PC Cochrane North): 308. https://archive.org/details/mar19hansard1953ontauoft/page/308/mode/2up

[23] White, *Ontario,* 275.

municipalities to bankruptcy, they are going the right way about it."[24] Such a stance appears to have superseded party affiliations in the province. If Ontario was to afford the demands of supporting the common good, so the 1954 Speech from the Throne stressed, "we need, we sorely need, a readjustment of governmental revenues all along the line."[25] Without increased financial resources and the autonomy to manage such revenue, politicians viewed First Nations peoples as an economic burden Ontario could not afford. Frost and his government repeatedly stressed Ottawa's complete monetary responsibility for First Nations' welfare.[26]

The project of integration, however, did not die. Frost did not maintain the same staunch opposition to federal-provincial cooperation that his predecessors had. As Randall White described, George Drew was "the last uncompromising defender of the tradition of the Ontario regional state begun by Oliver Mowat…some three quarters of a century before." Frost, elected Premier in 1949, instead "pursued a new 'spirit of cooperation' in federal-provincial relations [that] did not exactly give up on the old claims of the regional state, but…began a process of modernization."[27] Aided by his qualities as a "warm, practical, and friendly man," Frost and Prime Minister Louis St. Laurent developed a "positive warmth."[28] In addition to this new spirit of cooperation, recent changes to the *Indian Act* in 1951 had called on the provinces to make certain decisions about the

[24] Ontario, Legislative Assembly, Hansard, 9 April 1952 (William H. Collings, PC Beaches): 40. https://archive.org/details/apr910hansard1952ontauoft/page/n5/mode/2up
[25] Ontario, Legislative Assembly, Hansard, 16 February 1954 (Speech from the Throne): 56. https://archive.org/details/hansard1954ontauoft/page/56/mode/2up
[26] Ontario, Legislative Assembly, Hansard, 2 April 1953 (Leslie Frost, PC Victoria): 1308. https://archive.org/details/mar30hansard1953ontauoft
[27] White, *Ontario,* 276. Unlike Drew who was born into a Loyalist family in Guelph, Ontario, Frost did not readily express the same level of allegiance to heritage. As White explains, "Under [Frost] progressive conservatism in Ontario developed a remarkable capacity to bring diverse strands of the region's past together. Frost befriended Ontario's two Communist legislators, Salsberg and MacLeod, whom he saw simply as "Radicals" with a rash zest for improving the province." White, *Ontario,* 273.
[28] Robert Bothwell, Ian Drummond, and John English, *Canada Since 1945: Power, Politics and Provincialism* (Toronto: University of Toronto Press, 1981), 150.

experience of First Nations within their borders. Particularly, the new Act specified that provincial governments could decide whether First Nations peoples would be allowed to consume alcohol in licenced establishments. Moreover, provincial observers could not ignore either the rising birth rates in First Nations communities or the increase in migration off reserves.[29] It would also hardly pass the notice of policy makers in the province that in the 1950s Ontario was home to the largest population of First Nations peoples and had the most acreage within reserve boundaries.[30] Frost thus found himself unable to escape further consideration of the 'Indian problem' in Ontario. By 1953, he recognized in the provincial legislature that it was clearly the desire of the people of Ontario to "raise the status…the standard of living, and the way of life of the Indians."[31] The following month, Frost established *The Select Committee Appointed by the Legislative Assembly of the Province of Ontario to Inquire into the Civil Liberties and Rights with Respect to the Indian Population and Matters Relevant Thereto,* hereafter referred to as the Select Committee. Its task was to consider and negotiate the complex political, social, and economic context just described; namely, if the provincial government operated in a social and political milieu in which overt racial discrimination was politically unpalatable, but racialized economic anxieties about First Nations' capacities limited political will for the full extension of citizenship rights, then who, or rather what, was the Indian to Ontario?

The Terms of Negotiation: The Select Committee and the "Indian problem"

[29] John F. Leslie, "Assimilation, Integration or Termination: The Development of Canadian Indian Policy, 1943-1963" (Ph.D. Diss. Carleton University, 1999), 261.
[30] Carisse, "Becoming Canadian," 70.
[31] Ontario, Legislative Assembly, Hansard, 13 March 1951 (Mr. Leslie Frost): 160-162 (I-4). https://archive.org/details/mar13hansard1951ontauoft/page/162/mode/2up?q=Frost&view=theater

In his introduction of the Select Committee to the provincial legislature, Frost skillfully towed an ambiguous line. Wary to openly engage with racial discrimination or to commit his government to increased financial responsibility, Frost articulated that First Nations peoples were "citizens…in a different sense."[32] Certainly, First Nations peoples experienced a differentiated standard. Even though Frost claimed them to be citizens of Ontario, First Nations peoples in 1953 could not vote in its provincial elections, consume alcohol on reserves or in public drinking establishments, and were disqualified from the benefits of certain provincial legislation because their reserves lacked municipal status. In addition, Frost stressed that while First Nations peoples could be citizens of Ontario, the attendant status of Indian referred to an individual who remained the financial responsibility of the federal government. The Indian to the Frost government was therefore neither a 'normal' citizen of the province nor their ward. A race-based distinction, however, was not a viable option for a province that had committed to anti-discrimination work. While ever mindful of the limitations imposed on them by the *BNA Act*, the members of the Select Committee endeavoured to determine where and how Ontario "might assist the Indian toward the eventual goal of equality with the non-Indian."[33] But until the release of the findings of the Select Committee, First Nations peoples would remain situated in a second-class provincial citizenship.

The willingness of Frost to acknowledge the distinct experiences of First Nations peoples in Ontario appears at odds with the rising tide of universalism and equality that Frost himself, to a degree, had endorsed. Like the federal government and the Joint Committee of 1946-1948, Frost

[32] Ontario, Legislative Assembly, Hansard, 2 April 1953 (Mr. Leslie Frost): 1290. https://archive.org/details/mar30hansard1953ontauoft/page/n1289/mode/2up

[33] For a complete list of members of the Select Committee see appendix C. Members were selected to represent both the north and south of the province and were drawn from those MPPs with reserves in their ridings. Members John A. Fullerton (Thessalon), Wm. G. Noden (Fort Frances), Albert Wren (Sioux Lookout), and Grummett (Ansonville) were from the north of the province while the remaining members lived in the south.

and the Select Committee began their work with the belief that differences needed to be identified in order to be remedied. To be fair, a surface level of difference was acceptable to the settler state. Frost was keen to see First Nations continue to access their "ancient grandeur" and felt that they should be allowed to continue what the Select Committee described as their "picturesque and interesting customs."[34] But to permit segregation or inequality of treatment was no longer a politically viable stance in the postwar period. Equality was the watchword of the day, and it catalyzed an adjustment to politicians' conceptualization of the 'Indian problem.' Whereas the notion had once referred to the management of a racially segregated population within Canada, in post-war Ontario, political leadership joined a new discussion wherein the terms of negotiation centred on how legal ideas of race had created barriers to equality. The Select Committee was therefore not to examine the social exclusion and political oppression of First Nations peoples, but to review how the constructed legal status of the Indian other operated in the province. How could a population under federal jurisdiction truly be equal citizens of Ontario? Treaties and land rights were signals of difference, not of egalitarianism. In the summer of 1953, the eleven-man Select Committee, headed by Minister of Public Welfare William A. Goodfellow, set out to complete the province's first survey of conditions found among First Nations peoples living in Ontario.

In their investigations into the lived realities of First Nations, the members of the committee were never without stories of discrimination and harm over the loss of treaty rights and livelihoods. Members of the Tyendinaga community described the embarrassment they felt being turned down in beverage rooms, especially for those who had served with the Canadian Forces in World War

[34] Frost Ontario, Legislative Assembly, Hansard, 2 April 1953 (Mr. Leslie Frost): 1296. https://archive.org/details/mar30hansard1953ontauoft/page/n1295/mode/2up; Legislative Assembly of Ontario. *Civil Liberties and Rights of Indians in Ontario Final Report*. Toronto: 1954. https://archive.org/details/civillibertiesri00onta/mode/2up

II where no such restrictions had existed for them.[35] In addition, the Chief and Council of the Osnaburgh Band (Mishkeegogamang Nation) expressed their frustrations with discrimination in the granting of fishing licences where they witnessed a clear preference given to White fishermen.[36] Many communities articulated similar frustrations and shared their own stories of discrimination in employment as well as the challenges they encountered in benefiting from the material prosperity of the land. As Chief Jim Horton of the Rainy River First Nation explained, "the Indian never gets in on anything. There have been great mineral discoveries by the Indians—improvements are going on, but there is not one Indian being employed in all these improvements. We have asked about it, and there have [sic] been considerable controversy."[37] When First Nations individuals did find employment, conditions could be horrendous. The members of the Select Committee were met with stories of First Nations individuals who worked as farm labourers on fruit and tobacco farms in Southern Ontario in which they were "housed little better than cattle."[38] Far from the work of a few bad apples, discrimination seemed alive and well in the province.

Members were also met with narratives of loss. As the Mishkeegogamang Nation recounted in their brief to the Select Committee, their community was made to suffer the consequences of

[35] Select Committee on the Civil Liberties and Rights of Indians in Ontario, (October 1953), RG49-132 Container B234948 File Proceedings April, AO.
[36] Testimony at Sioux Lookout, Select Committee on the Civil Liberties and Rights of Indians in Ontario, 1953. RG49-132 Container B234948 File Proceedings August 29, 1953-September 2, 1953, AO. Such discrimination was a particular form of insult added to injury. From the perspective of the settler governments, treaty agreements with First Nations peoples had represented land surrender agreements, for which treaty parties were paid, on average, between four and five dollars a year. In 1946, the Ontario Department of Lands and Forests expected that every First Nation family that wanted access to a provincial trapline to pay an annual fee of five dollars a year back to the settler government. Proceedings Select Committee on the Civil Liberties and Rights of Indians in Ontario, (23-24 November 1953), RG 49-132 Container B234948 File Proceedings, AO.
[37] Chief Horton testimony to Select Committee on the Civil Liberties and Rights of Indians in Ontario, (29 August 291953- 2 September 1953), RG 49-132 Container B234948 File Proceedings, AO.
[38] Legislative Assembly of Ontario. *Civil Liberties and Rights of Indians in Ontario Final Report*. Toronto: 1954. https://archive.org/details/civillibertiesri00onta/mode/2up

settler-colonial commercial activities without adequate compensation. The brief testified to the economic, physical, social, and spiritual loss:

> Inadequate payment for all homes when they were flooded by the raising of the lakes by the Provincial Hydro Electric Power Commission. Also affected were our rice grounds and muskrat trapping in and around a chain of lakes in the central portion of our Indian Reserve #63 A. Following the rise of water these lakes lost our means. They have not produced [musk]rats or rice which was a severe blow especially to the older Indians who can only travel a short distance. Our graveyards were also flooded which exposed at least 10 of the remains. To our knowledge, no compensation was allowed for this devastation. Thus, the raising of the lakes benefited the P.H.E.P.C. but left us and our deceased without any of the benefits enjoyed by the white man.[39]

Likewise, Chief Jim Horton of the Rainy River First Nation added to the narratives of loss. While seated at a table draped with the large Union Jack flag that had been presented to the community when Treaty #3 was signed with them in 1873, Horton shared his communities' experience with negligence, discrimination, and broken trust:

> We have been listening to all these fine promises, even in writing, and yet, we are gradually losing our Reserves. We are told that they are sold, but I have never seen a red cent from the property which has been sold. We have not seen any proceeds from the minerals on our reserve, and they have employed all white people. There is a highway going through our reserve, but none of our people have been employed. Even cutting grass at the sides of the road—they have never employed any of our Indians. Just let me try and get a job on the highway and see what happens![40]

As signatories of treaties #9 and #3 respectively, both the Mishkeegogamang and Rainy River Nation had every right to expect such benefits, remediation, and support.[41]

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[39] Brief from Mishkeegogamang Nation (listed as Osnaburgh) to Select Committee on the Civil Liberties and Rights of Indians in Ontario, (29 August 1953- 2 September 1953), RG 49-132 Container B234948 File Proceedings, AO.
[40] Chief Horton testimony to Select Committee on the Civil Liberties and Rights of Indians in Ontario, (29 August 1953- 2 September 1953), RG49-132 Container B234948 File Proceedings, AO.
[41] Each treaty promised that signatories could expect "to make a treaty and arrange with them so that there may be peace and good will between them and Her Majesty and that they may know and be assured of what allowance they are to count upon and receive from Her Majesty's bounty and benevolence…. To have and to hold the same to Her Majesty the Queen, and Her successors forever." *The James Bay Treaty - Treaty No. (Number) 9 (Made in 1905 and 1906) and Adhesions Made in 1929 and 1930, Reprinted from the edition of 1931 Roger Duhamel, F.R.S.C.* (Ottawa, Queen's Printer and Controller of Stationery, 1964); *Treaty 3 between Her Majesty the Queen and the Saulteaux Tribe of the Ojibbeway Indians at the Northwest Angle on the Lake of the Woods with Adhesions Reprinted from the edition of 1966 Roger Duhamel, F.R.S.C.* (Ottawa, Queen's Printer and Controller of Stationery,

The sentiment of exploitation was not reserved for northern communities. Chief Telford Adams of the Aamjiwnaang Nation echoed such frustrations, explaining:

> The Indians once owned this country—but in 1952, the Province of Ontario derived $300,000 from wildlife. We would appreciate anything that could be done to help us—our mineral rights—we are entitled to a portion of that. Remember that we once owned this country…Always remember, too, that we are not exactly a financial detriment to the Federal Government. They have had a lot of free rides from the Indians in Canada.[42]

The field reports of meetings in First Nations communities thus add particularly damning evidence against the argument that First Nations peoples needed to contribute more to Ontarian society to 'earn' the benefits that integration policy sought to extend to them. In reality, the advocacy of First Nations leaders reveals the long-ignored and ever-increasing debt owed to First Nations peoples. Moreover, these testimonies collectively highlight with greater specificity the depth of settlers' inadequate efforts to honour treaty promises. In their repeated attacks on First Nations access to and relationships with land, settlers profoundly failed to protect First Nations well-being.[43]

Chair of the Select Committee, W.A. Goodfellow responded to such grievances in broad terms. Records of the field visits are filled with speculations and vague suggestions. At Tyendinaga,

1978). See also, Brittany Luby, "The Department is Going Back on These Promises": An Examination of Anishinaabe and Crown Understandings of Treaty," *The Canadian Journal of Native Studies,* XXX, no. 2 (2010): 203-228. John S. Long, *Treaty No. 9: Making the Agreements to Share the Land In Norther Northern Ontario in 1905* (Montreal-Kingston: McGill-Queens Press, 2010).

[42] Chief Telford Adams, Aamjiwnaang Nation (Listed as Sarnia Reserve) to Select Committee on the Civil Liberties and Rights of Indians in Ontario, (23-26 September 1953), RG 49-132 Container B234948 File Proceedings, AO.

[43] Nishnaabeg scholar Leanne Simpson describes what Nishnaabeg diplomats expected from treaty signing with settlers: "This was the impetus for those very first treaties— Nishnaabeg freedom, protection for the land and the environment, a space—an intellectual, political, artistic, creative, and physical space where we could live as Nishnaabeg and where our kobade [grandchildren] could do the same." Leanne Betasamosake Simpson, *As We Have Always Done: Indigenous Freedom Through Radical Resistance* (Minneapolis: University of Minnesota Press, 2017), 9.

Goodfellow explained that, *if possible,* they hoped to make life better for that community.[44] At Six Nations, he pointed out that "There are other services, which, through co-operation with the Federal Department, *might* be extended to the Indian people."[45] As a fact-finding tour, however, Goodfellow and his colleagues had to remain vigilant against making promises that would not or could not be kept. Instead, the pursued path of remediation focused heavily on the ways in which First Nations' lives could be materially improved without destabilising the institutional status-quo. In particular, significant attention was paid to the extension of the right to vote to First Nations people so that they could advocate for themselves within the established settler system. As Committee member W.J. Grummett explained to a group gathered at Manitou Rapids, "If you had voice in the Province, you could 'lick' some of your own difficulties. Your representative would speak up and express your rights for you. If you helped elect your own representative, you would have more attention paid to your problems."[46] From this position, it is clear that while the members of the Select Committee felt reservations about the degree to which Ontario could aid First Nations peoples, they were more than willing to increase the reach of colonial sovereignty through the extension of the vote and its allied contract of ('full') citizenship.

Whether, and in what form, First Nations communities wanted any or all of the privileges and responsibilities that Canadian citizenship was alleged to offer them deserves a much more thorough and community-led historical examination than is possible here. It is nevertheless important to highlight that, settler archives contain ample evidence of a clear pattern of wanting

[44] William A. Goodfellow at Tyendinaga. Select Committee on the Civil Liberties and Rights of Indians in Ontario, (April, October 1953), RG49-132 Container B234948 File Proceedings, AO.
[45] W.A. Goodfellow at Six Nations [Emphasis added] Select Committee on the Civil Liberties and Rights of Indians in Ontario, (23-26 September 1953), RG 49-132 Container B234948 File Proceedings, AO.
[46] W.J. Grummett at Manitou Rapids. Civil Liberties and Rights of Indians in Ontario, (29 August-2 September, 1953), RG 49-132 Container B 234948 File Proceedings, AO.

more from Canada than what Ottawa was willing to offer. Specifically, the field meetings of the Select Committee reflected a unified interest in the maintenance of Indigenous or treaty rights and improvements in the standard of living/well-being for First Nations peoples. At Six Nations, for example, community member Mr. Stocks, challenged the settler governments to end their discriminatory and isolating treatment of his community, and drew on the social anxieties of the time to argue that First Nations on reserves lived behind "an iron band…a red curtain." He explained, "I would like to see our rights given back to the Indians; but our rights go further than that. If we are given the right to vote, then we should be given the benefits of all the welfare schemes. An agreement could be made between the Province and the Federal Government. They could work together to help the Indians."[47] Others in the community expressed greater skepticism about settler intentions. An unnamed member of the Six Nations offered a warning to his community. "The Six Nations are treaty people," he explained,

> and they have been overlooked. They are planning to destroy the Indian rights. They are planning the future of another race, another people. That is a serious thing in a country of this kind. Parliament is due at any time to dissolve all our councils, and make municipal entities of these reserves—turn them over to the province. This is the step you are preparing to make. Perhaps we will get a good many benefits from it, but I do not want to sell my future destiny for the privilege of indulging in a glass of beer.[48]

Despite this pointed criticism of settler practice, the member was not wholly against collaboration. He turned to the members of the Select Committee present, "we are glad you are taking an interest in us" he clarified "but work it out in a different manner."[49]

[47] Mr. Stocks testimony, Six Nations, Select Committee on the Civil Liberties and Rights of Indians in Ontario, (23-26 September 1953), RG 49-132 Container B 234948 File Proceedings, AO.
[48] Unnamed community member at Six Nations to Select Committee on the Civil Liberties and Rights of Indians in Ontario, (23-26 September 1953), RG 49-132 Container B234948 File Proceedings, AO.
[49] Unnamed community member at Six Nations to Select Committee on the Civil Liberties and Rights of Indians in Ontario, (23-26 September 1953), RG 49-132 Container B234948 File Proceedings, AO.

Clearly then, despite evidence of harms and broken trust, communities still maintained a desire to nurture and repair a suffering relationship. Standing again in front of a tattered Union Jack, Chief Horton declared "this is our first flag, given to us after the signing of the treaty. We are very loyal. We like that old flag. All our treaties are gradually disappearing, and we do not have any rights, but, in spite of all this, we like that old flag."[50] The field reports reveal, however, that such repair could not occur under the current paternalistic and hegemonic power of the settler state. Instead, there were renewed calls for a change in the terms of negotiation. This shift in perspective was succinctly summed up by Mrs. Leslie Cross, the President of the Homemakers' Club at Tyendinaga, when she explained "We often hear the expression, 'the Indian problem'…what to do about the Indian…he is a problem…but I would like to say—we are not the problem. It is you who are the problems to us. It is all in the point of view." Cross then continued to offer an alternative path forward, "we must reach decisions, whatever they are, just as our ancestors did. They came to some conclusions and acted upon them. We must do the same. We must ask questions. If we talk over the little problems, have discussions and come to a mutual understanding, then we can mould something to be treasured by future generations."[51] The call for a fundamental reframing of the causal agents of First Nations' suffering and to reconcile the broken trust in the relationship between First Nations peoples and settler governments remained unheeded.

Instead, members of the Select Committee pushed forward their myopic agenda. Time and again members expressed their belief that the best chance for First Nations to achieve prosperity in the 'modern' world was to integrate into White settler society. The depth of this confidence can be

[50] Chief Horton testimony to Select Committee on the Civil Liberties and Rights of Indians in Ontario, (29 August-2 September 1953), RG 49-132 Container B234948 File Proceedings, AO.
[51] Mrs. Leslie Cross, President of the Homemakers' Club at Tyendinaga. Select Committee on the Civil Liberties and Rights of Indians in Ontario, (April; October 1953), RG 49-132 Container B234948 File Proceedings, AO.

seen in the ways in which members framed the extension of citizenship to First Nations peoples as both natural and inevitable. Notwithstanding the repeated articulations that the Committee had no desire to interfere in the lives of First Nations communities, in their addresses to communities at various field visits, the discourse of committee members removed the concept of choice for First Nations peoples about whether they wanted to be citizens of Ontario or not. First Nations peoples were repeatedly told that they were already citizens of Ontario, had been citizens of Ontario long before many of the members of the Select Committee, and that their children would be "our future citizens."[52] How an individual could be a Citizen*, a citizen with neither the right to vote nor access to the same social services as other citizens, was not discussed. In discussions with First Nations communities, citizen appeared to be a stand-in for a resident who could hope for such privileges when the Ontario government deemed that it was ready to extend them. The framing was certainly strategic. As anthropologist Raymond Apthorpe has highlighted, "policy language is itself a form and source of policy power. Policy discourse tries more to persuade than describe."[53] With the naturalization of First Nations' provincial citizenship status, members of the Select Committee pursued settler agendas and sidelined alternative forms of relationship. To further champion the 'rightness' of their cause, members also drew on their positions of power to define which kinds of responses were deemed rational or appropriate. For example, when a community came out against the extension of the vote, great suspicion was expressed but not when the opposite outcome occurred. When a community spokesperson raised the issue of land loss, the representativeness of such a position was called into question. Resistance to the extension of the

[52] See Goodfellow and Cathcart, Civil Liberties and Rights of Indians in Ontario, (29 August- 2 September 1953), RG 49-132 Container B234948 File Proceedings, AO*;* Select Committee on the Civil Liberties and Rights of Indians in Ontario, (April; October 1953), RG 49-132 Container B234948 File Proceedings, AO.
[53] Raymond Apthorpe, "Writing Development Policy and Policy Analysis Plain and Clear: On Language, Genre and Power," in *Anthropology of Policy: Critical Perspectives on Governance and Power,* eds. C. Shore and S. Wright (London: Routledge, 1997), 43-58.

provincial vote was also explained away as the result of 'primitive' mindsets from communities who had had only limited interaction with White communities.[54] For a committee tasked with the investigation of an issue, they appeared to have come with their answers predetermined. The *zeitgeist* of integration remained powerfully entrenched.

Equality as a Tool of Colonialism

When the members of the Select Committee set out to complete their mandate, they sought to remedy their self-professed ignorance of 'the way in which the Indian lives…of his relations with the non-Indian, and his problems of adjustment to modern day living."[55] Upon completion of their work, a final report was compiled to share their findings with Premier Frost, their fellow MPPs, and the public. After nine meetings, over 26 days, visits to 16 agencies, and submissions from 37 First Nations communities, Ontario had its proposed pathway to manage the 'problem' of the post-war Indian. In his address to the provincial legislature, Goodfellow stressed that the work of the Committee could provide no 'cure all' for the many problems which "beset two civilizations living together" but, he nevertheless hoped that their recommendations would "assist the senior government in its work toward the eventual integration of Indians."[56] In brief, Ontario was now ready to begin the move towards the extension of 'full' citizenship to First Nations communities for whom their citizenship status had been qualified to be little more than a stand-in for resident.

[54] Mr. Nixon, Select Committee on the Civil Liberties and Rights of Indians in Ontario, (23-24 November 1953), RG 49-132 Container B234948 File Proceedings, AO. Select Committee on the Civil Liberties and Rights of Indians in Ontario, (April; October 1953), RG 49-132 Container B234948 File Proceedings, AO.
[55] Legislative Assembly of Ontario. *Civil Liberties and Rights of Indians in Ontario Final Report*. Toronto: 1954. https://archive.org/details/civillibertiesri00onta/mode/2up
[56] Ontario, Legislative Assembly, Hansard 29 March 1954, (W.M. Goodfellow): 875. https://archive.org/details/hansard1954ontauoft/page/874/mode/2up?view=theater

Table 3: Summary of Recommendations of the Select Committee

1. Give Indians equal voting rights with non-Indians.
2. All levels of government should intensify efforts to encourage Indians to make use of huge acreage of good farmland at their disposal.
3. Allow Indians to drink in licenced establishments.
4. Reach agreements with the Indian Affairs Branch to allow Indians to access provincial Homes for the Aged.
5. Reach agreements with Indian Affairs Branch to enable the extension of Children's Aid Societies services on reserve, with full compensation from the federal government.
6. Appoint an Indian liaison person to work under the Minister of Public Welfare or the Minister of Education.
7. Ensure the widespread dissemination of this report.

The recommendations of the Select Committee offered a three-fold approach. To actualize what Goodfellow deemed the "emancipation of the Indian", the province needed to negotiate the end of the protective paternalism of the federal government, expand training in areas that the Ontario government approved, and impose standards of equal treatment.[57] Significant gestures to remove race-based discrimination came in quick succession. In 1954, the Lieutenant-Governor announced in his prorogation speech that henceforth First Nations in Ontario would have full voting rights in provincial elections. A few months later, in February 1955, the *Indian Welfare Service Act* was introduced which would allow First Nations widows whether on or off reserve to benefit from the Ontario Mother's Allowance Act. In addition, First Nations peoples would now have equal access to various welfare programs in Ontario, including the Blind Persons' Allowance, Disabled Persons' Allowances and Old Age Assistance. The following year, the federal and provincial government also agreed to enter negotiations to develop agreements to extend the services of child

[57] Ontario, Legislative Assembly, Hansard 29 March 1954, (W.M. Goodfellow): 875. https://archive.org/details/hansard1954ontauoft/page/874/mode/2up?view=theater

welfare services onto reserves and to allow First Nations peoples to access homes for the aged when in need.[58] First Nations people also became eligible to drink in licensed establishments. Finally, the provincial government hired a prominent figure from Six Nations, Elliot Moses, to serve as a liaison officer under the Minister of Public Welfare. The path to equality and integration seemed well underway.

At first glance, such developments appear laudatory. First Nations communities would have access to social services as never before in the province of Ontario. From the perspective of Critical Race Theory and Post-Colonial Theory, however, the discourse of the Select Committee, its final report, and Ontario's response to it held some unsettling assumptions. Indeed, Anishinaabe scholar Leanne Betasamoke Simpson has warned against the uncritical acceptance of incremental change. She argues, "Neoliberal states manipulate the processes that maintain settler colonialism to give the appearance that the structure is changing…colonialism as a structure is not changing. It is shifting to further consolidate its power, to neutralize resistance, to ultimately fuel extractivism."[59] Notably, the above mentioned all make it clear that the First Nation individual is to be the centre of change and that without this change, First Nations could become a liability for the province.[60] This stance was the result of the longstanding and racialized anxiety discussed earlier that First Nations peoples did not have the capacity or the desire to contribute to the settler state. Like the

[58] For more on the relationship between racism, colonialism, and child welfare in Canada see Cindy Blackstock, "The Occasional Evil of Angels: Learning from the Experiences of Aboriginal People and Social Work," *First Peoples Child and Family Review* 4, no. 1 (2009): 28-37. The passage of this agreement played a critical role in the horrific practice of 'scooping' Indigenous children from their families and communities and placing them into settler homes. See, Allyson Stevenson, *Intimate Integration: A History of the Sixties Scoop and the Colonization of Indigenous Kinship* (Toronto: University of Toronto Press, 2020).
[59] Simpson, *As We Have Always Done,* 46.
[60] By 1954, various provincial departments in Ontario were already spending $600,000 per year on 'Indians.' A figure that amounted to approximately $17 per capita. Ontario, Legislative Assembly, Hansard 29 March 1954, (W.M. Goodfellow): 877. https://archive.org/details/hansard1954ontauoft/page/876/mode/2up?view=theater

federal government, members of the Select committee endorsed the perspective that First Nations peoples when left alone, without training and the educative example of the 'modern' White man, would languish in contemporary Canada and remain content to subsist on perceived undeserved support. This fear found clear space in the Committee's final report, which articulated the belief that "Indians lack the healthy respect for the future held by the rest of the population."[61] Given several comments uttered at field meetings, such content was unsurprising. Members repeatedly expressed their belief that First Nations peoples could find employment if they only tried or that the reason many First Nations children suffered in school was because they came from undisciplined homes. 'The Indian' as a race remained the problem in spite of commitments to anti-discrimination.[62]

One strategy to ameliorate the anxiety of politicians in Ontario was to take a page from the federal government and stress that new investments in First Nations peoples were exclusively voluntary.[63] Furthermore, Goodfellow explained that the province should be ready to accept a larger role in the provision of services to First Nations peoples, but the Federal government, with its significant tax powers, should remain as the prime financial backer of such efforts.[64] These rhetorical bulwarks against financial obligation allowed the provincial government to provide services for First Nations 'citizens' but on terms they were financially and ideologically comfortable with. For

[61] Legislative Assembly of Ontario. *Civil Liberties and Rights of Indians in Ontario Final Report*. Toronto: 1954. https://archive.org/details/civillibertiesri00onta/mode/2up

[62] Anthropologist Patrick Wolfe has explored the settler-colonial use of the "organizing grammar of race" to further the aims of the settler colonial state in other international contexts. Patrick Wolfe, "Settler Colonialism and the Elimination of the Native," *Journal of Genocide Research* 8, no. 4 (December 2006): 387-388.

[63] Ontario, Legislative Assembly, Hansard 29 March 1954, (W.M. Goodfellow): 877. https://archive.org/details/hansard1954ontauoft/page/876/mode/2up?view=theater

[64] Ontario, Legislative Assembly, Hansard 29 March 1954, (W.M. Goodfellow): 878. Goodfellow noted that if the province was to "assume the problem of extending health care and education to the Indians…it is only logical that the Federal Government should pay for them."
ttps://archive.org/details/hansard1954ontauoft/page/876/mode/2up?view=theater

Ontario's leadership, integration was not to dissolve the jurisdictionally divided financial responsibilities within the *BNA Act.*

In addition, the Select Committee placed their enthusiasm in the realm of education. If the racialized Indian citizen could be trained to think and behave as a White citizen, then it was believed that the 'Indian problem' would be solved. This perceived sameness on the part of settlers could then be used to undermine the treaty rights of First Nations peoples. Here, the observations of Mr. J.A. Pringle (PC, Addington), member of the Select Committee, are illustrative. After travelling about the province, Pringle "arrived at…Tyendannaga [sic]… [where he] did not see an Indian there who could be readily distinguished as such. They are just white people, and it surprised me that those people whom one could not distinguish from other Canadians were still living on a reserve and demanding that $4 or $5 a year, for the one and only purpose of avoiding tax."[65] In drawing on behavioural comparisons, Pringle both employed reified racialization through the attribution of a particular kind of behaviour and reinforced the notion that the Canadian way of life was seen as White. From this standpoint, First Nations peoples could access elements of Whiteness through trained changes in their thought and behaviour. Then, equality discourse was employed to frame any form of differentiated treatment, especially treaty rights, as access to "unequal privileges." Settlers in positions of power therefore not only maintained earlier racialization and its hierarchies but also continued the settler colonial project to destabilize First Nations assertions of sovereignty and treaty partnership. Such efforts stem from what anthropologist Patrick Wolfe has termed "the logic of elimination," in which settler colonialism is a malleable structure that

[65] Ontario, Legislative Assembly, Hansard 1 April 1994, (J.A. Pringle): 1090. https://archive.org/details/hansard1954ontauoft/page/1088/mode/2up?q=%22just+white+people%22

continuously works to remove Indigenous sovereignty to land rather than a single event of invasion.[66]

Of additional and related concern for Select Committee members was the desire to see that First Nations peoples be trained to become 'productive' members of settler society. Here too, provincial leaders took from the example of the federal government who for generations "were determined to subdue Indians and to teach them lessons in liberal economic theory and individual survival in the marketplace."[67] To achieve this aim, Select Committee members suggested a return to a longstanding approach: teach First Nations people to farm. Members had discovered on their fact-finding tour that many acres of land were "lying idle," and they feared that "some of the best agricultural land anywhere [was] going to waste on Indian Reserves."[68] They therefore included in their final recommendations that "renewed and extended efforts be made by all levels of government to encourage Indians to make use of the huge acreages of good agricultural land at their disposal."[69] Not only would that produce sustenance for reserve communities, but the surplus could also be sold to generate income for the residents. First Nations and their land could then become producers for Ontario, contributing to the wider community, and "earning" the right to Ontario's help. It is worthwhile to note that the federal government shared this concern and desire to see land reserved for First Nations peoples developed as natural resources for market production. The annual reports of the Indian Affairs Branch frequently listed the branch's financial gain from

[66] Wolfe, "Settler Colonialism and the Elimination of the Native," 387-388.
[67] Hugh Shewell, *'Enough to Keep Them Alive': Indian Welfare in Canada, 1873-1965* (Toronto: University of Toronto Press, 2004), ix.
[68] "W.A. Goodfellow. Select Committee on the Civil Liberties and Rights of Indians in Ontario, (23-24 November 1953), RG 49-132 Container B234948 File Proceedings, AO, Legislative Assembly of Ontario. *Civil Liberties and Rights of Indians in Ontario Final Report*. Toronto: 1954. https://archive.org/details/civillibertiesri00onta/mode/2up
[69] Legislative Assembly of Ontario. *Civil Liberties and Rights of Indians in Ontario Final Report*. Toronto: 1954. https://archive.org/details/civillibertiesri00onta/mode/2up

timber, oil exploration rights and land sales. In 1954 for example twenty-four permits to prospect were issued on reserves in Ontario to add to the assessment work on 109 claims already underway.[70] To add urgency to this proposed pathway, members of the Select Committee framed the choice of First Nations peoples to be a matter of survival. In an echo of the earlier discourse of 'the dying race', Goodfellow explained that "through education, the Indians will gradually appreciate the fact that in spite of their desires which they inherited to retain their own way of life, to survive and to progress, they must, of necessity, assume full citizenship."[71] Like their federal counterparts, settler politicians thus defended their power to define post-war problems, to determine acceptable pathways forward, and to maintain the status quo.[72]

Finally, the work of the Select Committee made clear the perspective among those in positions of power, that First Nations peoples could not be extended the social rights of Ontarian citizenship without their acceptance of its responsibilities. In fact, Goodfellow went so far to suggest his concern at a closed meeting of the Committee that if the privileges of citizenship were extended in great advance of the acceptance of responsibilities, then "what encouragement would that be for them to become assimilated."[73] Given that the IAB's annual reports in the 1950s stressed that First

[70] Department of Citizenship and Immigration, *Report of the Indian Affairs Branch for the Fiscal Year Ended March 31, 1955.* Ottawa: Queen's Printer, 1955. *Library and Archives Canada.* https://recherche-collection-search.bac-lac.gc.ca/eng/home/record?app=indaffannrep&IdNumber=34021&new=-8585511377371153976

[71] Ontario, Legislative Assembly, Hansard 29 March 1954, (W.M. Goodfellow): 879. https://archive.org/details/hansard1954ontauoft/page/878/mode/2up?view=theater

[72] Anishinaabe Scholar Leanne Betasamosake Simpson highlights how the settler desire for land has been about both financial exploitation as well as direct attacks on Indigenous person and nationhood: "A great deal of colonizer's energy has gone into breaking the intimate connection of Nishnaabeg bodies (and mind and spirits) to each other and to the practices and associated knowledges that connect us to land, because this is the base of our power. This means land and bodies are commodified as capital under settler colonialism and are naturalized as objects for exploitation." Leanne Betasamosake Simpson, *As We Have Always Done: Indigenous Freedom Through Radical Resistance* (Minneapolis: University of Minnesota Press, 2017), 41.

[73] W.A. Goodfellow. Select Committee on the Civil Liberties and Rights of Indians in Ontario, (23-24 November 1953, RG 49-132 Container B234948 File Proceedings, AO. An editorial in the Kingston-Whig Standard went even further to express outrage at the prospect of giving First Nations people the right to vote without the guarantee of accepted responsibilities. "'No taxation without representation' was a good cry," the article claimed, and "we think

Nations peoples were experiencing material improvements and "shared fully in national prosperity," settler leadership resented any attempt on the part of First Nations to shirk the responsibilities of citizenship they were offered, namely taxation.[74] Here again, the trope of the "lazy Indian" resurfaced.[75]

In response, committee members presented acceptance of this responsibility and the wider contract of settler citizenship as a choice that could only be in First Nations' best interests.[76] For example, committee members stressed on the fact-finding tour that engagement in such a contract would place First Nations, as citizens of the province, in a better position to advocate for themselves in the future. Moreover, it was felt that the extension of the right to vote to First Nations living on reserves would encourage a sense of belonging among First Nations people within the settler state.[77] This hoped-for sentiment was a key objective of both levels of settler government, whose colonial project remained unfulfilled while pre-existing sovereignties existed on the land.[78] The

'no representation without taxation' is just as good." "Editorial," *Kingston-Whig Standard* (Kingston, Ontario): April 1,1954, 4.

[74] Department of Citizenship and Immigration, *Report of the Indian Affairs Branch for the Fiscal Year Ended March 31, 1953.* Ottawa: Queen's Printer, 1953. *Library and Archives Canada.* https://recherche-collection-search.bac-lac.gc.ca/eng/home/record?app=indaffannrep&IdNumber=33925&new=-8585511376537661284

[75] See John Lutz's elucidation of settler-colonialism's development of and investment in the trope of the "lazy Indian" in greater detail in *Makúk: A New History of Aboriginal-White Relations* (Vancouver: University of British Columbia press, 2009), 33-34.

[76] Scholar Paulette Regan has explained the value of this framing to settler peoples, "Canadian society subscribes to the peacemaker myth" Regan argues, "as we cast ourselves as heroes on a mythical quest to save Indians. In this way we deflect attention from the settler problem. To do otherwise, would engender our own collective identity crisis and expose us to the trauma of admitting uncomfortable truths." Paulette Regan, *Unsettling the Settler Within: Indian Residential Schools, Truth Telling, and Reconciliation in Canada* (Vancouver: University of British Columbia Press, 2010), 34-35.

[77] See W.A. Goodfellow at Tyendinaga. Select Committee on the Civil Liberties and Rights of Indians in Ontario, (April; October 1953) RG 49-132 Container B234948 File Proceedings, AO*;* and Bryan L. Cathcart at Manitou Rapids, Select Committee on the Civil Liberties and Rights of Indians in Ontario, (29 August – 2 September 1953), RG 49-132 Container B234948 File Proceedings, AO.

[78] Wolfe, "Settler Colonialism and the Elimination of the Native," 387-409. In the specific discourse of citizenship, Derek Heater has explained that "all theories of citizenship based on the notion of popular sovereignty assume that the exercise of power by any individual or group is legitimate only if, in the last resort, it is sanctioned by the people as a whole." Heater, *Citizenship,* 164. See also, Emma Battell Lowman and Adam J. Barker, *Settler: Identity and Colonialism in the 21st Century Canada* (Halifax: Fernwood Publishing, 2015).

goal was to establish individual citizens of the province, not engage with competing nationhoods. Thus, alternative claims to settler assistance, such as the land sharing agreements of Treaties 3 and 9 in the north of the province were not seen as germane to provincial efforts. Instead, committee member Mr. Bryan Cathcart went so far as to align the acceptance of settler citizenship responsibilities with a call to arms in war: "We appreciate the fact that many of you protected our land in war time, but there is a job to do in peacetime. You should be accorded the responsibility to put yourselves in a position that you could approach us for future benefits."[79] Put another way, without the acceptance of responsibility to the settler state, First Nations peoples should have limited hope that the province would increase support. Treaty rights need not apply.

The ultimate message of the Select Committee is that First Nations peoples could indeed expect better from the provincial government in the post-war period, but they could not expect a recognition of rights and privileges beyond that of the average Ontario citizen. The final report of the Select Committee succinctly articulated this widely held settler sentiment: "The time is not far off when the Indian will take his rightful place alongside his non-Indian neighbour with full equality—neither maintaining his present exceptional benefits, nor his now almost imaginary disadvantages."[80] Thus, provincially led changes did little to disrupt the status quo. Instead, the final report stressed the need to educate First Nations peoples in the ways of settler life and to encourage them "to leave their protective shelter under the provisions of the *Indian Act*."[81] Would

[79] Bryan L. Cathcart in Nipigon Region. Select Committee on the Civil Liberties and Rights of Indians in Ontario, (29 August – 2 September 1953), RG 49-132 Container B234948 File Proceedings, AO.
[80] Legislative Assembly of Ontario. *Civil Liberties and Rights of Indians in Ontario Final Report*. Toronto: 1954. https://archive.org/details/civillibertiesri00onta/mode/2up
[81] Legislative Assembly of Ontario. *Civil Liberties and Rights of Indians in Ontario Final Report*. Toronto: 1954. https://archive.org/details/civillibertiesri00onta/mode/2up

this entrenchment of settler-colonial priorities over calls for new policies and renewed relationships truly facilitate improvements to First Nations peoples' well-being?

A Second-Class Citizenship: The Case of Red Lake

Of course, it is too much to expect one case study to encapsulate the diverse experiences of many communities across Ontario. A brief review of the experience of several off-reserve First Nations individuals around the vicinity of Red Lake in Northern Ontario is nevertheless useful. The case of Red Lake reveals the precarious position that many First Nations peoples were placed in when neither the federal nor provincial governments heeded their call for a new relationship in the post-war period based on mutual respect and well-being, not colonial aims. Moreover, it illuminates the devastating consequences for populations who were left to fall through the cracks when all levels of settler governments deemed their care a burden and all but turned away.

Red Lake is a small municipality in the northwestern region of Ontario, just 100 km from the Manitoba border, approximately 500 kms from Thunder Bay, and within the boundaries of Treaty Three.[82] By the mid-1950s, both provincial and federal actors expressed concern for and about a group of 102 First Nations families who lived within the district of Red Lake. By all accounts, conditions at Red Lake were terrible. First Nations individuals were described as living in little more than abandoned prospectors' shacks and lakeshore tents. Local Conservative MP W.M. Benidickson wrote to Col H.M. Jones, Director of the Indian Affairs Branch, to stress his belief that "the prevailing conditions create a widespread public scandal for which the Federal

[82] The closest First Nations communities to Red Lake are the Lac Seul First Nation and Wabauskang First Nation.

Administration in the end will receive indelible blame." He went on to criticize the Federal government's policy decisions as completely ineffective; "I have never understood why the Indian Department Health Nurse would be located in Kenora where there are adequate health services. I do believe that if a nurse is required on Government staff it would be better to have her based in the Red Lake area, where health and welfare conditions are admittedly deplorable."[83] Jones did not address Benidickson's concerns but, instead, forwarded them to Percy Moore at the Indian Health Services branch of the Department of National Health and Welfare.

Such information would not have been new to either Jones or Moore. Seven months earlier the two senior leaders had exchanged concerned correspondence about the First Nations individuals they viewed as "squatters" at Red Lake. Then in September, the Sioux Lookout News had reported that the Northwest Ontario Associated Chambers of Commerce had passed a resolution urging the federal government to conduct a thorough probe of the situation.[84] Finding a solution, however, Moore stressed to Jones was not their responsibility alone. In line with integration efforts, the fact that this group did not live on a reserve dictated, for federal leadership, provincial involvement. As Moore speculated to Jones, "I wonder if, as a result of your conversations with provincial authorities, and mine with the Health Department, we are going to be able to convince the province to accept responsibility for these people...I will be glad to co-operate with you and with the provincial authorities to work out any feasible program for their improvement."[85] For the Indian

[83] Letter from W.M. Benedickson to H.M. Jones, quoted in letter from Jones to P.E. Moore. Department of National Health and Welfare, (2 November 1955), RG 29 Vol 2911 File 851-1-A494 Pt. 3, Indian and Northern Health Services, Sioux Lookout District, LAC.
[84] "Urge Probe of Indians at Red Lake," Sioux Lookout News, (28 September 1955), [cited in Department of National Health and Welfare, (2 November 1955), RG 29 Vol 2911 File 851-1-A494 Pt. 3, Indian and Northern Health Services, Sioux Lookout District, LAC.
[85] Letter from P.E. Moore to H.M. Jones, (25 April 1955), RG 29 Vol 2911 File 851-1-A494 Pt. 3, Indian and Northern Health Services, Sioux Lookout District, LAC.

Health Services branch in particular, since the early 1950s, they had doubled down on their policy to only give aid to First Nations peoples who had resided on a reserve within the last twelve months.

Despite the rhetoric of the Select Committee two years previously that First Nations peoples were citizens of the province, aid was not forthcoming. In response to Moore's call for personnel support to improve the health and sanitary conditions of those First Nations at Red Lake, the Deputy Minister of Health for Ontario, Dr. J.T. Phair implied there was little he could do. With an expression of regret, Phair explained "we here have no itinerant staff who can move from one place to another [therefore] I am frankly unable to offer anything in the way of help."[86] As the Ontario Health Survey indicated in 1952, Ontario faced its own acute shortage of trained nursing staff and Phair was himself likely frustrated with his own workforce limitations.[87] The lack of government will for even a small contribution in the face of such extreme suffering, however, served to remind First Nations individuals and communities that their needs did not constitute a priority; especially when the rationales of jurisdictional division could be drawn on to dismiss provincial accountability.

Five years later the conditions had not improved. A survey conducted by the District of Kenora Health Unit, painted a bleak picture of the encampment now known by the racist moniker as "Tomahawk Village." Among the various problems of the encampment, the report noted how adequate food storage was non-existent, and that the lack of municipal garbage or night soil

[86] Letter from Dr. J.T. Phair to P.E. Moore, (15 November 1955), RG 29 Vol 2911 File 851-1-A494 Pt. 3, Indian and Northern Health Services, Sioux Lookout District, LAC.
[87] Ontario Health Survey Committee, "Report of the Health Survey Committee, Vols I, II, III," *Government of Ontario* (1952): 24. https://archive.org/details/b32170877/page/n5/mode/2up

removal from the town facilitated "sanitation conditions [that] are primitive in the extreme." In addition, the poor structure and quality of the housing (most were made from scrap lumber and lined with cardboard boxes) left one observer to wonder how such places could be heated without going up in flames.[88] In total, the Unit found thirteen basic housing deficiencies with respect to facilities, maintenance, and occupancy. Health conditions were no better. The Unit reported incidences of whopping cough, bacillary dysentery, impetigo and other skin infections, to be higher in this settlement than in other areas of the Red Lake Township. The quality of the nearest water source was also of significant concern. Water used for eating and washing was taken directly from Howey Bay which had consistently shown "innumerable E. coli counts indicating gross human wastes contamination," the source of which was no great mystery. As the report exposed, "Three private sewage treatment plants discharge[d] chlorinated septic tank effluent into the bay and a creek also carried surface pollution from a good portion of Red Lake Township."[89] Such conditions speak far more to the desperation of inhabitants to survive on their own terms than a group of individual seeking to shirk the settler desired tax payment.

Shortly after the Report's release in November 1960, Percy Moore wrote to MP Benidickson to thank him for sharing the findings of the Kenora Health Unit with him. He admitted his field officials were aware of the "rather discouraging living conditions" and that they had in the past made "some strenuous efforts to have something done about it." The field report, however, suggests such labours had been ineffective. The future did not look much better. In response to Benidickson's repeated suggestion that a public health nurse from a neighbouring unit might be

[88] District of Kenora Health Unit Report on Tomahawk Village, (September 1960), RG 29 Vol 2911 File 851-1-A494 Part 5B, Indian and Northern Health Services, Sioux Lookout District, LAC.
[89] District of Kenora Health Unit Report on Tomahawk Village, (September 1960), RG 29 Vol 2911 File 851-1-A494 Part 5B, Indian and Northern Health Services, Sioux Lookout District, LAC.

sent to Red Lake to ameliorate conditions there, Moore responded that his staff were "too thin on the ground in this vast area to take on any additional duties except in an emergency."[90] Moore himself admitted that "there would appear to be a great reluctance on the part of any agency to accept any responsibility in improving the living conditions of these people."[91] Benidickson had come to the same conclusion. Regardless of the suffering such jurisdictional debates maintained, different levels of government continued to "buck pass" when a solution could have been found.[92]

The records that were available to this study do not reveal much more detail about how various levels of government responded to such a damning report of conditions. Nevertheless, the case of Red Lake offers useful insights into the continuities in treatment of First Nations peoples despite previous commitments to change. Like earlier periods, as late as the 1960s, municipalities still reinforced the notion that the bodies of First Nations peoples were of less value than those of settler communities.[93] At the same time that the Kenora Health Unit acknowledged the threat to health that the poor living conditions of the Red Lake encampment created, they expressed a more serious concern for their own community's well-being; "the houses are a health hazard to their residents" the report recognized, "but *even more important* they are a health hazard to the entire Township of Red Lake, acting as a continual focus of communicable disease, always posing a threat of

[90] Letter from P.E. Moore to MP W.M. Benidickson (Kenora-Rainy River), (31 November 1960), RG 29 Vol 2911 File 851-1-A494 Part 5B, Indian and Northern Health Services, Sioux Lookout District, LAC.
[91] Letter from P.E. Moore to MP W.M. Benidickson (Kenora-Rainy River), (31 November 1960), RG 29 Vol 2911 File 851-1-A494 Part 5B, Indian and Northern Health Services, Sioux Lookout District, LAC.
[92] Letter from MP W.M. Benidickson (Kenora-Rainy River) to P.E. Moore, (2 November 1960), RG 29 Vol 2911 File 851-1-A494 Part 5B, Indian and Northern Health Services, Sioux Lookout District, LAC.
[93] Maureen Lux, *Medicine that Walks: Disease, Medicine and Canadian Plains Native People, 1880-1940* (Toronto: University of Toronto Press, 2001); Mary-Ellen Kelm, "Diagnosing the Discursive Indian: Medicine, Gender, and the 'Dying Race," *Ethnohistory* 52, no. 2 (2005): 371-406.

epidemic."[94] Fear of First Nations peoples as a source of disease outbreak maintained its position as a rallying cry for action, more so than concern about the well-being of neighbouring peoples.

Settler communities also continued their problematization of First Nations attitudes, with their assessment often grounded in stereotype and self-interest. Take, for example, the conclusion of IHS Sioux Lookout Zone Superintendent F.W. Stewart who wrote to Moore after the release of the Kenora Report about his belief that "the big trouble in the Red Lake area is, *of course,* liquor."[95] Despite the many challenges highlighted in the report, IHS staff sustained their focus on the racialized association of alcohol and First Nations' capacity to 'handle' its consumption. The omnipresent concern for the education of First Nations peoples is equally revealing. In the brief from the Northwest Ontario Associated Chamber of Commerce, members complained of their inability to force the children who lived in the Red Lake encampment to attend school.[96] Like politicians, the members of this group believed that the education of First Nations children in settler institutions was the best way to integrate First Nations peoples into society. The language of force evokes a continued sense of paternalism that settlers know the best solution. Furthermore, it left little space for a conversation about the anxieties that First Nations parents may have felt about the prospect of integrated education or the conditions under which they would have found such an arrangement acceptable. Instead, settlers persisted in identifying First Nations' attitudes as a problem to overcome rather than as a perspective to accommodate or concerns to address. Finally, the insufficient efforts to remedy the conditions at the Red Lake encampment over many years

[94] [emphasis added] District of Kenora Health Unit Report on Tomahawk Village, (September 1960) RG 29 Vol 2911 File 851-1-A494 Part 5B, Indian and Northern Health Services, Sioux Lookout District, LAC.
[95] [emphasis added] Letter from F.W. Stewart to P.E. Moore, (24 November 1960), RG 29 Vol 2911 File 851-1-A494 Part 5B, Indian and Northern Health Services, Sioux Lookout District, LAC.
[96] "Urge Probe of Indians at Red Lake," Sioux Lookout News September 28, 1955, cited in Department of National Health and Welfare (2 November 1955), RG 29 Vol 2911 File 851-1-A494 Pt. 3, Indian and Northern Health Services, Sioux Lookout District, LAC.

highlight the sad fact that there remained a social acceptability in allowing First Nations peoples to suffer. Even when First Nations individuals had found employment and paid rent, federal and provincial levels of government continued to 'pass the buck' on a population viewed as the burdened responsibility of the other.[97] Despite the efforts of alarm-bell ringers such as Benidickson, the usefulness of colonial and racialized ideologies was not easily relinquished.

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When Chief Jim Horton of the Rainy River First Nation addressed the Select Committee at a field visit to his community, he bemoaned settlers' repeated dismissal of treaties: "If I were to mention all the treaty rights that have been taken away from us the sky would darken with sadness."[98] As this chapter has revealed, Horton's comments fell onto deaf ears. Provincial actors were not interested in a repair of the settler-state relationship, but instead sought to extend the reach of the province's powers. Indeed, several scholars have charted the numerous legal battles of the province of Ontario to expand the areas of its imposed sovereignty in the first half of the 20th century.[99] Integration was arguably the next battle. The rhetoric of equality and the project of integration maintained a thoughtless prejudice that did not destabilize the status quo.

[97] The Kenora Health Unit report noted that of the 21 family heads, only 3 were currently unemployed. In addition, the report found that as tenants, First Nations families were required to pay rental fees totaling between 10-25 dollars per month to several different landlords. District of Kenora Health Unit Report on Tomahawk Village, (September 1960), RG 29 Vol 2911 File 851-1-A494 Part 5B, Indian and Northern Health Services, Sioux Lookout District, LAC.

[98] Chief Horton testimony to Select Committee on the Civil Liberties and Rights of Indians in Ontario, (29 August – 2 September 1953), RG 49-132 Container B234948 File Proceedings, AO.

[99] See the St. Catherine's Milling Case (1888) in Brittany Luby, "The Department is Going Back on These Promises": An Examination of Anishinaabe and Crown Understandings of Treaty," *The Canadian Journal of Native Studies* XXX, no. 2 (2010): 203-228. Sara J. Mainville, "Manidoo Mazina'Igan: An Anishinaabe Perspective on Treaty 3" (Master of Law, University of Toronto, 2007). John S. Long, *Treaty No. 9: Making the Agreement to Share the Land in Far Northern Ontario in 1905* (McGill-Queen's Press, 2010). For the 1924 Canada-Ontario Indian Reserve Land Agreement, see Carisse, "Becoming Canadian."

Significantly, equality discourse served to absolve settler governments from accusations of the most overt forms of racial discrimination but masked more insidious racialized beliefs and colonial objectives that remained intact. In particular, the Ontario government continued to benefit from the jurisdictional divisions that facilitated their ability to turn away from the suffering of First Nations peoples and to maintain institutional and cultural ideas that framed 'the Indian' as largely to blame for their own suffering. Moreover, the substantial focus on the education of First Nations peoples continued to draw on hierarchical positionings that saw White settler society as the only viable form of human organization in the 'modern' age. This chapter has therefore argued that politicians' expressed post-war unease around inequality was as much a racialized colonial tool as a means to improve human well-being. It facilitated a hegemonic prescription for community life that would allow some cultural diversity but also demanded adherence to capitalist agendas and settler sovereignty and power. Equality could not just be extended, it had to be earned.

Thus, it becomes clear that integration and equality were far from a colour-blind response to racial inequity. Fundamental assumptions about race, and the settler colonial project, permeated Ontario's planning and policy. First Nations peoples remained a racialized problem and burden for settler governments; they continued to be framed as less worthy of care, and unworthy of investment if they continued to challenge the settler colonial capitalist project. Instead, assistance would only be enthusiastically extended when First Nations peoples agreed to abandon their treaty rights and participate in Ontarian society on an "equal" footing with other citizens. Consequently, the Ontario government's paternalistic programs continued their attempts to justify the social, economic, and political domination of Whiteness in society.

So engrained was this belief that when the Select Committee compiled its final report, its members did not feel it necessary to return to the communities they had consulted for final approval. Instead, Committee member Mr. Harry Nixon unilaterally proclaimed to a gathering of his peers that Mr. Goodfellow "certainly discharged his important duties as chairman of that committee in a manner which was able, fair, satisfactory, and certainly acceptable to every member of the committee, to the public at large, and to the bands of Indians we had the privilege of visiting."[100] Even when fellow MPP J.B. Salsberg, a member of the Labour-Progressive party who represented the riding of St. Andrew, argued that justice required that the Select Committee gather "an assembly of democratically elected representatives of every Indian community of the province, and present the report to them… to make recommendations about which all the matters contained in it which affected their well-being," such a call went unheeded.[101] First Nations peoples were neither invited to share in the power to define the scope of negotiations nor to shape proposed pathways forward. For those in positions of political power, First Nations peoples would remain situated as citizens*, a second-class citizenship in a colonial order. Far from an ideological exercise, this positioning resulted in substantial material harms.

[100] Ontario, Legislative Assembly, Hansard 29 March 1954, (Harry C. Nixon, Brant): 879. https://archive.org/details/hansard1954ontauoft/page/878/mode/2up?q=%22certainly+discharged+his+important+duties%22&view=theater

[101] Ontario, Legislative Assembly, Hansard, 2 April 1953 (J.B. Salsberg, St. Andrew): 1089-1090. https://archive.org/details/hansard1954ontauoft/page/1088/mode/2up?q=%22an+assembly+of+democratically+elected+representatives%22&view=theater

Chapter 4

Participants Not Partners: The Intensification of Integration Policy, 1956-1969

At the close of Indian Health Services' first ten years, Ottawa's political and bureaucratic commitment to the project of integration remained unabated. While challenges unquestionably remained, a new joint committee of the Senate and the House of Commons happily proclaimed in 1961 that "the winds of change have been blowing through the ranks of the Indian people and that there is a growing awareness and recognition of their problems and needs amongst the non-Indian population."[1] Integration, they believed, was in the air. With persistent fervour, Ottawa continued to make its claim to absolute sovereignty on the land and maintained that First Nations' best chance to thrive in the modern world was to accept the rights and benefits of an equalizing Canadian citizenship. With the general ethos of integration now widely supported in both public and private spheres, greater attention shifted to its enactment. Through the expansion of health and social welfare programs for Canadians broadly, the hope was that First Nations would be enticed to join Canadian citizenship as soon as possible and their separate health care service would end.

Yet, the political context in which such sentiment existed remained equally full of questions, concerns, and contradictions about the aims of integration. Integration's call to invite First Nations peoples to participate in Canadian society as citizens had yet to incentivize the federal government to extend on-reserve First Nations peoples the right to vote in federal elections without the loss of

[1] Final Report of the Joint Committee. *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, March-July, no. 1-16* (Ottawa: The Queen's Printer and Controller of Stationary, 1961): 605.

their status and privileges as legal status-Indians. While some federal MPs called once again for the immediate end to the reserve system, others believed in the need for a course of action patronizingly referred to as "a weaning process."[2] In addition, many First Nations individuals and communities outright rejected Canada's invitation to participate in Canadian society as citizens under settler sovereignty. As this chapter will highlight, they argued against Ottawa's colonial treatment of their peoples, resisted imposed policies of hospital treatment and medical payment, and fought back attempted erasure of their indigeneity. First Nations were Canada's *partners*, they argued, owed special rights and privileges, and a meaningful seat at the decision-making table. They were not mere participants in Canada's society bound to the unilateral pronouncements of the Canadian state. They called for a renewal of a nation-to-nation relationship.

Thus, as integration became entrenched as federal policy, many tensions and competing perspectives endured: participants or partners; equality or erasure; IHS expansion or contraction; self-help or sovereignty. How these tensions played out over the next decade, and their discursive and material consequences for health care access, is the subject of this chapter. First, it will examine Ottawa's renewed commitment to settler colonial logics through an account of the operations of the second Joint Committee on Indian Affairs. Second, it will explain how the Indian Health Services leadership of the DNHW responded to the political and bureaucratic pressure to intensify integration efforts—namely the withdrawal of IHS services and the continued denial of First Nations' unique health care rights— in response to rising federal costs and First Nations

[2] Walter Dinsdale (Progressive Conservative). House of Commons. Edited Hansard, 22nd Parliament, 3rd Session) June 19th, 1956). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1859448/

demographics. Finally, this chapter will end with a critical account of how settler choices stymied First Nations' access to high quality health care.

Integration's Internal Review: The Second Joint Committee

The end of the 1950s saw a series of events that catalyzed renewed efforts to sort out Canadians' "Indian problem," now mostly seen as the struggle to transition First Nations peoples from wards to citizens. On the international stage, rising criticism of apartheid in South Africa, along with the successful independence movements in the Global South, facilitated an international conversation in which the suppression of a people's rights based on race seemed to belong to another era. Closer to home, in the United States the civil rights movement was well underway. Notably in 1954 the Supreme Court declared racial segregation in public schools to be illegal in its now famous Brown v. Board of Education ruling. Moreover, Canada's own leadership at the United Nations, especially its role in the Suez Crisis and Lester Pearson's later Nobel Peace Prize award in 1957 established an expectation that Canada would uphold or model a high standard of respect for international covenants, including the Declaration of Human Rights. Indeed, in 1960 Prime Minister Diefenbaker's government would pass its own Canadian Bill of Rights. This context created an environment in which the suffering of a population within Canada's borders held the potential to generate international shame. While several scholars have effectively argued that a revolution in human rights thinking in Canada did not fully manifest until the 1970s, historians have revealed the significant efforts of both federal politicians and bureaucrats to avoid embarrassment at the

UN.[3] While this potential for embarrassment was not likely the biggest driving force in Ottawa's push for First Nations integration, this international context provides a fuller window into political decision-making.

In Canada, events and personalities favourable to change emerged. In the 1957 federal election, John Diefenbaker led the Conservatives to a win that not only ended the 22-year long Liberal reign but also put in place a leader with no ties to the previous regime. Significantly, as historian John F. Leslie describes, Diefenbaker was both a populist and a civil libertarian, whose many years' experience working with First Nations peoples and advocating on their behalf meant that Diefenbaker "would require little prompting to decide a thorough review of Indian policy was warranted."[4] Moreover, the reality that the Liberals had reigned in Ottawa over such an extended period of time made Diefenbaker and his cabinet "suspicious of the senior civil service…[knowing that] most officials were Liberal-appointed and Liberal-trained."[5] Certainly that was true of both the Department of National Health and Welfare's Deputy Minister of Health, G.D.W. Cameron and IHS Director Percy Moore. Unsurprisingly then, Diefenbaker initiated a series of government-sponsored studies including the Glassco Commission on Government Organization and the Hall Commission on Health Care, to evaluate the current state of government operations and possibilities for change. Among such review efforts was the creation of a new Joint Senate House of Commons Committee on Indian Affairs to take stock of Canada's treatment of First Nations peoples.

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[3] See edited collection, *Taking Liberties: A History of Human Rights in Canada,* ed. David Goutor and Stephen Heathorn (Oxford: University of Oxford Press, 2013). In particular Jennifer Tunnicliffe's chapter, "A Limited Vision: Canadian participation in the Adoption of the International Covenants on Human Rights."
[4] John F. Leslie, "Assimilation, Integration or Termination: The Development of Canadian Indian Policy, 1943-1963" (Ph.D. Diss. Carleton University, 1999), 302-303.
[5] Robert Bothwell, Ian Drummond and John English, *Canada Since 1945: Power, Politics, and Provincialism* (Toronto: University of Toronto Press, 1981), 197.

The second Joint Senate House of Commons Committee on Indian Affairs began its mandate in 1959, under the joint chairmanship of MP Noel Dorion and Senator James Gladstone, the first, and at the time only, First Nations Senator. In addition, the committee was made up of 11 other senators and 23 MPs. Beyond Senator Gladstone, the second joint committee followed in its predecessor's footsteps that no First Nations representative would be invited to join. Their perspectives, however, were dutifully welcomed.

During the decade that had elapsed since the first Joint Committee on Indian Affairs, improvements in the experiences of First Nations peoples in Canada had occurred.[6] Nevertheless, First Nations leaders still had longstanding grievances to air to the new committee. The Fort Albany First Nation, for example, highlighted that trapping remained the only way to make a living on the reserve and with poor returns for many years, the community was suffering. As Chief James S. Wesley explained in their brief, "our children are underfed and do not have enough warm clothing. They are always getting sick because of this and we have no nursing station here on the reserve and the nearest doctor is about 150 miles away by air. There is no possibility of getting emergency aid. If there were, many lives would be saved, and much suffering would be prevented."[7] Likewise, representatives of the recently formed Union of Ontario Indians spoke of the many material harms originating from settler interest in Indigenous territory, including the loss

[6] For example, significant strides in the management of tuberculosis among First Nations peoples and an increase in health care institutions available to them in certain areas had been achieved. In fact, members of the House of Commons felt the work of IHS to be so successful that it was claimed "now instead of a vanishing race we have a multiplying race." John Hornby Harrison (Liberal), House of Commons. Edited Hansard, 22nd Parliament, 3rd Session (July 27th, 1956). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/1869552/

[7] Brief Submitted by Albany Band to the Joint Committee. *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, April-May* 1960, no. 1-7. (Ottawa: The Queen's Printer and Controller of Stationary, 1960): Appendix E.

of a high percentage of their lands, and restrictions on their mineral, timber, fishing, and hunting rights. Despite all the work that had occurred since the end of the Second World War, many communities stressed that much more aid was needed.

First Nations communities not only asked for material aid to ameliorate the conditions that colonialism had imposed but significant attention was also devoted to the critique of settler ideas. For example, communities actively challenged the stereotype of the "lazy Indian" who passively waited for settler welfare support or training. As the Martin Falls Band noted, "The Indians of this part of Northern Ontario are capable and have taste mostly for three types of work: trapping, guiding, pulpwood cutting. We wish that opportunities be created along these lines in our respective territories." Ready and willing to work, this community explained that one of their greatest obstacles was not laziness but the devaluing of First Nations businesses over powerful corporate stakeholders. The brief went on, "it would be necessary to observe that it is almost impossible for an individual Indian to undertake and succeed in a private business of his own in this part of the country on account of the powerful monopolizing attitude of the Hudson's Bay Company and its influence on some department officials."[8] Significantly, in their push back against institutional racism, the Martin Falls community did not call to be left alone. Instead, they articulated a clear role for Ottawa in the improvement of the conditions faced by the band until other arrangements could be developed. The community noted, "We plead the same tax exemption and free hospital care be granted to all Indians equally until an agreement has been reached between the Government and our Band of Indians to drop these privileges for all of us. We resent

[8] Brief Submitted by the Martin Falls Band to the Joint Committee, *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, April-May* 1960, no. 1-7. (Ottawa: The Queen's Printer and Controller of Stationary, 1960): Appendix E7.

that such an important matter be left to the arbitrary [sic] of the local Superintendent."[9] Here was a call for new ideas and a renewed partnership.

In addition, Chief Omer Peters of the Moravian Reserve described how the paternalism of federal officials had repeatedly stifled the initiatives of community leadership, an experience repeatedly noted in First Nations briefs. For decades, Chief Peters explained to the committee, "all resolutions passed at our band council seem to have been…a one-way street…we never get back approval of these resolutions."[10] Such frustrations were clear condemnations of the paternalism the federal government had strongly maintained despite the criticism their peers in the House of Commons levied against them nearly fifteen years earlier during the early push towards integration.[11] Understandably then, a major demand of the Union of Ontario Indians' brief called for an immediate end to Indian agent gatekeeping and for the resources to support increased autonomy.[12]

[9] Brief Submitted by the Martin Falls Band to the Joint Committee *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, April-May* 1960, no. 1-7. (Ottawa: The Queen's Printer and Controller of Stationary, 1960): Appendix E7.

[10] Brief and Presentation of the Union of Ontario Indians to the Joint Committee. *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, June-July 1960, no. 8-15.* (Ottawa: The Queen's Printer and Controller of Stationary, 1960): 1359.

[11] The Indian Advisory Committee for the Ontario Department of Public Welfare recounted a similar experience of paternalism representative of a larger pattern. E. Moses described how at a council meeting, "the manager of the Bell Telephone Company was present. He came down to suggest to the council that the time had come, because of the great many users of phones on the reserve, when we should have a special building set up in the village of Oshwegan [sic] to facilitate the matter of sending and receiving calls….the council readily agreed to give the Bell Telephone Company a 99 year lease on a half-acre or an acre of land as the case may be. The land was available. The building was needed to give better service to our Indian people. We were greatly concerned because most of us had so many persons on our line that we were not getting a dollar's value for the use of it. This resolution was forwarded to Ottawa. When it came back it was pointed out to us that the act would not allow them to give that sort of a lease to the Bell Telephone company." Presentation of the Indian Advisory Committee of the Ontario Department of Public Welfare: *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, April-May* 1960, no. 1-7. (Ottawa: The Queen's Printer and Controller of Stationary, 1960): 311.

[12] Presentation of the Union of Ontario Indians to the Joint Committee. *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, June-July 1960, no. 8-15.* (Ottawa: The Queen's Printer and Controller of Stationary, 1960): 1324.

Some of the most scathing criticisms of federal government beliefs came from the Six Nations Confederacy. As its representatives reminded the committee, the Confederacy "long ago organized into a sovereign government" and their relationship with the British Crown was one of allies offered a treaty of protection forever and not a position of wardship, a fact that had not changed with the arrival of increased aid.[13] During the Confederacy's presentation to the Committee, Representative Mr. Erwin Logan stressed this fact. Logan pushed back against Committee member Senator R.B. Horner who claimed that First Nations peoples had accepted the help of Canada for many years in the form of old age pensions and family allowances and thus "it was surely established that Canada was one country and not split up."[14] In response, Logan challenged Horner to reflect on the aid that Canada had long received from the United States, especially their military aid, and suggested that Canada was effectively under the protection of the United States. Using Horner's own logic, Logan asked, did that fact make Horner an American citizen? Clearly, a dual standard existed. Following the Confederacy's presentation to the Committee, Arthur Anderson, Secretary of the Confederacy, wrote to the Committee to stress their discontent once again and to call on members to reflect on the position in which First Nations in Canada existed in relation to the Canadian state. Specifically, Canadian rhetorical hypocrisy was on display again when Anderson recalled how many Canadian politicians encouraged the liberation efforts of countries around the world; "you profess to encourage the re-birth of new Countries" Anderson wrote, "and yet you are striving to integrate the Indian." Without an increase in the explicit attention given to the attacks on Indian status in Canada, Anderson claimed the Confederacy would be "forced to

[13] Presentation of the Six Nations Confederacy. *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, June-July 1960, no. 8-15.* (Ottawa: The Queen's Printer and Controller of Stationary, 1960): 1149.
[14] Presentation of the Six Nations Confederacy. *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, June-July 1960, no. 8-15.* (Ottawa: The Queen's Printer and Controller of Stationary, 1960): 1182.

send circular letters to every member of Parliament and to every member of the United Nations and save Canada from being guilty of genocide."[15] Here Anderson drew on the international rhetoric of human rights that Canada had to a certain degree aligned itself with and demanded Canada turn its focus inwards. Anderson's use of the word genocide would likely have shocked many members of the Joint Committee, but it also clearly revealed the depth of betrayal felt. Integration from this standpoint was genocide. Whereas settler politicians believed they offered First Nations peoples an attractive offer of equality with Canadian citizens, First Nations communities saw a system of erasure.

Even representatives who did not call for a complete denial of Canadian citizenship did not mince words when it came to their assessment of the federal government's ideas and behaviour. Andrew Paull, Grand Chief and President of the Grand Council of the North American Indian Brotherhood described his perspective:

> While the Proclamation of King George III [in] 1763 and subsequent actions of the Sovereign have always been to protect the interests of the Indians and the Parliament of Canada … but despite all these efforts economically and politically, the Indians of Canada are nothing but the Peons of the Conquestrians [sic]. The Indians of Canada have made great contributions in manpower and money. In every War that Canada has participated in, many were decorated and many made the supreme sacrifice for liberty and freedom of our British Sovereign. Yet, despite all these efforts by the Indians to publicly demonstrate themselves as true Canadians, we find ourselves in dire straits.[16]

[15] Letter from Arthur Anderson, Secretary of Six Nations Confederacy to Mr. M. Slack, Clerk of Joint Committee on Indian Affairs, *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, March-July, no. 1-16* (Ottawa: The Queen's Printer and Controller of Stationary, 1961): Appendix S1, 628. The Joint Committee was certainly not the last time the Haudenosaunee would accuse Canada of conducting genocide in the 1960s. In 1965, the Globe and Mail reported a protest on Parliament Hill. "Charge Genocide: 20 Indians Parade, Protest Against Act," *Globe and Mail* April 28, 1965, pg. 31

[16] Andrew Paull, Grand Chief and President, Grand Council North American Indian Brotherhood. Minutes *of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, March-July, no. 1-16* (Ottawa: The Queen's Printer and Controller of Stationary, 1961): 586.

On full display in this submission as well as many others was not a plea for charity but a demand that sacrifices be honoured, and treaty promises fulfilled. First Nations submissions repeatedly made these requests in both broad and specific terms. Here the submission from the Temagami band is illustrative: "we strongly commend that all broken Indian treaties be retained by all Indians resided in Canada for the simple reason that it only be appropriate since it was their right in the first place. Excerpts from the Indian Treaty reads 'As long as the sun shines and the rivers flow,' we wish to stress the fact that we haven't as yet seen the rivers dry." Moving on to specific grievances, the brief continued, "Indians reject the demand that they should pay for hospital insurance plans, medicines, etc. Considering that white people took our country with all its riches, without adequate compensation on their part it is the least that the government should regard as their obligation to carry out this duty without resorting to the sale of health insurance."[17] Here again was a call for new ideas and a renewed partnership based more on treaty rights or nation-to-nation relationships than on citizen or human rights.

Despite widespread agreement among many First Nations' briefs that treaty promises had been broken, the Joint Committee seemed much more concerned with the differing opinions of First Nations groups about the nature or desirability of citizenship in Canada. After all, the Joint Committee had not been established to question the advisability of a program of First Nations' integration into Canadian citizenship but to determine the challenges to its actualization. Thus, as historian John Leslie articulated, "the absence of an Indian consensus in regard to integration and the lack of enthusiasm for attaining Canadian citizenship was disconcerting to members of the

[17] Brief of the Temagami Band submitted to the Joint Committee. *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, April-May* 1960, no. 1-7. (Ottawa: The Queen's Printer and Controller of Stationary, 1960): Appendix E12.

joint committee."[18] Their investigations into First Nations perspectives did not provide them with a clear sentiment of support for settler postwar priorities and plans. Unwilling to sacrifice the power that settler-colonial ideologies and structures offered them, the majority of the Joint Committee eagerly turned to the presentation of non-Indigenous briefs to locate endorsements of integration.

An important factor which distinguished the second joint committee from its predecessor is what historian John F. Leslie describes as an "expanded policy community." According to Leslie, federal policy makers were much more beholden to, or at least informed by, the commentary of a wider network of organizations, like non-profits. These included organizations such as the Indian-Eskimo Association of Canada (IEA).[19] The IEA, first established as the National Commission on the Indian Canadian in 1957, was formed in 1960 and aimed to assist all Indigenous peoples both on and off-reserve. While remaining largely a non-Indigenous organization with clear connections to Catholic and Quaker communities, the IEA did maintain a certain percentage of Indigenous membership and had Dr. Gilbert C. Monture and Mr. Elliot Moses, both from Six Nations, on its executive.[20]

In their brief and presentation, the IEA echoed some of the material suffering that First Nations had outlined in their own contributions. Specifically, the IEA highlighted the need for more

[18] Leslie, "Assimilation, Integration or Termination," 338.
[19] Leslie, "Assimilation, Integration or Termination."
[20] Father Renaud, an early champion of the IEA, had direct ties to the Catholic Church. In fact, he made presentations to the joint committee on behalf of both the IEA and the Canadian Catholic Conference. In addition, the IEA's Director, Dr. John Melling, was a Quaker. Melling was educated at Brasenose College, Oxford, where he studied economics and philosophy. Leslie, "Assimilation, Integration or Termination," p. 342.

income, better houses, greater diffusion of education, and improved health care.[21] The overall character of the IEA's brief, however, was marked more by its dissonance from the many conclusions found within the briefs already discussed. Specifically, using language like "charity" and "free gifts," the IEA echoed the perspective that nothing was owed to First Nations peoples either from legitimate treaty partnership or from land theft. Instead, First Nations peoples were expected to earn the support of the Canadian community through participation within settler economies and political systems. The contingent nature of this aid is clearly expressed in the IEA's brief: "An Indian is perfectly entitled to keep his Indian culture…provided he does not ask the white man to pay the whole cost of the decision or even costs that are not necessary. That is to say, there are practical limits to the amount of Indian cultural distinctiveness that *can* be retained—unless the Indian is prepared to cut ties for worse as well as for what may seem to him to be better."[22] Like the federal government, the IEA endorsed the position that First Nations peoples were desired to be participants in Canadian society neither free to determine their own systems of commerce and government nor owed special benefits from land-sharing agreements.

To bolster their arguments, the IEA spent a significant portion of its brief drawing racialized portrayals to describe the ways in which First Nations peoples in Canada must change for their own good to become productive participants in Canadian society. In much the same way that 19th century settler discourse drew a racialized line between "barbarous" and "civilized peoples," the IEA articulated a set of perceived psychological inadequacies of Indians that served to justify

[21]Presentation and Brief of the Indian-Eskimo Association of Canada to the Joint Committee. *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, April-May* 1960, no. 1-7. (Ottawa: The Queen's Printer and Controller of Stationary, 1960): 364.
[22] Presentation and Brief of the Indian-Eskimo Association of Canada to the Joint Committee. *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, April-May* 1960, no. 1-7. (Ottawa: The Queen's Printer and Controller of Stationary, 1960): 367.

settler-colonial incursion. These included a lack of independence of spirit, limited sense of effective responsibility, and lack of confidence in the future. Remedial efforts stemmed from a belief, as historian Mary Jane Logan McCallum described, that modernity had "wreaked havoc" in First Nations communities.[23] It was settlers' responsibility—as a people already believed to be equipped to handle modern life—to instil these characteristics for First Nations best interests.

Notably, the IEA's brief also included calls to action for the federal government. No doubt inspired by the concept of community development that had galvanized international and local development work throughout the 1950s, the idea that individuals and communities should be aided to solve their own problems in order to join "liberal democracy and the capitalist economy," held great attraction for the IEA leadership.[24] In an echo of the 1948 Joint Committee's call to "help the Indian help himself," the IEA's brief called for the federal government to pursue the following pathway: "What the situation calls for is wiser giving by the white man, and greater opportunity for effort by the Indian…The Indian…must be given the chance to contribute his best over a period of time, being helped to see that any ultimate failure will be his."[25] The IEA thus called for Ottawa to make significant efforts to decentralize control, to initiate training programs, to give First Nations individuals the right to vote without loss of status, and to spearhead negotiations with the provinces to provide services to First Nations communities without federal duplication. Significantly, the IEA argued that because the anticipated transition of legal wards to

[23] Mary Jane Logan McCallum, *Indigenous Women, Work, and History, 1940-1980* (Winnipeg: University of Manitoba Press, 2014), 143.
[24] For more on community development work with First Nations Communities see Will Langford, "Jean Lagassé, Community Development, and the 'Indian and Métis Problem' in Manitoba in the 1950s-60s," *The Canadian Historical Review* 97, no. 3 (September 2016): 346-376.
[25] Presentation and Brief of the Indian-Eskimo Association of Canada to the Joint Committee. *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, April-May* 1960, no. 1-7. (Ottawa: The Queen's Printer and Controller of Stationary, 1960): 365.

fellow citizens would be a long process, the federal government should focus substantial attention and resources on the development of on-reserve communities.

As a representative sample of non-federal voices, the IEA captured many of the sentiments expressed in other briefs. The Saskatchewan government, for example, stressed the inevitability of First Nations integration into Canadian society. In fact, they went so far as to remove any human agency in the decision, arguing that "the increasing integration of the Indian into Canadian life is a desirable process which will occur eventually *whether or not anything is done* to ease the transition difficulties."[26] In addition, both the United Church and the Anglican Church of Canada supported economic and capacity development initiatives, with the Anglican Church calling for the gradual and complete integration of First Nations peoples.[27] It is crucial to acknowledge, however, that while all these briefs supported First Nations integration, and no doubt believed they worked in First Nations' best interest, their emphasis on community development to integrate into settler economic and political systems had more problematic implications. In effect, they obscured broader realities of systemic and cultural racism and did little to endorse First Nations' calls for sovereign self-determination and fulfillment of treaty rights. Dominant settler discourse had spoken; First Nations participation in their society was wanted, not a renewal of partnership. The Joint Committee had found its endorsement of integration.

[26] Brief of Government of Saskatchewan to the Joint Committee, *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, June-July 1960, no. 8-15.* (Ottawa: The Queen's Printer and Controller of Stationary, 1960): 1071.
[27] Briefs of the United Church and Anglican Church of Canada to the Joint Committee. *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, June-July 1960, no. 8-15.* (Ottawa: The Queen's Printer and Controller of Stationary, 1960): p. 863 and 793 respectively.

After 97 meetings, listening to more than 100 witnesses and reading 80 written briefs, the members of the Joint Committee had a lot to digest. On Saturday July 8th, 1961, the co-chairs James Gladstone and Lucien Grenier (who had replaced Noel Dorion when he was appointed secretary of state) submitted their final report. Like its predecessor, this Joint Committee reaffirmed a belief in the necessity to break from past traditions of government paternalism and the segregation of First Nations peoples through instruments like the reserve system. Moreover, the final report stressed the desirability of continuing programs of integration for First Nations peoples. More than ever, the committee concluded, First Nations peoples can and should be aided to assume the rights and responsibilities of Canadian citizenship. Thus, their comments and recommendations focused on facilitating this transition process with "sufficient flexibility to meet the varying stages of development of the Indians during the transition period."[28] Among the Committee's recommendations for General Indian administration were calls to continue community development studies and the formation of a Dominion-Provincial Conference to transfer federal responsibility for First Nations peoples to the provinces. Both directives highlight the explicit goal to end First Nations' dependency on Ottawa and to promote self-reliance akin to that expected of other Canadians.

Importantly, as John Leslie explains, the articulated aim of the Joint Committee was never to develop a Canadian version of the United States policy of "Indian termination" but, rather, to "set Indian administration on a new enlightened course."[29] The final report stressed that First Nations peoples were to be encouraged and supported to maintain their languages, cultures, and historic

[28] Final Report of the Joint Committee, *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, March-July, no. 1-16* (Ottawa: The Queen's Printer and Controller of Stationary, 1961): 605.
[29] Leslie, "Assimilation, Integration or Termination," 390-391.

rights as a kind of "citizens plus" – a term that Harry Hawthorn and Alan Cairns would popularize six years later. It is crucial to articulate, however, that a notion of First Nations' special status was not grounded in an acknowledgement of First Nations' title to land but, as Leslie described, "in part based on the dominant society's acceptance of post-war Canadian cultural pluralism that recognized the contributions of non-traditional cultures to the Canadian mosaic…[and] on the policies and practices of the post-war welfare state that afforded assistance to the destitute."[30] For example, the Joint Committee maintained the rhetoric that public funds needed to be expended on First Nations peoples and that it was appropriate for First Nations peoples to maintain certain elements of their culture. Nevertheless, the language of the committee still drew on a deficit framework of First Nations' lifestyles that positioned them in need of 'development.' In other words, assistance to First Nations peoples was offered less because of privileges owed than on the assessment that First Nations peoples were unable to help themselves. To reinforce this interpretation, when the governments of John Diefenbaker and later Lester Pearson introduced bills to create the Indian Claims Commission called for in both joint committee reports, the concept of Aboriginal title or its equivalent was not mentioned.[31] With this perspective and approach, First Nations were perceived less as citizens plus than as the Citizen* described in chapter 2. Their distinction offered little to honour and encouraged paternalism to persist. Understandably then, many First Nations expressed immediate hostility to the Joint Committee's final report. Indeed, the committee's co-chair Senator James Gladstone, himself from the Kainai Nation in Treaty 7 territory, expressed embarrassment over the report's conclusions, which endorsed the status quo

[30] Leslie, "Assimilation, Integration or Termination," 391.
[31] The first bill was introduced in 1962 under the Diefenbaker government but was soon defeated with the federal election the following year. The Pearson government then introduced bills in 1963 and 1965. The bills, especially those introduced by the Pearson government, generated significant push back from First Nations communities for the limited scope of admissible claims. See Sally Weaver, *Making Canadian Indian Policy: The Hidden Agenda, 1968-1970* (Toronto: University of Toronto Press, 1980), 37-40.

rather than heed First Nations' call for change.[32] Once again, Ottawa sought endorsement over critical engagement.

The Joint Committee thus upheld the view that First Nations' integration into Canadian society as participants—citizens—rather than as partners—allies—was the best pathway forward. The stance is unsurprising given settler-colonial imperatives to remain the sole sovereign presence on a territory. But this imperative was also entrenched due to other political concerns of the period. As the 1960s progressed, major fears about Canadian national unity grew steadily.[33] In particular, Quebec's agitation for special status, or at times outright rejection of existence within Canada, took up substantial political attention. As anthropologist Sally Weaver notes, "special' and 'separate' became loaded words in the national political vocabulary."[34] For a population with little political clout in the Canadian context, the privilege of special legal status was resisted. The Joint Committee's long-term vision was to choose Indigenous erasure and to offer citizenship equality.

The federal government, first under Diefenbaker and then Pearson, readily embraced the ethos, if not all the recommendations of the Committee's final report. Significantly, even prior to the culmination of the Joint Committee hearings in 1960, First Nations peoples on reserve had been granted the federal vote without the requirement that they accept enfranchisement. In the Indian Affairs Branch, still then placed in the Department of Citizenship and Immigration under the

[32] Hugh Shewell, *'Enough to Keep Them Alive': Indian Welfare in Canada, 1873-1965* (Toronto: University of Toronto Press, 2004), 290-291.
[33] In fact, David Goutor and Stephen Heathorn have argued that Diefenbaker's Bill of Rights in 1960 was produced less because of Diefenbaker's personal commitment to the protection of human rights and far more in response to concerns over national unity. As Goutor and Heathorn explain, equal access to citizenship rights was a key to nation-building during this period in light of the negative reaction to Ottawa's use of wartime powers to curtail individual freedoms and following the Gouzenko Affair. Goutor and Heathorn, *Taking Liberties,* 44.
[34] Weaver, *Making Canadian Indian Policy,* 13.

leadership of Ellen Fairclough, the Joint Committee's final report "triggered a series of program innovations."[35] Specifically, under the enthusiastic efforts of Walter Rudnicki, the Welfare Division established a series of community development initiatives which aimed to foster First Nations' capacity to operate within settler economic, social, and political systems.[36] In May of 1964, Cabinet approved Indian Affairs' plans and soon after, 25 community development officers had been hired.[37] No doubt aided by the Pearson government's "war on poverty," the winds of change appear to have brought with it a spirit of hope that First Nations integration was within reach. But how did officials in Indian Health Services plan to respond?

Dancing the Dialectic: The Expansion and Contraction of First Nations Health Services

Like the Indian Affairs Branch, the Indian Health Services embraced the integration ethos with vigor. A telling reflection of this commitment manifested in 1962, when the IHS ended its existence as a separate branch with its own director and became part of the newly established Medical Services Branch. The MSB, with a single director, now covered vastly expanded areas of responsibility: civil aviation; civil service health; Indian and Northern Health Services; Quarantine, Immigration, and Sick Mariners. While Percy Moore remained a familiar presence as the appointed director of MSB, the merger was another administrative move that eroded a structural impression of First Nations distinctiveness. In the same way that the absorption of the Indian Affairs Branch into the Department of Citizenship and Immigration implied a connection between the needs of immigrants and First Nations peoples, the creation of MSB served to

[35] Weaver, *Making Canadian Indian Policy,* 12. Some of Ottawa's more egregious forms of paternalism required amendments to the *Indian Act*, which was beyond the capacity of Indian Affairs bureaucrats.
[36] Shewell, *'Enough to Keep Them Alive',* 300.
[37] Shewell, *'Enough to Keep Them Alive',* 311.

obfuscate a special status based on Indigenous title and treaty rights for First Nations peoples. Instead, they became another special interest group for whom the organization of medical care was deemed the responsibility of the federal government. To be fair, the merger was also likely a direct response to the work of the Glassco Commission on Government Organization, which sought to increase efficiency generally—a phrase used in an explanation of the merger.[38] In the context of a wider policy of integration, however, the further consequences are difficult to ignore.

In addition to an endorsement of integration, the efforts of the Joint Committee had also resulted in an increased public and political awareness of the suffering that many First Nations communities endured. The Canadian Press in particular crafted informative articles on "Indian poverty and alienation", which Sally Weaver has argued, fostered "a collective sense of guilt about the historical treatment of Indians and the federal government came under heavy criticism."[39] While integration policy called for an end to segregated treatment for First Nations peoples, to suddenly cut the dedicated and separate assistance that had developed to aid a suffering population would likely have caused significant popular and political pushback. Ottawa unquestionably desired the full integration of First Nations peoples, but its immediate realization remained untenable. As a result, the DNHW committed to the continuation, and at times, expansion, of its separate First Nations health care service in the 1960s. It never wavered, however, on the point that the existence of the IHS was always temporary. The ethos of equality would not permit the "extra" health care spending for long.

[38] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1963,* Ottawa: Queen's Printer, 1948. Accessed, *Internet Archive*, September 2021.
[39] Weaver, *Making Canadian Indian Policy,* 15.

Throughout the late 1950s and the 1960s, the IHS managed this dual expansion and contraction in the context of two major concerns. First, the Department expressed repeated and obvious anxiety about the rising birth rate within many First Nations communities. For example, the 1963 annual report noted, the "Natural increase of the Indian population is now over 3.47 per cent per annum and for the first time since the advent of the white man, Indians now number more than they did at that time, having increased in number from about 90,000 at the turn of the century to over 200,000 today."[40] Given the reality that only a small percentage of First Nations peoples became enfranchised each year, plus the ever-growing cost to the federal government of HIDS and serious federal consideration of a national medical care insurance program, First Nations health policy makers had every reason to expect significant increases in clientele and in expenditures.[41]

A second key area of concern was the rising DNHW expenditure broadly. The past 10 years had already seen Department financial responsibilities expand enormously with a variety of programs, especially the health and hospital construction grants, and various federal-provincial cost sharing welfare agreements. Then, in March 1958, Department expenditure exceeded, for the first time, one billion dollars.[42] With the Hospital Insurance and Diagnostic Services Act receiving royal assent the previous May, Department officials nervously anticipated a rapid and exponential growth in their spending. And they were right. Between March 1957 and March 1963, the Department spent over a billion dollars on HIDS payments alone.[43] Under pressure to keep

[40] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1963,* Ottawa: Queen's Printer, 1948. Accessed, *Internet Archive*, September 2021.
[41] In 1957, only 750 registered Indians were enfranchised. Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1957,* Ottawa: Queen's Printer, 1957. Accessed, *Internet Archive*, September 2021.
[42] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1958,* Ottawa: Queen's Printer, 1948. Accessed, *Internet Archive*, September 2021.
[43] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1963,* Ottawa: Queen's Printer, 1948. Accessed, *Internet Archive*, September 2021.

inflation down during a period of economic recession that had already begun when Diefenbaker took office, the Department of Finance discouraged new spending.[44] Indeed, judicious spending in DHNW programs, including the IHS, became political and economic imperatives.

As noted, for the IHS, this rise in spending resulted in both expansion and contraction. The federal government's large investment in provincial hospitals encouraged the closure of IHS hospitals in favour of smaller, more isolated institutions that would cover the "cracks" in regular provincial health coverage (see Table 4). While the early appeal of IHS hospitals was that IHS leadership promised that its service would "operate at half the costs of provincial hospitals" and thereby limit federal expenditure of those deemed "unproductive wards," as the postwar period progressed, it was felt that even this restricted expenditure was no longer necessary. [45] With the gradual closure of IHS hospitals, IHS would be able to direct its limited allotment to expand other, less costly, endeavours.[46] For example, the IHS did see a continual rise in staff employed directly with the federal government (see Table 5).

Table 4: IHS Institutions

Type of Institutions	**1960**	**1970**
Hospitals	22	14
Nursing Stations	33	64
Clinics	30	21
Health Centres	79	99
Health Stations	0	112

Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1970,* Ottawa: Queen's Printer, 1948. Accessed, *Internet Archive*, September 2021.

[44] Bothwell et al., *Canada Since 1945,* 215.
[45] Maureen Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s* (Toronto: University of Toronto Press, 2016), 130.
[46] Lux, *Separate Beds,* 14.

Table 5: IHS Staffing Levels

	Total Staff	Rate of Increase
March 1957	1, 917	
March 1958	1, 932	0.8%
March 1959	2, 311	19.6 %
March 1960	2, 336	1.1 %
March 1961	2, 517	7.7 %
March 1962	2, 949	17.1 %
March 1966	3, 182	7.9 %

Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1957-1962; 1966,* Ottawa: Queen's Printer. Accessed, *Internet Archive*, September 2021.

This expansion of certain facets of the IHS and contraction of others was a dance the IHS would need to negotiate in response to shifting political priorities and increasingly crowded budgets. With the arrival of new spending in other areas of the DNHW's mandate, the justification for IHS spending became ever more imperative and, at the same time, challenging.

What remained static during this period was the IHS position that its existence was finite, and its claim that any financial and institutional growth were only necessary temporary investments to ensure First Nations peoples did not suffer undue hardship while making the transition to citizenship. The impermanent quality of the investment is borne out in the Department of National Health and Welfare's financial records (see Table 6). While the monetary contribution of the federal government went up in absolute numbers between 1959 and 1961 (the years for which such information is available in the DNHW annual reports), the percentage of the DNHW's Health Branch funds devoted to IHS work took a precipitous decline.

Table 6: DHNW Expenditure by Program

	Fiscal Year 1958-59	**Fiscal Year 1959-60**	**Fiscal Year 1960-61**
Indian Health Service	$20, 723, 423 (23.3%)	23, 829, 552 (10%)	24, 379, 754 (9.8%)
National Health Grants	48,000,000 (58.8%)	46,000,000 (19.1%)	48, 000,000 (19.2%)
Hospital Insurance Program	55,000,000 (40.2%)	160,000,000 (66.7%)	167, 000,000 (66.9%)

Select DNHW Health Branch Expenditures expressed as percentage of total Health Branch Expenditure Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1959-1961,* Ottawa: Queen's Printer. Accessed, *Internet Archive*, September 2021.

With a glance at the above figures, it is easy to imagine how Department officials interpreted an expensive duplication of services. Given the growth of Ottawa's costly program of investment in provincial facilities as well as a hospital insurance program well underway, what justification was there, settler politicians and bureaucrats asked, to maintain an entirely separate health care system for individuals deemed unworthy of anything but equal treatment with Canadians citizens?

As the Canadian economy began to pick up steam once again in the 1960s, and with the election of the Liberal government in 1963 under the leadership of Lester Pearson, Ottawa's spending program for its citizens became even more ambitious. At the Liberal's planning conference in Kingston during the fall of 1960, Pearson's key advisor, Tom Kent, had called for a massive investment in social services for Canadians, including a state medical insurance system and a rise in unemployment benefits.[47] Pearson's campaign had run on a promise of '60 days of decisions' to ignite anticipation for government action on social services as well as other federal matters. Over his tenure as Prime Minister from 1963-1968, Pearson oversaw the enactment of the Canada

[47] Bothwell et al. *Canada Since 1945,* 255.

Assistance Plan, medicare, and an expansion of old age pensions, to name but a few cost-sharing programs that remained a somewhat uncontrollable expense for the government.[48] Taken together, these programs presented a profound challenge for Canada's finance minister, but they also had important ramifications for the rhetoric and policies surrounding First Nations health care access. The path forward for department leadership was clear; continue the post-war program of IHS dismantlement, dismiss claims on a separate service and invite First Nations individuals, when deemed ready, to access the health care system provided to all Canadians.

One of the IHS' most targeted approaches to Ottawa's expenditure in First Nations health was to identify individuals for whom the IHS could cease coverage. The increased withdrawal of IHS Services from First Nations individuals is clear in Department records, specifically the use of INHS Form 8009, Notice of Loss of Benefit. Created in 1957, Form 8009 informed recipients that the IHS had concluded that the Service was no longer willing to contribute to the named individual's medical care and outlined the reasons for the decision. They included: removal of the individual's name from the band list; the "indigent clause" which stemmed from the belief that the individual had sufficient private resources to be responsible for their own care and thus IHS would only cover the health care costs of those living in poverty; the understanding that the individual was eligible for care from another agency; the believed responsibility of a third party involved in the matter (such as private insurance); enfranchisement through application or marriage; and finally, the "disassociation from the native way of life," which was understood to derive from living away from a reserve or 'Indian community' for a period of greater than twelve months.[49] To take one

[48] Bothwell et al. *Canada Since 1945,* 330.
[49] Form 8009 "Loss of Benefit Notice," RG 29 Vol 2905 File 851-1-A479 Pt. 3, Indian and Northern Health Services, Branford District, LAC.

community as an example, between 1963 and 1967, IHS sent out at least 256 such forms at the Six Nations Reserve. Tellingly, the conclusion that an individual had "sufficient private resources" to ensure their own health care needs were met accounted for the vast majority of noted reasons, 88 per cent, or 226 of the total count.[50] The disproportionate balance of this reason on IHS forms underscores IHS belief that if a First Nations individual succeeded economically in Canadian society then they must accept a responsibility to organize their own care, *just as other Canadians did.* By the 1960s, the aforementioned blurring of the citizen-tax payer distinction had become largely a fait accompli.[51] As historian Shirley Tillotson has shown, this connection ignited an anger towards anyone seen to be "free riders, getting more than they contributed."[52] Moreover, the marriage of settler belief that health care provision was only on matter of charity rather than duty and the potency of the "lazy Indian" trope added a powerful impatience to IHS policy.[53] Policy makers had little tolerance for people they believed "chose" to remain "burdens on the state". Officials in Ottawa therefore made significant efforts to support only those they deemed the most financially needy.

Significantly, civil servant advocacy at the local level could at times stymie Ottawa's formidable push for integration. In January of 1957, Percy Moore wrote to Regional Superintendent W.J. Wood to explain that Indian Affairs had notified Moore that the financial contributions taken from the Fort William Band funds to assist in the provision of health care for the whole agency was to

[50] The percentage of other reasons were as follows: Disassociation from native life (41 or 16%); Eligible for care from another source: 9 or 3.5%; Enfranchisement (applied or by marriage): 2 or 0.78%; and Non-Member of Band: 2 or 0.78%. RG 29 Vol 2905 File 851-1-A479 Pt. 3, Indian and Northern Health Services, Branford District, LAC.
[51] Shirley Tillotson, *Give and Take: The Citizen-Taxpayer and the Rise of Canadian Democracy* (Vancouver: University of British Columbia Press, 2017), 304.
[52] Tillotson, *Give and Take*, 304.
[53] Historian John Lutz elucidates settler-colonialism's development of and investment in the trope of the "lazy Indian" in greater detail in *Makúk: A New History of Aboriginal-White Relations* (Vancouver: University of British Columbia press, 2009), 33-34.

cease. Moore thus stressed to Wood that "our program of selecting those who should be able to pay their own way should therefore be intensified as we feel that a goodly number of this Band are or could well be employed in the industries about the Twin Cities."[54] Wood pushed back with a very different picture. While he explained that many members of the Fort William Band were employed, "none earned over $175.00 a month; all had large families; [and] none were in a position to pay for their medical services, especially hospital care." Wood concluded that it would thus "appear inadvisable to deprive this Band of hospital care when the breadwinner was employed, unless his salary was increased to a considerable extent."[55] How Moore responded to this letter is not known. Given the IHS' hierarchical structure of decision-making in which Ottawa made all significant decisions for the Service, to say nothing of the immense pressure to restrict expenditures that Moore no doubt experienced from his Minister, the chances that such pushback would be well-received are unlikely.

Other actions by IHS officials reveal that concern over economic expenditure increasingly trumped the old rhetoric of humanitarian duty in IHS policy. Despite Ottawa's long-standing claims of a moral duty to assist First Nations peoples, officials' rhetoric and actions increasingly revealed the opinion that IHS expenditure should constitute a form of investment. IHS wanted economic assets not "drains." Representative of this concern was the experience of a high school principal in Marathon, Ontario. In 1966, Mrs. R. Carton received a letter from an IHS official inquiring as to the scholastic ability of one of her students. The student in question was applying to have dental work completed at IHS expense and IHS officials had expressed concerns about the high cost. In

[54] Letter from P.E. Moore, Director, IHS, to Dr. W.J. Wood, Regional Superintendent, (3 January 1957), RG 29 Vol 2911 File 851-1-A492 Pt 2, Indian and Northern Health Services, Lakehead District, Thunder Bay, ON, LAC.
[55] Letter from Dr. W.J. Wood, Regional Superintendent to P.E. Moore, Director, IHS, (23 January 1957), RG 29 Vol 2911 File 851-1-A492 Pt 2, Indian and Northern Health Services, Lakehead District, Thunder Bay, ON, LAC.

response, Carton wrote to Alan MacEachen, Minister of the Department of National Health and Welfare to express her frustration at the request:

> I find it hard to believe that your Department should require evidence of satisfactory school progress before providing such essential service as dental care…what possible connection is there between a student's school progress and the need for care of her teeth? If this is really the policy of your government, then I consider that all the harsh things said about Canada's treatment of the Indians are more than justified.[56]

Thus, despite the repeated suggestions that IHS policy was formed in the interests of what was fair for all Canadians as a whole, average citizens did not always agree with the work done in their name. In a draft response to Carton, the civil servants rested on the belief that outrage was only born of ignorance of the "true" nature of federal responsibilities to First Nations peoples. The letter explained to Carton that her, "concern about the restrictive program of dental care for Indians *would* be fully justified if you do not appreciate the rather nebulous basis upon which the health and medical treatment program as provided by the federal government rests."[57] The letter continued,

> There is not any statutory requirement either in law or by treaty for a comprehensive medical care program for Indians except that annually in the recent past a sum has been allotted by Parliament to provide essential treatment for Indians so financially or geographically situated that the individual, family or community resources are insufficient.[58]

With this self-professed brief outline of an involved subject, it was hoped Carton's frustrations would dissipate. The final version of the letter sent to Carton, was less critical of her lack of knowledge, using language such as "you may be surprised to learn," however, the sentiment

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[56] Letter from Mrs. R. Carton, Principal Marathon High School to Alan MacEachen, Minister of Department of National Health and Welfare, (22 December 1966), RG 29 Vol 2905 File 851-1-A492 Pt. 3, Indian and Northern Health Services, Lakehead District, Thunder Bay, LAC.
[57] Draft Letter from Alan MacEachen to Mrs. R. Carton, Principal Marathon High School (29 December1966), RG 29 Vol 2905 File 851-1-A492 Pt. 3, Indian and Northern Health Services, Lakehead District, Thunder Bay, LAC. [emphasis added]
[58] Letter from Mrs. R. Carton, Principal Marathon High School to Alan MacEachen, Minister of Department of National Health and Welfare, (22 December 1966), RG 29 Vol 2905 File 851-1-A492 Pt. 3, Indian and Northern Health Services, Lakehead District, Thunder Bay, LAC.

remained the same. The IHS wanted to know whether the health and well-being of this student was worth the investment. As the letter ended, "if she is a promising student going on to make an economic contribution to her society, she merits most sympathetic consideration."[59] In this interchange the federal government's desire to offer financial support only to those First Nations peoples who wanted or were able to transition into tax paying, wage-earning economic assets is clear. Thus, as this section has shown, not only did IHS policy actively shy away from the offer of assistance on any grounds other than increasingly limited humanitarian aid, but they also gradually infused decision-making with concepts of investment and returns.

With anxieties around ever-rising costs and an "Indian problem" of a separate population, department leadership also clamped down on a First Nations health policy in which uncontrolled claims on federal funds would not be permitted to exist, namely treaty rights to health care. As Moore explained at a hearing of the second Joint Committee, a legislative acknowledgement of a treaty right to health care, "would open the door to many types of practices…It would be impossible to have budgetary control…if there was a statutory obligation, an Indian could walk into the city of Toronto, or Ottawa, go to the best specialists, run up any kind of bill in any hospital or receive any type of medical care, and it would be just absolutely beyond our budgetary control."[60] Throughout the years of this study, and indeed to this day, the federal government has remained adamant that it has had no legal obligation to provide health services to First Nations peoples in Canada. While some cracks began to appear—for example Treaty Six, which contained

[59] Letter from Alan MacEachen to Mrs. R. Carton, Principal Marathon High School (6 January 1967), RG 29 Vol 2905 File 851-1-A492 Pt. 3, Indian and Northern Health Services, Lakehead District, Thunder Bay, LAC.
[60] Brief and Presentation of the Canadian Medical Association to the Joint Committee, *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, March-July, no. 1-16* (Ottawa: The Queen's Printer and Controller of Stationary, 1961): 66.

a "medicine chest" clause, first appeared in the annual reports of the DNHW in 1957—the belief held firm that the IHS offered health care during a transition period in which First Nations peoples would in time earn the right to health care through acceptance of the responsibilities of Canadian citizenship. Once that transition was completed, it was hoped that the IHS would cease to exist.

Despite the certainty with which the federal government denied the existence of a statutory obligation to provide health care for First Nations peoples across the period under study, they were never without push back from individuals and groups. In 1962, for example, the son-in-law of an Anishinaabe man with connections to the Red Rock community, wrote to the Prime Minister regarding his father-in-law's access to federally funded medical care. O.J. Rath, Regional Superintendent of the Central Region of IHS explained that there was nothing the Service could do for the individual in question. "As you are no doubt aware," Rath began, "though the medical care of Indians is not a legal obligation, the Federal Government has, through its Indian Health Services, assumed the responsibility for such care on humanitarian and moral grounds, and offers to all Indians a free *public health service."* [my emphasis]. When it came to curative treatment, however, Rath explained the various reasons why the IHS felt this individual to be ineligible.[61] Tellingly, as the integrationist policy required, Rath's letter made no mention of treaty or Indigenous rights.

[61] To begin, he had been away from his reserve for more than twenty years while living in the Township of Nipigon. Second, like IHS, the Indian Affairs Branch did not consider him eligible for assistance from their sources. Third, the IHS stressed that the individual should be able to apply for assistance from the Ontario Department of Public Welfare at Port Arthur or the local Municipal Welfare Department, but later qualified that his status as an employed man would likely make him ineligible. This qualification aside, Rath concluded his letter with the assurance that they now understood that the "correct authority to whom [this individual] should now direct any requests for assistance" was municipal and provincial sources. Letter from O.J. Rath, MD. DPH, Regional Superintendent, Medical Services to P.C., (10 September 1962), RG 29 Vol 2905 File 851-1-A492 Pt. 2, Indian and Northern Health Services, Lakehead District, Thunder Bay, ON, LAC.

This family, however, was not so easily dismissed. In 1967, they wrote directly to the Minister of Indian Affairs with the assertion that medical care should be provided as a matter of treaty right. While the individual explained that he had never lived on a reserve, he maintained that he "lived all my life as a treaty Indian…[and] I insist on my treaty rights."[62] In response, the IHS' new Director, H.A. Procter, upheld the longstanding government policy:

> I gather from your correspondence that you feel medical care should be provided to you as a treaty right. This is not the case, as the federal government is not under treaty nor statutory obligation to provide such care. It has now been ascertained that residential and other factors make you ineligible for assistance from this Department. However, you qualify for assistance from provincial or municipal agencies."[63]

Health care assistance could acceptably be a right of Canadian citizenship, but not of treaty. The former was an indicator of permanence, the latter a temporary form of aid until the "Indian problem" was at last solved. As per the interests of settler colonialism, only the Canadian citizen was offered a place in the future.

To stave off accusations of abandonment, the federal government framed the eventual withdrawal of health services to First Nations peoples as the growing burden it simply could no longer afford to maintain, especially in light of medicare and the rising population of First Nations peoples.

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[62] Letter from P. D. to Minister of Indian and Northern Affairs, (30 September 1967), RG 29 Vol 2905 File 851-1-A492 Pt. 3, Indian and Northern Health Services, Lakehead District, Thunder Bay, LAC.

[63] Letter from H.A. Procter, Director General, Medical Services to P.D., (1 February 1968), RG 29 Vol 2905 File 851-1-A492 Pt. 3, Indian and Northern Health Services, Lakehead District, Thunder Bay, LAC. It is worthwhile to note that the response to this second letter demonstrates that the IHS leaderships' stance on treaty rights and access to health care caused distress and confusion for their own staff. As the nurse explained, "the treaty Indians insist they are entitled to free medical, surgical, dental, glasses, and free transportation, regardless of whether they are working or not. They claim they are all under 'Treaty.'" In contrast, the nurse recounted, IHS policy specifically, and the federal government more broadly, continued to deny any kind of right to medical care as a matter of statutory or treaty obligation. Given the dissonance of these positions, the nurse wrote to her superiors to express her confusion and declare that she found it "rather difficult to know what policy to follow." Clearly then First Nations voices were certainly heard but their opinions did not align with the priorities and desires of the IHS nor the federal government's broader mandate. How her superiors responded to this letter is not readily available in the records. Letter from Mrs. K. Lawman, RN, Nurse in Charge, Medical Services, Port Arthur, to Zone Director, Sioux Lookout, (21 November 1967), RG 29 Vol 2905 File 851-1-A492 Pt. 3, Indian and Northern Health Services, Lakehead District, Thunder Bay, LAC.

When MPs questioned Minister of National Health and Welfare Allan MacEachen in the House of Commons about Ottawa's programs for First Nations health, economic anxieties are clear. MacEachen explained that the Department, like others, had "to scrutinize our estimated expenditures for the coming year, and while we have been able to maintain at least the same level of expenditure in northern health services and Indian health services as was established last year, we have not been able to maintain the significant increase which prevailed over the preceding year."[64] He went on to stress that his Department felt "no lack of sympathy or concern" but that the economic demands of other branches of DNHW required such policy. Not everyone agreed with MacEachen or believed the funds could not be found. Known today as the father of Medicare, Tommy Douglas pushed back against MacEachen, explaining "if the government has to curtail expenditures there are other places it might look than at this rather meagre sum which we are spending on our native people." Douglas went on to highlight, for example, the recent government decision to overhaul and re-equip four destroyers with a price tag around $200 million.[65] Nevertheless, MacEachen and his Department were unmoved. Instead, his willingness to direct new funds away from a separate service for First Nations peoples at a time when provincial health care access was anticipated to expand, underscores the ultimate priority of the DNHW. As MacEachen had explained earlier to his peers in the House of Commons, "the *main* objective of our service, so far as the Indian population is concerned is to make sure that our Indians belong to

[64] Allan MacEachen (Liberal Party House Leader and Minister of National Health and Welfare), House of Commons. Edited Hansard, 27th Parliament, 2nd Session (March 14, 1968). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/2538789/

[65] Tommy Douglas (Leader of the New Democratic Party), House of Commons. Edited Hansard, 27th Parliament, 2nd Session (March 26th, 1968). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/2541696/

the mainstream of the Canadian community."[66] The maintenance of a separate service was not a financial priority.

Push back against the federal government's unilateral decision to withdraw support continued. When a First Nations individual had their claims for payment refused, the Indian Youth Friendship Centre of the area felt compelled to step in.[67] The Centre's Director and President of the Northwestern Ontario Indian Association, Xavier Nichon, wrote to Robert Andras, the recently appointed Minister without portfolio to assist Indian Affairs minister Jean Chrétien, to explain their frustration.[68] He began, "I want you to know of the hardship and despair the Indian people must face when they attempt to integrate into the 'dominant society.' In particular, the present Medical Services Act calls for a discontinuation of medical care when an Indian moves off the reserve." A major flaw in this policy, Nichon explained, is that most people who integrated could only find temporary or seasonal work. He continued, "the total earnings that these people procure is never enough to support their families and at the same time provide for medical care which is so expensive and yet so necessary. Outdated policies like the Medical Service Act can only keep the Indian people at the lowest level of human existence; they can only give them one alternative; to go back in complete despair to the ghettos of human misery that we call reserves."[69] Nichon's

[66] Allan MacEachen (Liberal Party House Leader and Minister of National Health and Welfare), House of Commons. Edited Hansard, 27th Parliament, 2nd Session (March 14, 1968. Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/2538789/ [emphasis added]
[67] Letter from John C. Munro, Minister Department of National Health and Welfare, to Robert Andras, Minister without Portfolio, (8 November 1968), RG 29 Vol 2911 File 851-1-A492 Pt2, Indian and Northern Health Services, Lakehead District, Thunder Bay, ONT, LAC.
[68] Peter H. Russell, explained that ministers without portfolio were an invention of Prime Minister Pierre Trudeau, "intended to bring extra cabinet heft to departments taking on major policy challenges." Andras, Russell continues, was a northern Ontario businessman new to world of federal politics, who "attached himself closely to the process of consulting with Indians on *Indian Act* reform, a process inherited from the Pearson government." Peter H. Russell, *Canada's Odyssey: A Country Based on Incomplete Conquests* (Toronto: University of Toronto Press, 2017), 318.
[69] Nichon continued to argue that upcoming health insurance programs in Ontario and the country broadly, would do little to ameliorate the suffering that communities and individuals currently faced. As he explained, the added burden of medical services…would only mean…that the white man has taken one more step in lowering Indians'

description of settler medical care legislation as outdated reveals his frustration with Ottawa's repeated refusal to engage in a health care policy relationship based in anything but settler-defined priorities. Denial of First Nations' Indigenous and treaty rights to health care on their own terms did little to improve First Nations well-being. Nichon called not for settler-colonial power to be extended but for it to be reimagined. Unsurprisingly, the response to Nichon's letter followed the standard IHS line. The Zone Director of IHS explained to Nichon that he should guide the individual in question to seek assistance from the province.[70] Once again, an assertion of treaty rights was presented as First Nations' ignorance as to their "true" sources of support, a perspective employed to undermine challenges to settler power and legitimacy, and to limit Ottawa's financial expenditure for First Nations' health care.

Individual and organizational responses described here reveal both the sustained efforts of First Nations peoples to assert their rights as they upheld their responsibility for land sharing, and Ottawa's unrelenting efforts to deny such rights. When Canada's first program of national health insurance, medicare, arrived on July 1, 1968, this "universal" medical insurance program did little to change the minds of many First Nations who indeed wanted better health care for their communities but not at the expense of either treaty or aboriginal rights.[71] As historians Mary Jane Logan McCallum and Maureen Lux have demonstrated, First Nations "challenged the state and resisted the meanings of medicare in a prolonged struggle to protect treaty rights, arguing that the

already desperate condition." Letter from Xavier Nichon, Director of the Indian Youth Friend Centre and President of the Northwestern Ontario Indian Association to Robert Andras, Minister without Portfolio, (3 October 1968) RG 29 Vol 2911 File 851-1-A492 Pt 2, Indian and Northern Health Services, Lakehead District, Thunder Bay, Ont, LAC.

[70] Letter from K.F. Butler to Zone Director, Sioux Lookout Zone, (8 October 1968), RG 29 Vol 2911 File 851-1-A492 Pt. 2, Indian and Northern Health Services, Lakehead District, Thunder Bay, Ont, LAC.

[71] British Columbia and Saskatchewan signed on to the Medicare Program on this date. Later, Alberta joined on July 1, 1969, followed shortly by Ontario, in November. By April 1, 1972, all provinces had signed onto Medicare.

medicine chest, not medicare, should define the relationship between Indigenous peoples and the state in terms of health care."[72] Indeed, shortly after the release of the IHS' 1968 Health Plan to devolve its responsibility for First Nations' health provision, discussed at length in the next chapter, a group of 150 First Nations individuals marched on the Indian Affairs branch office at The Pas to protest its dismissal of treaty rights.[73] Whether as Canadian citizens or sovereign peoples, a commitment to treaty rights remained a widespread reality among First Nations peoples. Try as they might, it was not a perspective that the IHS could discount.

At What Cost? Consequences for Care

For a federal government to offer a medical service whose operating principles centred on the idea that its existence was a temporary service born of charity rather than obligation had significant consequences for the quality of health care available within the service—a standard of care worthy of analysis. In particular, it is important to highlight that the IHS maintained a service in which substandard care was deemed acceptable and where a choice in service was a privilege that only those who exercised their monetary responsibilities to the Canadian state were seen to have earned.

In 1957, R.A. Armstrong, the Consultant on Clinical Standards for Indian and Northern Health Services, wrote to Director Moore with a less than laudatory report of the state of the Service. He told Moore that "Indian Health Services is paying a great deal of money for substandard medical care in certain areas and that this substandard care, as well as having a great drain on our financial

[72] McCallum and Lux, "Medicare versus Medicine Chest," 103.
[73] David Orkilow (NDP), House of Commons, Edited Hansard, 27th Parliament, 2nd Session (March 26th, 1968). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/2541709/

resources, is not in the best interests of the sick Indian."[74] Armstrong explained, for example, how a First Nations individual had been diagnosed with tuberculous meningitis in December of 1956 and even after two months remained at the small isolated hospital for treatment. Given what Armstrong considered the medical advances of the period, he argued that "there is no excuse…for such a patient to be maintained and receive treatment in a small isolated hospital such as this." He went on to explain that "tuberculous meningitis requires expert judgement, and it requires good laboratory facilities, neither of these could be found at St. Pierre." Armstrong even questioned the accuracy of the patient's diagnosis owing to the lack of proper laboratory equipment and reminded Moore that "the difference in treatment between tuberculous meningitis and the acute bacterial meningitis is such that tragic consequences could result from improper diagnosis and, therefore, improper treatment."[75] While Armstrong provided only a few more additional cases to illustrate his claim of substandard care, he felt confident that a list of examples "could go on indefinitely."

A wider examination of IHS records supports this belief. The Department's hospital at Moose Factory consistently reported significant personnel shortages that were revealed to be characteristic of IHS institutions. As Zone Superintendent J.P. Harvey noted in his monthly report in February of 1961, "beyond the fact that all staff are learning that whether a government can run out of money or not, a department can, [and] this summary must deal with our shortages."[76] Harvey revealed that qualified people were needed in many departments including the powerhouse, the laboratory, the nursing, and the medical staff. In the following months the situation did not improve. Harvey

[74] R.A. Armstrong, MD, Consultant on Clinical Standards to. P.E. Moore, Director of INHS, (15 February 1957), RG 29 Vol 2866 File 851-1 Part 1 B, Medical Services Operations, LAC.
[75] R.A. Armstrong, MD, Consultant on Clinical Standards to. P.E. Moore, Director of INHS, (15 February 1957), RG 29 Vol 2866 File 851-1 Part 1 B, Medical Services Operations, LAC.
[76] Monthly Report, Moose Factory Zone Report, (February 1961), RG 29 Vol 3124 File 860-80X-275 Pt. 1, Zone and Regional Report, Moose Factory Zone, LAC.

reported in July that the hospital was in "dire need" of a laboratory technician while in September he alerted Ottawa that staff morale was low at the hospital likely due to insufficient staff because they remained "extremely short."[77] Still later, in February of 1963, Wiebe admitted to Moore that "within the Moose Factory Hospital itself there has been a continuing unsatisfactory situation over the years, frequently both as to number and quality of medical officers."[78] In 1965, fifteen years after the hospital first opened, the Zone superintendent painted an enduringly bleak picture: "During this two-month period, the number of qualified staff employed has reached a disturbing 'low', this being mainly due to the lack of graduate nurses, but also the loss of trained technical staff." The losses included the only qualified radiographer and the second most senior laboratory technician. These departures, in addition to the previous loss of an accountant, "was a particularly severe blow, at a time when it appeared that Moose Factory was just beginning to get on its feet administratively."[79] As Armstrong had highlighted earlier, without the skill sets such staff provided, the quality of care provided to First Nations patients would suffer.

Significantly, the limited numbers of IHS staff also had direct consequences for access to health care outside hospital walls. On more than one occasion, IHS outpost nursing stations were forced to close temporarily, not as a matter of IHS policy, but due to the inability to secure staff.[80] With neither sufficient financial resources invested into the Service to attract personnel to work in its

[77] Monthly Report, Moose Factory Zone Report, (July and September 1961), RG 29 Vol 3124 File 860-80X-275 Pt. 1, Zone and Regional Report, Moose Factory Zone, LAC.
[78] Monthly Report, Moose Factory Zone Report, February 1963, RG 29 Vol 3124 File 822-1-X175, Zone and Regional Report, Moose Factory Zone, LAC.
[79] Monthly Report, Moose Factory Zone Report, (February and March 1965), RG 29 Vol 3124 File 860-80X-275 Pt. 1, Zone and Regional Report, Moose Factory Zone, LAC.
[80] Sioux Lookout Zone Report for Landsdowne House, (October 1964), Accession: 02829-A0038264 File 860-8-X203 Pt. 1B, Organization and Administration, Sioux Lookout Hospital, LAC. In total for the 1966, the Sioux Lookout Zone reported vacancies in 16 of its 35 positions.

institutions nor a substantial effort to ensure the training of local staff, Armstrong's concerns about a service without universal access to high quality health care was set to continue.

Certainly, it is important to understand that nursing shortages were impacting health institutions across Canada during this time.[81] Historian Maureen Lux has demonstrated in her in-depth study of Indian Hospitals that choices of the IHS did little to create a work environment favourable to hiring or retention. Lux explains that "IHS hospitals earned a reputation as an employer that ignored professional nursing standards and ethics, and where low wages and long hours taxed poorly trained and ever-changing staff."[82] Moreover, this context alone cannot account for the limitations of IHS institutions. Even simple solutions to improve patient care were slow to come. The 1963 monthly report from the Moose Factory hospital explained:

> During the very hot days, when the ward doors need to be opened to provide more ventilation, the mosquitoes and flies were very troublesome. The children particularly seemed to be the victims of fly bites, not only making them uncomfortable, but the bites frequently become infected. When this problem was experienced last year, a request was submitted for some type of screening for the fire doors; this written request was repeated in the fall of 1962, in anticipation of the recurrence of the problem this year. No further action has been taken to deal with it.[83]

The slow movement of IHS bureaucracy in which the vast majority of IHS expenditures required approval from Ottawa no doubt contributed to the slow response to this concern. The context of anxieties over the costs of a separate service, however, cannot be forgotten. As noted earlier, with

[81] In 1954, the Ontario Department of Health Estimates reported noted a 20 per cent shortage in nursing staff. (March 24, 1954); Ontario, Legislative Assembly, Hansard, 24 March 1954. (Hon. MacKinnon Phillips): 765. https://archive.org/details/hansard1954ontauoft/page/764/mode/2up; Later, in 1968, MPP Mr. T.P. Reid of Rainy River presented a private member's motion that the government "investigate the extent of the shortage of doctors, dentists, and nurses in northwestern Ontario, and provide a comprehensive plan to ameliorate this shortage in order to ensure that the people of northwestern Ontario receive the health care they deserve. Ontario, Legislative Assembly, Hansard, 15 March 1968. (Mr. T.P. Reid): 847.https://archive.org/details/v1hansard1968ontauoft/mode/2

[82] Lux, *Separate Beds,* 83.

[83] Monthly Report, Moose Factory Zone Report, (June 1963), RG 29 Vol 3124 File 860-80X-275 Pt. 1, Zone and Regional Report, Moose Factory Zone, LAC.

the movement of IHS to DNHW, its leadership had promised that its service would "operate at half the costs of provincial hospitals."[84] With that priority in mind, certain standards of care had to be accepted.

As stated above, this rather grim portrait of Moose Factory's institutional challenges was not unique. In 1959, the staff of the Sioux Lookout Indian Hospital were informed of certain deficiencies in its operations. Namely, that certain surgical procedures could no longer be carried out without consent from patient, parent, guardian, or specific Indian Affairs staff. In addition, the hospital had to ensure that copies of births, stillbirths, and death certificates be included in all files where applicable. Finally, a review of hospital operations revealed lapses in adequate hospital reporting and record keeping. For example, when a patient died at Sioux Lookout hospital and an autopsy was ordered, the final autopsy report was never included in a patient's file.[85] Such administrative oversights were noted as significant obstacles if Sioux Lookout Hospital hoped to achieve accreditation standards on par with provincial institutions. Elsewhere, limitations in Service could be found outside hospital walls. Following a rise in tensions between the IHS nurse and the community of Sandy Lake over repeated negative health care encounters, Moore wrote to his Regional Superintendent to explain, "the only conclusion which we can draw…is that the nurse may have been in a state of complete exhaustion." Moore's own frustration at the financial and personnel restraints on the service is palpable; he goes on to write "Just as long as we are forced, due to staff shortages, to permit one nurse to provide a twenty-four-hour service, seven days a

[84] Lux, *Separate Beds,* 14.
[85] Report of Operations, Sioux Lookout Hospital, (October/November 1959), RG 29 Vol 2606 File 800-1-X228 Pt. 1, Organization and Administration, Sioux Lookout Hospital, LAC.

week, we shall also be forced to take serious risks."[86] Thus, both IHS leadership and staff were not without their own sense of frustrations about the limitations of the service they provided. Unfortunately for all involved, the imperatives of integration and the anxieties over a separate service remained more powerful motivators of action.

In light of the signs of substandard care outlined above, it is understandable why some First Nations individuals would choose to seek medical assistance beyond what IHS offered. One individual in Port Arthur, for example, when informed that their teeth extraction would take a month to schedule, took matters into their own hands. Five days later, the IHS received a letter from the individual in question to say that they had gone ahead and had their teeth extracted by a different physician in Nipigon and expected IHS to make a financial contribution. A registered nurse in the employ of the IHS responded to assert that the Service would be unable to do so. They explained that while they "understood that your teeth were making you sick," the appropriate lines of authority had to be respected.[87] First Nations patients could not be trusted to make the most economically judicious decisions without approval.

Faced with this policy, individuals were welcomed by the IHS to seek alternative care if they so desired, with the proviso that such a decision would come entirely at the individual's expense. As Dr. J.H. Wiebe, Regional Superintendent for the IHS explained to a member of the Six Nations community in April of 1965, because they had sought such medical care without the prior authorization of the IHS, the Service was "quite unable" to settle the account. The rationale for Dr.

[86] Letter from P.E. Moore to Regional Superintendent Central Region, INHS, (Feb 14, 1961), RG 29 Vol 2912 File 851-1-A494 Pt. 4, Indian and Northern Health Services, Sioux Lookout District, LAC.
[87] Letter from J.W. Maxwell, RN, Indian Health Service, (2 March 1960, and 19 March 1960), RG 29 Vol 2911 File 851-1-A492 Pt. 2, Indian and Northern Health Services, Lakehead Strict, Thunder Bay, ON, LAC.

Wiebe's decision rested on the long-used narrative that the Service had already reached the limit of its moral duty. While "we sincerely regret the necessity for this unfavourable decision," Dr. Wiebe explained in his letter, "you must realize…that it is hardly feasible for us to provide a hospital and medical staff for the treatment of patients from the Six Nations Reserve and then be expected to pay the medical bills whenever an individual decides, on his own, to consult an outside physician."[88] As Moore had previously outlined to the Joint Committee in 1961, IHS required budgetary control of its expenditures and would not allow First Nations peoples to define the terms of their care experience without IHS approval. As had been established as IHS policy for many years, choice was only offered to persons outside of the IHS. Such a choice was deemed to be the right of those persons who had accepted settler-prescribed notions of responsibility. Or, to use other language of the period, choice would only be afforded to those who had left the "primitive" mentality of separate treaty rights and "developed" into a modern Canadian citizen.

The policy restrictions on First Nations choice did not dampen the advocacy of First Nations groups dissatisfied with the unilateral control of health policy. In one avenue, many First Nations peoples agreed to work within the IHS as labourers to earn an income but also to serve as cultural brokers between First Nations peoples seeking settler care and the non-Indigenous individuals who staffed the centres.[89] In addition, beginning in the 1960s, and as part of the spirit of "community development" the IHS established the Community Health Representatives Program in which First Nations staff were trained and employed to help translate the public health teachings of the IHS in ways that were culturally sensitive and in the communities' own languages. While the CHR

[88] Letter from J.H. Wiebe, Regional Superintendent, INHS to member of the Six Nations," (26 July 1963), RG 29 Vol 2905 File 851-1-A479 Pt. 3, Indian and Northern Health Services Brantford District, LAC.
[89] Laurie Mejer Drees, *Healing Histories: Stories from Canada's Indian Hospitals* (Edmonton: University of Alberta Press, 2013).

program had many limitations, the willingness of First Nations individuals to participate in the program complicates a misguided narrative of First Nations peoples as passive recipients of settler care.[90] All spaces of settler-First Nations encounters are negotiated, even if the power differentials disproportionately favour one side over the other.

Another form of negotiated encounter was community-led advocacy. In 1968, eighteen members of the Deer Lake First Nation wrote to Federal Minister of Health Alan MacEachen to contest IHS policy. The group explained that IHS policy felt coercive, that the "making of their own decisions is denied and the Department is discriminating [against them]."[91] The policy with which the authors had a particular grievance was the instruction that medical treatment would only be paid for if the peoples of Deer Lake First Nation sought treatment at the assigned IHS institution, in this case, the Sioux Lookout Indian hospital. Failure to do so would require individuals to pay the full cost of their treatment. In response, the authors stressed that while IHS may desire that they go to Sioux Lookout, individuals had found they were not treated satisfactorily there. The members explained, for example, that at Sioux Lookout expectant mothers were left alone for long periods of time during their labour and that they "dreadfully fear being left alone at such a crucial time." In contrast, when treatment was sought out at Red Lake, they found the medical attention to be "superior and more personal." Despite previous threats that their community would have to pay the transportation costs, as well as outpatient room and board, the authors stood firm to critique

[90] Historian Mary Jane Logan McCallum has revealed the racialized and sexist ideas that permeated the program and described the job as "a dead-end precarious position low on the Health Services hierarchy and…ultimately created with the intention of being phased out to provincial services. McCallum, *Indigenous Women, Work, and History*, 123. In her study of CHRs, McCallum notes that in the first year of the program (1961-62), eleven individuals were trained. By 1969, the number had grown to seventy-three.

[91] Letter from 18 members of the Deer Lake First Nation to Alan MacEachen, Minister of Department of National Health and Welfare, (1 April 1968), RG 29 Vol 2912, File 851-1-A494 Pt. 4, Indian and Northern Health Services, Sioux Lookout District, LAC.

IHS standpoints. They included the following in their closing remarks: "The [IHS] sentiment is: We are not a people but thought of as a flock of chickens to be used or misused with no personality or feeling and forced to follow the whims of the Department."[92] This feeling of paternalism emanating from IHS policies raises substantial doubt whether the winds of change had truly blown.

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In the original version of the *Indian Act* of 1876, an Indian was described as someone other than a person. By the 1960s, that description had certainly changed. At the 1968 Dominion Council of Health Meeting, Dr. H.A. Procter, who had succeeded Moore as Director General of the Medical Services Branch in 1966, explained to the Ministers of Health present that "an Indian is a person whose name is on a register maintained by the Department of Indians Affairs and Northern Development."[93] In the former instance, a First Nations individual is denied both personhood and is deemed to be without a significant place in Canadian society. In the latter, individuals identified on the form are only placed in a temporary position of distinction. They are no longer denied personhood and their citizenship in Canada actively encouraged.

But if the winds of change had indeed blown in the 1960s, they nevertheless carried with them many colonial continuities. As this chapter has argued, these continuities abutted against many equally enduring tensions, however, settler interests and powers in the 1960s ultimately provided Ottawa with the solutions it was most comfortable with. They wanted participants not partners,

[92] Letter from 18 members of the Deer Lake First Nation to Alan MacEachen, Minister of Department of National Health and Welfare, (1 April 1968), RG 29 Vol 2912, File 851-1-A494 Pt. 4, Indian and Northern Health Services, Sioux Lookout District, LAC.
[93] Dominion Council of Health, 93rd Meeting, (October 1968), RG 29 Vol 2147, LAC.

equality as erasure, and the reduction of an "unequal" separate health care system. Even with a break in the Liberal party's dominance of federal politics in the twentieth century, settler colonial aims did more to unite partisan opinion than to divide it. As participants in Canadian society, it was believed that First Nations peoples were owed equality, nothing more. Taken together, these perspectives and actions created a First Nations health policy ethos in Ottawa in which permanent aid was held to be contingent on the acceptance of settler-colonial sovereignty and its chosen forms of social-economic and political organization.

Problematically for the federal government, First Nations people's resistance to such a perspective never disappeared. They called for partnership and asserted their privilege, not simple participation. Nevertheless, Ottawa persisted in prioritizing settler perspectives that dismissed treaty rights as a basis on which to extend health care services to First Nations peoples. Tragically, the health care they were offered would suffer from serious deficiencies.

With Ottawa's certainty of mission secured, other hurdles remained. Namely, if Ottawa wanted to dissolve its responsibility for the provision of health care services to First Nations peoples, the acceptance of First Nations individual responsibility to organize care *and* the support of the provinces were imperative to secure. As the previous chapter explored, Ontario had indicated some desire to work towards equality for First Nations individuals. But new tensions would emerge as Ottawa attempted to devolve its constitutional responsibility for First Nations health care. Would Ontario's willingness to support integration survive an intensification of integration efforts? How would First Nations respond?

Chapter 5

To Cease or Persist: Settler Responsibility Debates for First Nations' Well-being

When the second Joint Committee on Indian Affairs proclaimed in 1961 that the winds of change had blown, they readily concluded that "the time is now fast approaching when the Indian people can assume the responsibility and accept the benefits of full participation as Canadian citizens."[1] As the previous chapter explored, both politicians and bureaucrats at the federal level embraced an integration ethos that would enforce an equality of rights and responsibilities between First Nations peoples and Canadian citizens, one they hoped in time would become absolute. Leadership within the IHS had actively pursued policies that restricted First Nations access to federally provided health care services while they pointed to provincial and municipal governments as alternative sources of aid. This withdrawal of services, however, was only one of the tasks that integration required. Integration policy had three targets: the individualization of responsibility for well-being, the transformation over time of the band council into a municipal entity, and the provinces' acceptance of jurisdiction over First Nations residents as fellow citizens and not as federal wards.

Although riddled with qualifications, provinces had tepidly begun to accept the citizenship status of First Nations peoples living within their provincial boundaries. By the early 1960s, First Nations peoples shared access to programs universally accessible to provincial residents such as Old Age Security, Old Age Assistance, Blind and Disabled Persons Allowances, Hospital Insurance,

[1] Final Report of the Joint Committee, *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and House of Commons on Indian Affairs, March-July, no. 1-16* (Ottawa: The Queen's Printer and Controller of Stationary, 1961): 605.

Unemployment Insurance.[2] Yet, much to the frustration of the federal government, First Nations communities generally remained outside the "complex and intricate web of provincial-municipal relations, structures, and cost-sharing agreements" that provided a wide range of services such as health, education, welfare, roads, police protection, and recreation.[3] The provision of provincial and community facilities to First Nations peoples and communities was particularly piecemeal. Across the country, services were offered "as required" or "when convenient" through informal and unrecorded agreements or on an "unofficial and trial basis" as in the case of First Nations children attending so-called "integrated" schools.[4] Provincial reception to integration was hardly enthusiastic.

Ontario, however, proved to be slightly more open to the proposition. Following its Select Committee on Indian Affairs, discussed in chapter 3, Ontario made several concrete steps to extend provincial services to First Nations communities. In 1955, Ontario passed *the Indian Welfare Services Act*, which extended to "registered or treaty Indians" all assistance programs administered by the province. [5] Then in 1959, Ontario made amendments to the *Ontario General Welfare Assistance Act* to grant reserves an altered form of municipal status that would allow bands to administer the Act.[6] It was the first time that the Ontario government acknowledged any form of responsibility for "treaty Indians."[7] But many questions, details, and hurdles to equal treatment

[2] Hugh Shewell*, 'Enough to Keep Them Alive': Indian Welfare in Canada, 1873-1965* (Toronto: University of Toronto Press, 2004), 180; 238; 266.
[3] Federal Preparatory Material for 1964 Federal-Provincial Meeting on Indian Affairs, (N.D), RG 29 Vol 71, Miscellaneous Re. Indian Administration, LAC.
[4] Federal Preparatory Material for 1964 Federal-Provincial Meeting on Indian Affairs, (N.D.), RG 29 Vol 71 Miscellaneous Re. Indian Administration, LAC.
[5] Ontario, Legislative Assembly, Hansard, 17 June 1965 (Hon. L.P. Cecile, Minister of Public Welfare, PC): 4347-4348. https://archive.org/details/v3hansard1978ontauoft
[6] Shewell, *'Enough to Keep Them Alive,'* 268.
[7] Ontario, Legislative Assembly, Hansard, 17 June 1965 (Hon. L.P. Cecile, Minister of Public Welfare, PC): 4347. https://archive.org/details/v3hansard1978ontauoft

remained. How exactly did government leaders and officials interpret this new responsibility? Would their understanding of the scope of this responsibility expand or contract in the face of political pressure, First Nations agency, and jurisdictional debates? Would Ontario continue to see First Nations peoples as a kind of qualified provincial citizen, accept the full integration of First Nations individuals, or go another route entirely? And, crucially, who would remain on the peripheries of political power in the settler state?

The overall aim of this chapter is to examine the rationales, debates, and methods of Ottawa's attempt to devolve its responsibility for First Nations health care provision. It begins with an analysis of how Ottawa directed its efforts first towards First Nations individuals and communities and then on the provinces. Next, it will focus on the rhetoric and rationales that surrounded settler discussions of First Nations peoples in Ontario. Ontario is a useful case study as it took the earliest steps to extend First Nations' access to provincial services.[8] The chapter then considers debates between Ontario and Ottawa about their respective responsibilities for First Nations health care access. Collectively, these explorations will reveal an unsettled debate; while Ottawa actively sought to cease its responsibility for First Nations health care, many others called for their persistence in the field.

By Their Own Efforts: Courting Individual and Provincial Commitments to Integration

As earlier chapters have demonstrated, since the beginning of its integration policy, the federal government had resisted arguments that suggested it had any obligation, beyond a moral duty, to

[8] An examination of the full range of federal-provincial negotiations during the period of integration would require far more time and space than this study allows.

provide health care services to First Nations communities. Indeed, it is a well-known turn of phrase in historical analysis that the IHS believed that "no law or treaty" bound it to do its work. In addition, while the federal government could not deny that the *BNA Act* had assigned to it "Indians and lands reserved for Indians," as the lifespan of integration policy lengthened, the federal government found ways to shift the tenor of jurisdictional debates that allowed for new conversations. In sum, the federal government throughout the 1950s and into the 1960s, remained committed to the permanent transition of First Nations peoples from perceived helpless federal wards to self-sufficient citizens, operating in society without any privileges that their fellow Canadian citizens as provincial residents were not afforded. But how successful would this federal agenda be? What rhetorical and structural tools would they employ?

To consider the enthusiasm with which the federal government sought to individualize responsibility for First Nations' well-being, it is useful to return to the IHS's late 1950s payment policy that worked in tandem with numerous efforts to limit the Service's expenditure. In January of 1956, Percy Moore wrote to his deputy minister, G.D.W. Cameron, to request approval for the branch's new Self-Help Insurance Plan to catalyze integration efforts. The Plan encouraged employed First Nations peoples to subscribe to voluntary health insurance through their band councils. The link to integration was stated in no uncertain terms: "The plan is a device to improve the morale of Indians as individuals by inducing them to accept increased responsibility, the eventual aim being their integration into the Canadian society as equals…[and] to guard against unjustified expenditure of public funds."[9] Key features of the plan included, some relief of hospitalization and medical care costs for the IHS and the transfer of responsibility for proof of

[9] A Plan to Encourage Employed Indians to Subscribe to Voluntary Health Insurance Through their Band Councils, (January 1956), RG 29 Vol 2884 File 851-1-23 Pt. 1 [B], Medical Self Help, LAC.

indigency from the IHS to individuals who sought payment for medical care. At the time, it was agreed that a one-year education campaign was needed to inform individuals of their responsibilities after which "some pressure would gradually be put on."[10] As the previous chapter explored, this pressure operated through the IHS Form "Notice of Cessation of Acceptability." The Service, and the federal government more broadly, actively sought to instill settler-defined values of individual responsibility.

The content of one brochure in the federal government's education campaign, entitled "Don't Let Your Family Down," is worth quoting at length for its revelations regarding the ethos of IHS policy throughout the 1950s and 1960s.[11] Designed especially for First Nations individuals, it began with a statement about the claimed sovereignty and goodness of the Canadian nation-state in this land:

> Canada was built into a nation by its people, led by men and women with vision and faith. We love Canada because of its freedom, the chance it gives to hard working men and women, possessing integrity, good will and determination, although starting with little, to grow in position, in responsibility and in spiritual, mental and material wealth. This is our country. Our fathers made it and it is ours to sustain, to enrich, to work for.

The brochure then goes on to criticize those who have not accepted the values, beliefs, and community of the settler state:

> Unfortunately, as we look around at our fellow Canadians, we see some who are not making the most of their opportunities. Some of them neglect the educational opportunities available to them. Some of them seem to lack in public spirit and a sense of responsibility towards their community. Some of them could make much better use of the information about public health that is readily available to them. Some of them waste their money instead of using it wisely and saving it.
> …

[10] Letter from P.E. Moore, Director, Medical Services, to Deputy Minister of National Health, G.D.W. Cameron, (25 July 1962), RG 29 Vol 3001 File 851-9-15, Medical Services Insurance Plan General, LAC.

[11] The other brochures in the program were "Medical Care for Canada's Indians," which argued that 1) Indian Health Services had no legislative responsibility for this care; 2) that First Nations individuals capable of paying their own way should be responsible for doing so; and 3) urged subscription to voluntary medical insurance. The final pamphlet was "How to Obtain Insurance When Illness Strikes," which outlined the plan, and indicated how a First Nations individual who feels he needs financial assistance for medical care can apply for it." RG 29 Vol 2884 File 851-1-23 Pt. 1, Medical Self Help, LAC.

> It is unfortunate that some Canadian families have not seen the wisdom of buying this medical insurance; they trust to luck to get by or they depend on the good will of the taxpayer to meet their financial obligations to themselves and their families. You will agree that this is hardly fair—why should the man who works hard, saves his money and pays his taxes be expected to pay for the medical expenses of a person who has failed to contribute to a simple and inexpensive medical insurance plan, who probably spends on movies, candy, and soft drinks for himself as much in a month as the cost of medical insurance for the whole of his family, who probably smokes enough cigarettes to pay a monthly medical insurance premium of $8.00 for his whole family?

Finally, the document ends with the government's suggestion that First Nations peoples have only one path to a dignified life in this respect. The best part of medical insurance, it claims, is that it "permits [a man] to hold up his head and look his fellow citizens in the eye, knowing that in this matter he is pulling his weight in the community."[12] Through the discourse that the pamphlet employs, the First Nation individual is already naturalized as a Canadian citizen, and there is no room for debate on the matter. Moreover, its overtly paternalistic language also strove to evoke a sense of shame among those who choose a different interpretation of private health insurance as an appropriate means to secure well-being. The charge that individuals should not allow the Canadian government to pay for their medical care if they hoped to retain a sense of pride and self-respect reflected a deeply entrenched perspective that the Canadian state had the right to assess the worth of a person through a moral lens.[13] Despite years of criticism towards a paternalistic

[12] IHS Brochure, "Don't Let Your Family Down," (1956), RG 29 Vol 2884 File 851-1-23 Pt. 1, Medical Self Help, LAC.

[13] Percy Moore suggested as much when he wrote to O.J. Rath to explain that the Service could turn down accounts from individuals "where we feel that the individual should properly accept some responsibility as, for instance, is sometimes done in the case of alcoholics, habitual wife beaters, etc." Moore gave few additional details. Instead, he added that in future conversation they could be freer in their discussions whereas "writing can be used against us." Moore to Regional Superintendent Central Region, (July 26, 1963), RG 29 Vol 2912 File 851-1-A494 Pt. 4 (Indian and Northern Health Services, Sioux Lookout District 1960-1969) LAC. See also Carolyn Strange and Tina Look, *Making Good: Law and Moral Regulation in Canada, 1967-1939* (Toronto: University of Toronto Press,1997); Amanda Glasbeek, ed. *Moral Regulation and Governance in Canada: History, Context, and Critical Issues* (Toronto: Canadian Scholar's Press, 2006); Sarah Carter, *The Importance of Being Monogamous: Marriage and Nation Building in Western Canada to 1915* (Edmonton: University of Alberta Press, 2008); Mariana Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925* (Toronto: University of Toronto Press, 2008); Benjamin Hoy, "Policing Morality: Regulating Sexuality across the Canada-United States Border" *Canadian Historical Review* 99, no. 1 (Spring 2018): 30-62.

relationship with First Nations peoples as well as the rhetoric of universalism that aimed to dispel notions of the "undeserving poor', this settler service maintained the belief that their aid was contingent on a moral code unilaterally established by the Service and its wider society.[14]

The IHS's plan quickened federal efforts to escape its managerial role for First Nations health. It continued to broker negotiations between individual bands and private insurance companies who, as early as 1955, had begun to court the IHS. That year, the secretary of the Co-Operative Medical Services Federation of Ontario, which represented 34 medical co-operatives providing pre-paid health protection plans, had written to Regional Superintendent John S. Willis to argue their case. The author proposed that given IHS policy shifts to encourage First Nations peoples with means to take up private insurance, the Federation "might solve many of the problems which you would face in undertaking such a project."[15] Willis and his superiors were obviously attracted to the proposition. On offer was the infrastructure to tangibly devolve their responsibility for First Nations health onto individuals, even if Ottawa remained temporarily responsible for some level of financial contributions. In 1959, the Treasury Board authorized the Department of National Health and Welfare to enter into agreements for the provision of medical care, through private

[14] Certainly, First Nations individuals were not the sole target of such rhetoric. In 1970, Mr. J. Edward Broadbent (Oshawa-Whitby, NDP), challenged in the House of Commons what he called the "abusive myth" of Canadian's welfare access. Broadbent explained, "This is a view held by many people in this country, unfortunately, and it goes as follows: the people on welfare really tend to abuse the system, that they live high on the hog, that they use their welfare payment for a down payment on a new car. All kinds of bizarre and, in my judgement cruel, stories go around to this effect." Thus, class paternalism was a process that crossed racialized lines. It is essential to remember, however, the racialization coloured the tenor of this class-based paternalism, for example, through the creation and perpetuation of "the lazy Indian trope" or the on-going misconception that First Nations people did not pay any taxes. Such a stereotype was of value to settler society as it became a racialized tool to encourage those seen to be uninterested in the "normal" forms of state contribution, such as taxes, to change their ways. Edward Broadbent, House of Commons. Edited Hansard. 28th Parliament, 2nd Session. (April 6, 1970). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/2657065/

[15] Letter from Co-Operative Medical Services Federation of Ontario, Secretary to John S. Willis, Regional Superintendent, Eastern Canada, Indian Health Services, (23 November 1955), RG 29 Vol 2884 File 851-1-23 Pt. 1, Medical Self Help, LAC.

insurance plans, to members of specified bands.[16] Less than two years later, it authorized an expansion of this coverage for additional bands.[17] Using information about band and individual finances shared from field agents and the Indian Affairs Branch, IHS officials targeted "wealthy" communities who were deemed to be in a financial position to develop "the same sense of responsibility for medical and welfare care…as is held by necessity by other citizens.'"[18] In its early stages, records demonstrate that the IHS intended to focus its attentions on communities in Southern Ontario.[19]

Significantly, the IHS's commitment to a gradual withdrawal of federal health care services for First Nations peoples could occasionally result in bully-tactics. In July of 1962, officials of the IHS travelled to the Tyendinaga Reserve to answer any questions the community had about the proposed Physician Services Incorporated (PSI) health insurance coverage. The community's medical officer, Dr. Boyce, was approaching compulsory retirement age and the occasion seemed

[16]Moore had initially approached Treasury Board to seek a "general authority" but Treasury worried that it "might have the effect of increasing the workload of the Indian Affairs Branch, Citizenship and Immigration, and that "the Board was reluctant to grant the general authority requested by your minister." Instead, they offered approval for Medical Services to work with a few communities to see how the policy worked in practice. Letter on behalf of Treasury Board Secretary to Dr. G.D.W. Cameron, Deputy Minister, DNHW, (21 December 1959), RG 29 Vol 3001 File 851-9-15, Medical Services Insurance Plan General, LAC.

[17] Letter from G.D.W. Cameron, Deputy Minister DNHW to C.G.E. Steele, Secretary Treasury Board, Department of Finance, (30 November 1962), RG 29 Vol 3001 File 851-9-15, Medical Services Insurance Plan General, LAC.

[18] Letter from P.E. Moore to Director of Indian Affairs Branch, (8 June 1955), RG 29 Vol 2884 File 851-1-23 Pt. 1, Medical Self Help, LAC. The Plan proposed that communities and individuals be expected to contribute three percent of their net income to health insurance in light of the fact that in calculating taxable income, "the taxpayer is allowed to deduct only that portion of his medical expenses…up to a certain maximum." The Self-Help Plan thus concluded that this amount was "not unreasonable sum for a family to spend on medical costs." If a family had no taxable income, the IHS would assess individuals financial responsible through an evaluation of "monies invested in certain specified luxury goods and in entertainment." Indian Health Services, "A Plan to Encourage Employed Indians to Subscribe to Voluntary Health Insurance Through Their Band Councils," (January 1956), RG 29 Vol 2884 File 851-1-23 Pt. 1 [B], Medical Self Help, LAC.

[19] To administer the "Medical Self Help Plan" IHS divided reserves in Southern Ontario into the following priority groups: (A) March 1956: Deseronto, Six Nations, Sarnia, Saugeen, Walpole (B) April 1956: Cape Croker, Muncey (C) July 1956: Kettle Point, Christian Island, Golden Laken, Rama, Rice & Mud Lakes, etc." Interdepartmental Correspondence from John S. Willis, Regional Superintendent (Eastern Region) to file, (27 January 1956), RG 29 Vol 2884 File 851-1-23 Pt. 1 [B], Medical Self Help, LAC.

a ripe opportunity for the IHS to encourage a shift in coverage. Chief Melville Hill chaired the meeting and was joined by members of the band council, IHS officials, and representatives from PSI. If the panel expected an easy sell, they were sorely disappointed. The proposal met with fierce and almost unanimous opposition. A band resolution was called for and only two community members present voted in favour of PSI coverage. Fifty-four were against. Instead of PSI, the audience asserted their desire that a successor for Dr. Boyce be found and suggested that at least one, if not more, local private physicians would be interested.

Clearly displeased with the decision, the Zone Superintendent R.A. Sprenger, reported the meeting to his superiors with apparent disdain. Sprenger wrote, "the audience of seventy-five were obviously not in a receptive mood to intelligently and courteously discuss the problem. Indeed, the problem was treated with unwarranted levity and Doctor Wiebe had several times to plead for attention amidst frequent interruptions."[20] In a later report to Percy Moore, another official added their suspicion that the two leading protestors were "obviously under the influence of alcohol."[21] Such a negative framing of those who resisted IHS programs was a rhetorical tool that IHS officials frequently employed, consciously or unconsciously. For example, when Eastern Region Regional Superintendent, J.H. Wiebe, reported on a visit to the Saugeen reserve to Moore, a dichotomous framework of judgement was clear. The Indian Affairs official at the reserve was described as "a vigorous Indian Superintendent with an incisive mind, quick to grasp possibilities and with a good deal of information on his own particular Indians." In contrast, the community leadership was given sparse and biting comment; "his present Chief of Council is unco-operative and

[20] Letter from Southern Ontario Zone Superintendent, R.A. Sprenger to Regional Superintendent Eastern Region, (12 July 1962), RG 29 Vol 3001 File 851-9-15, Medical Services Insurance Plan General, LAC.
[21] Letter from Regional Superintendent, Eastern Region to P.E. Moore, Director, Medical Services, (19 July 1962), RG 29 Vol 3001 File 851-9-15, Medical Services Insurance Plan General, LAC.

unintelligent."[22] First Nations' resistance to federal plans evoked neither understanding nor empathy.

Moore's response to the situation at Tyendinaga was swift. Less than two weeks later, he wrote to Colonel Jones of the Indian Affairs Branch to explain the situation at Tyendinaga. While Moore acknowledged that the community "understandably" did not wish to pay for "anything they can get for free," he stressed that such abnegation of responsibility could not be allowed to continue. Moore explained, "we think the time is now right for such places as Loretteville, Caughnawaga, Tyendinaga, Six Nations, Sault Ste. Marie and some of the oil-rich reserves in Alberta be made to meet some of their obligations."[23] For the eastern reserves, Moore proposed that IHS inform identified individuals known to be in a financial position to meet their own medical costs be issued a notice of cessation of IHS payment acceptability. Failing to embrace the IHS program, would be shown to have consequences. By November of that year, a combination of community interest in securing private health insurance and the pressure of the federal government produced a new sentiment in Tyendinaga. Deputy Minister G.D.W. Cameron wrote to the secretary of the Treasury Board to explain that attitudes towards the development of a cost sharing agreement for medical coverage was now "most encouraging" and Cameron felt confident that the conclusion of a mutually satisfactory agreement was on the horizon.[24]

[22] Report of Saugeen Reserve Visit by J.H. Wiebe, Regional Superintendent, Eastern Region, RG 29 Vol 2884 File 851-1-23 Pt. 1 [B], Medical Self Help, LAC.
[23] Letter from P.E. Moore, Director, Medical Services Branch, to Col. H.M. Jones, Director, Indian Affairs Branch (1 August 1962), RG 29 Vol 3001 File 851-9-15, Medical Services Insurance Plan General, LAC.
[24] Letter from G.D.W. Cameron, Deputy Minister of National Health to C.G.E. Steele, Secretary Treasury Board, Department of Finance, (30 November 1962), RG 29 Vol 3001 File 851-9-15, Medical Services Insurance Plan General, LAC.

On a more sinister note, in the appendix to the original Self-Help Plan in 1956, there was a section specifically devoted to "the recalcitrant who refuses to have anything to do with either [insurance] scheme."[25] Once again, it drew on dichotomized language of the reasonability of the plan and the presumed irrationality or dangerousness of those who refused. The section began with the assertion that "it is an accepted principle in the civilized world that the head of the family must provide his family with the necessities of life, including medical care."[26] It then went on to stress that if a head of a First Nations household did not endeavour to provide this care either through insurance plans or proof of indigency to IHS, then the "innocents", the children, would be presumed to be in danger. In response, the IHS would cooperate with the Children's Aid Society who, unlike the IHS, had the power to "use force where persuasion has failed." Like the residential school system, the IHS used the threat of and enforced removal of First Nations' children from their home and community as a tool to inculcate settler values and practices. Usefully for the IHS, it was highlighted in the plan that because the Children's Aid Society was in no way affiliated with IHS, "any antagonism built up by its actions against individuals is not necessarily directed to our Service."[27] With a sense of happy conclusion, the section ended, "this puts us in a unique and favourable position with regard to forcing un-cooperative Indians into participation in these

[25] A Plan to Encourage Employed Indians to Subscribe to Voluntary Health Insurance Through their Band Councils, (January 1956), RG 29 Vol 2884 File 851-1-23 Pt. 1 [B], Medical Self Help, LAC. The two schemes referred to were for either individual subscription or group-based band subscription.

[26] Well into the post-war period, government-sponsored reports continued to describe First Nations peoples as coming from a "primitive culture." Dr. G. Graham Cumming's Report to the First Meeting of the Advisory Committee on Epidemiology for the Dominion Council of Health in December 1962 is particularly reflective on this trend. In it he described the "primitive living" of Indians and Eskimos, which he pathologizes and judges as weaker than European culture. He also described their "minority group psychoses" and the reality of "clashing cultures." Moreover, despite widespread criticism of racial thinking, Cummings purported the Indian and the Eskimo to be "a different kind of man with quite specific genetic inheritance." In addition, he did not shy away from employing the homogenized concept of "Indian blood." See "Indian and Northern Health Services Report of Dr. G. Graham Cumming," Minutes of the First Meeting Advisory Committee on Epidemiology, (3-5 December 1962), RG 29 ATIP Accession 1991-92/028 Box 2, LAC.

[27] Perhaps wary to leave a paper trail, Percy Moore wrote to the Department's Solicitor to suggest that he discuss this matter verbally with other IHS officials. Letter from P.E. Moore to L. G. Archibald, Departmental Solicitor, Legal Division, (1 May 1956), RG 29 Vol 2866 File 851-1-1 Pt. 1 [B], Medical Services Operations. LAC.

Schemes." Despite the rhetoric of change, one can again reasonably question the degree to which integration had ever been a true break from assimilation. Certainly, IHS' support of Children's Aid Society's pattern of removing First Nations children from their families and communities did little to challenge what has infamously become known as the "Sixties Scoop."[28] Given the mechanics of settler colonialism, both assimilation and integration amount to the same goal of Indigenous annihilation.

Not only did the arrival of private insurance programs feed the federal government's ambition that First Nations' individuals and communities take on responsibility to "help themselves", but there were also financial benefits to the endeavour. Cameron had estimated in his letter to the Treasury Board that the total cost of providing coverage through private insurance to the Tyendinaga community would be $23,000, a sizeable increase from the approximately $19,500 the department had expended the previous fiscal year. Cameron suggested to the Board that should it approve the extension of private insurance that maximum departmental contribution could be capped at $19,000 per year.[29] With such an agreement, the federal government could challenge accusations of jurisdictional abandonment while continuing its overall objective to ever-decrease IHS expenditure. In 1957, however, the federal government passed the *Hospital Insurance and Diagnostic Services Act*. The Act caused a significant redirection of federal attention. With hospital insurance's arrival and a medical insurance plan potentially on the horizon, the early 1960s saw

[28] See Allyson Stevenson, *Intimate Integration: A History of the Sixties Scoop and the Colonization of Indigenous Kindship* (Toronto: University of Toronto Press, 2021); Joyce Timpson, "Four Decades of Child Welfare Services to Native Indians in Ontario: A Contemporary Attempt to Understand the "Sixties Scoop" in Historical, Socioeconomic, and Political Perspective." PhD. Diss. Wilfrid Laurier University, 1993.
[29] Letter from G.D.W. Cameron, Deputy Minister of National Health to C.G.E. Steele, Secretary Treasury Board, Department of Finance, (30 November 1962), RG 29 Vol 3001 File 851-9-15, Medical Services Insurance Plan General, LAC.

an intensification of federal efforts to negotiate a transfer of responsibility onto provincial governments.

By 1963, the federal government's ethos of integration had guided federal thought and action for nearly two decades. While bureaucrats and politicians would readily admit that much work remained to achieve the integration of First Nations peoples into Canadian society as citizens, many in government believed that they had at least teased out integration's most important features and concerns. These principles were perhaps most succinctly articulated by a committee appointed to study the administration of Indian Affairs as part of the preparations for a Federal-Provincial Conference scheduled for the fall of 1963. This group articulated a compendium of "desirable long-range objectives and policies applicable to the Indian people" along with basic principles.[30] The list echoed much of what earlier federal committees had stressed: Equality of opportunities and equitable provision of both services and programs according to what was offered to other communities; an increase in participation of First Nations peoples in the management of their own affairs with a concurrent development of First Nations leadership; finally, a matter of great concern to all involved, "agreement as to the appropriate and equitable financial arrangements" to achieve such goals.[31] Two of the principles that guided this work are worthy of reflection. First, the committee recognized that these objectives could not, and should not, be realized without consultation with First Nations peoples. Here, one can clearly see the influence of theories of community development but, crucially, also the impact of continued First Nations' advocacy for

[30] Federal-Provincial Conference on Indian Affairs 1964, Minutes of Proceedings, Appendix D "Opening Remarks and Speech made by Hon. R, Tremblay Minister of Citizenship and Immigration," Ottawa, (1964), RG 10 Vol 11580, LAC.
[31] Federal-Provincial Conference on Indian Affairs 1964, Minutes of Proceedings, Appendix D "Opening Remarks and Speech made by Hon. R, Tremblay Minister of Citizenship and Immigration," (1964), RG 10 Vol 11580, LAC.

their voices and resistance to unilateral decision-making both explored in earlier chapters. Second, the committee confirmed a long-standing belief that as First Nations peoples in Canada gained access to services, programs, and opportunities in a manner equal to Canadians, their "special supports and protections historically provided to [them] should be progressively adjusted."[32] Settler anxiety to erode any form of special status for First Nations peoples was subtle but remained present. Twenty years of experience may have added clarity to federal integration policy, but never altered its fundamental ethos.

Taking advantage of what IAB Director, R.F. Battle, described as "the favourable climate that has developed in federal-provincial relations on Indian affairs since last fall," the 1963 findings formed the framework for further discussions the following year.[33] In October of 1964, the first Federal-Provincial Conference to focus solely on Indian Affairs began. It commenced with a mood that First Nations integration had come of age. Indeed, when the 1963 committee recognized that "the time had come to find the basis on which the widest possible range of Federal, Provincial, and Municipal services can be extended to Indians," Federal Minister of Citizenship and Immigration, Rene Tremblay, took this statement as the theme of the 1964 Conference. That his opening remarks began with an assertion that the federal-provincial gathering represented "both a historic and auspicious occasion in the annals of Indian affairs administration in Canada," no doubt added to a sense of momentousness.[34] Federal representatives hoped to achieve a "change in the concept and pattern of [First Nations] administration," namely a breakdown of the ideas and policies that had

[32] Federal-Provincial Conference on Indian Affairs 1964, Minutes of Proceedings, Appendix D "Opening Remarks and Speech made by Hon. R, Tremblay Minister of Citizenship and Immigration," (1964), RG 10 Vol 11580, LAC.
[33] Memorandum to Deputy Minister from R.F. Battle, Director, Indian Affairs Branch, (6 May 1964), RG 19 Vol 4763 File 5535-04/139 (65), Other Federal Provincial Conferences & Meetings—Indian Affairs Conference, LAC.
[34] Federal-Provincial Conference on Indian Affairs 1964, Minutes of Proceedings, Appendix D "Opening Remarks and Speech made by Hon. R, Tremblay Minister of Citizenship and Immigration," (1964), RG 10 Vol 11580, LAC.

siloed First Nations administration into the exclusive preserve of the Federal government. The federal line was clear: all levels of government had some obligation to First Nations peoples.[35]

The first major task for the federal government at the conference then was to demonstrate that no legal barrier existed to their policy of integration. In its package of material sent to each provincial delegate, the federal government readily acknowledged that two legal principles effectively prevented the transfer of jurisdiction over "Indians and Indian Affairs" from the Parliament of Canada to the Legislature of any province. These included Section 91 (24) of the *BNA Act* which gave legal authority for Canada to make laws in relation to Indians and lands reserved for Indians and established the legal inability of the federal parliament to grant provincial legislatures the right to make laws in relation to any subject not reserved for it in the Constitution, or vice versa. The federal government therefore stressed to the provinces that what it sought in relation to Indian administration was not a transfer of jurisdiction but, rather, a transfer of responsibility. In other words, through a set of Federal-Provincial agreements, Canada could employ a provincial agency to carry out its obligations and duties under the *Indian Act*.[36] Thus, the federal government claimed there was no inconsistency between Canadian law and the concept of First Nations as citizens of provinces for whom provincial governments had the same obligations as to its other citizens. Significantly, several of the federal government's arguments to the provinces centred on disproving the belief that First Nations individuals do not contribute financially to the provinces.[37]

[35] Federal-Provincial Conference on Indian Affairs 1964, Minutes of Proceedings, Appendix D "Opening Remarks and Speech made by Hon. R, Tremblay Minister of Citizenship and Immigration," (1964), RG 10 Vol 11580, LAC.
[36] Federal-Provincial Conference on Indian Affairs 1964, Minutes of Proceedings, Appendix J "Legal Jurisdiction over Indians and Indian Affairs," (1964), RG 10 Vol 11580, LAC.
[37] Federal material reminded the provinces that "Indians, although granted certain tax concessions by federal legislation, in other respects contribute to the general revenue of the Province on the same basis as other citizens." Moreover, they stressed, "that to deny any Provincial responsibility is to hold that the Indian is not a citizen of a Province—a position that is inconsistent in most Provinces with his right to vote in Provincial elections, and his

Analyzing this strategy offers a reminder that both federal and provincial governments were attuned to the continued othering of First Nations peoples as "a burden." The task ahead for the federal government was not an easy one.

When the historic conference began in October, the provinces demonstrated a clear awareness of the unique status of First Nations peoples in Canada. Ontario's Minister of Public Welfare, Louis P. Cecile, affirmed that "the Indian has been considered a person apart [and that] this situation has largely arisen because, through the lifetime of the nation, the Federal Government has maintained direct and almost total jurisdiction over the Indian population."[38] But change was in the air. Cecile continued that Ontario "looked forward with expectation to some new thinking in the treatment of the Indian which will be appropriate to the actual situation now, and which will, in the future, encourage the Indian to participate in the progress and the benefits enjoyed by the population as a whole."[39] Indeed, Cecile promised Ontario's fullest cooperation in this endeavour. Quebec and British Columbia adopted a similar tone to Ontario. Other provinces, however, were less enthusiastic, perhaps due to their smaller economic capacity or the high visibility of First Nations populations in the Prairie Provinces. Nova Scotia was pleased the federal government was not attempting to transfer jurisdiction and New Brunswick explained they were "happy to participate in the creation of a new environment" but remained non-committal on details. Manitoba expressed far more enthusiasm for joint federal-provincial efforts to facilitate employment opportunities and community development programs than a wide-ranging cooperative program. Saskatchewan

obligation to pay provincial licence fees, sales tax, and all indirect taxes." Federal-Provincial Conference on Indian Affairs 1964, Minutes of Proceedings," (1964), RG 10 Vol 11580, LAC.

[38] Remarks from Province of Ontario, Louis P. Cecile, at the Federal-Provincial conference on Indian Affairs, Federal-Provincial Conference on Indian Affairs 1964, Minutes of Proceedings, (1964), RG 10 Vol 11580, LAC.

[39] Remarks from Province of Ontario, Louis P. Cecile, at the Federal-Provincial conference on Indian Affairs, Federal-Provincial Conference on Indian Affairs 1964, Minutes of Proceedings, (1964), RG 10 Vol 11580, LAC.

proposed to being ready "as soon as possible to extend provincial services to treaty Indians," but equally stressed their belief that provinces should not be expected to contribute toward general assistance payments to First Nations individuals in either initial or transitional stages of integration. Alberta was perhaps the most adamant that the provinces should not interfere in the rights and separate status that First Nations peoples enjoyed because of their relationship with the federal government. Nevertheless, while Alberta desired to wait for a constitutional change in relationship, the province still expressed agreement with the principle that First Nations individuals should be encouraged to assume attendant responsibilities when provided with services.

With a consensus that an intensification of integration was, in a variety of forms, a welcome step forward, two main issues came to the fore. First, unlike policies of assimilation, the rhetoric of integration policy stressed that First Nations individuals should not be forced to become Canadian citizens but that they should be gradually trained to adopt core values and practices of Canadian society. Thus, a defining feature of this period of First Nations-Settler relations was the repeated refrain that individuals and communities must be consulted on program and policy development. To this point, the federal government stressed to the provinces that "the utmost care must be taken, at this critical juncture, to ensure that the Indians are not again presented with a fait accompli in the form of a blueprint for their future which they have had no part in developing and which they have been given no opportunity to influence."[40] Provincial representatives echoed these sentiments. But, as earlier chapters and other historians have highlighted, First Nations communities had many reasons to be wary of this kind of language.[41] Earlier efforts to

[40] Federal Preparatory Material for 1964 Federal-Provincial Meeting on Indian Affairs, (N.D.), RG 29 Vol 71, Miscellaneous Re. Indian Administration, LAC.
[41] For example, Karl Carisse described the following incident: "Despite having chosen the debates, [for 1953 discussions of the Indian Act], government officials became suspicious that these Native spokesmen were pressing

meaningfully consult with First Nations peoples had certainly led to some changes in Federal Indian policy but just as often First Nations resistance to Federal perspectives, especially around treaty rights, had been overlooked. Despite the rhetoric of consultation, it is telling that no representatives of First Nations communities or organizations were invited as delegates to this "historic and auspicious" conference.[42] Delegates agreed to the establishment of an Indian Advisory Committee, but the provinces and federal government continued to deny First Nations space on the ground floor of negotiations. Paternalism's powerful talons and settler-colonial investment in the status-quo refused to relinquish their hold.

The second major issue for discussion at the 1964 Conference was funding. In the preparatory material sent out to conference delegates, the federal governments asked the provinces to consider three financial arrangement proposals for First Nations services provision. The first suggested that the government could operate on a function-by-function provision of services through which agreements would be made in a piecemeal fashion. The second involved an overall payment to the provinces for the assumption of responsibility for all the basic functions of health, welfare, education, and municipal services. This option was the clear preference of the 1963 committee.[43]

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their own political views and represented neither regional Native viewpoints nor the opinions of Natives on reserves. Dissatisfied with the suggestion proposed by the Aboriginal leaders, in 1955, the federal government decided to hold a series of regional Native conferences across Canada presided over by the Minister and Deputy Minister of Citizenship and Immigration. Official agenda items were set in advance and questions relating to treaty matters, land claims, or special rights were avoided. The focus of discussion was the Branch's administration of the *Indian Act* and the improvement of social services to Natives. Karl Carisse, "Becoming Canadian: Federal-Indian Policy and the Integration of Natives, 1946-1969: The Case of Ontario" (MA Thesis, University of Ottawa, 2000), 64.

[42] Elliot Moses of the Six Nations attended the conference as part of Ontario's delegation. Moses attended in his role as Chairman of the Provincial Advisory Committee on Indian Affairs.

[43] The proposal specified that the grant money to the provinces would come from the current appropriations of Indian Affairs and Indian Health Services, fifty-five and twenty-five million dollars respectively, less the amount of money required by the Federal Government to meet on-going financial obligations. These were broadly defined as: treaty obligations; land administration and custody of Indian trust funds; and special services which are not now part of normal provincial agreements. Federal Preparatory Material for 1964 Federal-Provincial Meeting on Indian Affairs, (N.D.), RG 29 Vol 71, Miscellaneous Re. Indian Administration, LAC.

A function-by-function option, the committee felt, would require the continuing statistical segregation of the First Nations case load and "carried the disadvantage of federal and provincial officials both operating within the restricted confines of the Indian community." Such an arrangement, it was believed, would create "unavoidable conflicts, jurisdictional squabbles and the absence of any one authority with responsibility for the overall development of the community as an entity." Federal documents produced the following May, however, articulated a preference for the function-by-function approach noting that this method was easier and offered "the most promising possibility for federal, provincial, and Indian consensus."[44] Finally, the provinces were asked to reflect on the financial requirements for Indian bands and reserve communities to operate as municipalities within their respective provinces.[45] In response, several expressed a strong desire for the comprehensive approach that the 1963 Committee had suggested, but the majority ultimately conceded that the most practical option for the moment was to pursue an extension of services function-by-function and province by province.

It is likely that such a conclusion was motivated as much by economic concerns and mistrust of federal intentions as by considerations of practicability. Manitoba, for example, reminded the delegates that the First Nations populations were increasing "at a world record rate," which raised concerns about the increase in financial expenditure required. The establishment of a comprehensive program now would not be nearly as useful to negotiate appropriate levels of compensation over time as a more piecemeal approach. In addition, the provinces had clear reasons to be suspicious of federal intentions. Despite the federal government's repeated assertion that it

[44] Memorandum to Deputy Minister from R.F. Battle, Director, Indian Affairs Branch, (6 May 1964), RG 19 Vol 4763 File 5535-04/139 (65), Other Federal Provincial Conferences & Meetings—Indian Affairs Conference, LAC.
[45] Federal Preparatory Material for 1964 Federal-Provincial Meeting on Indian Affairs, (N.D.), RG 29 Vol 71, Miscellaneous Re. Indian Administration, LAC.

was not attempting to transfer jurisdiction for First Nations peoples to the provinces, a close reading of their proposals suggests an attempt to do just that. Instead of framing the federal government's relationship with First Nations peoples as the product of treaty relationships or indeed even its own constitution, the federal proposal anchored its relationship to a temporary phenomenon. As the proposal articulated, "the aim and objective of Canadian policy is to narrow the economic and social gap separating Indians from the rest of the community. It is this gap which is the true measure of the special federal responsibility toward Indians."[46] Once such a gap was deemed no longer to exist, the only path to the successful extension of services would be to lay responsibility where it was deemed rightly to belong—within provincial jurisdiction, and on individual shoulders.

When the conference ended after two days of consultation and debate, Minister of Citizenship and Immigration, Rene Tremblay reminded delegates that it was never the intention of the federal government to reach "and complete financial agreements on any of the topics." Nearly two decades into integration policy, everyone was aware that the journey could be long. Nevertheless, important progress had been made. Provinces had clearly acknowledged an openness to a fuller integration of First Nations individuals as citizens of their provinces. Moreover, the very fact that the conference even existed demonstrated an unprecedented degree of attention to federal-provincial negotiations over Indian Affairs. But with resistance to a national plan or a comprehensive approach to service extension, the conference revealed the complexity of provincial integration. Among all provincial governments, one province seemed most willing to advance.

[46] Federal Preparatory Material for 1964 Federal-Provincial Meeting on Indian Affairs, (N.D.), RG 29 Vol 71, Miscellaneous Re. Indian Administration, LAC.

Ontario Takes the Lead: Services and a Summons to "Modernity"

In the aftermath of Ontario's 1953 Select Committee on Indian Affairs and its final report, discussed at length in chapter 3, the Ontario government had set about removing barriers to First Nations access to provincial services. In the space of approximately six years, there was a flurry of activity. In 1955, Ontario passed legislation that allowed First Nations residents on reserves to receive the same benefits under the Disabled Persons Act as non-First Nations residents. Ontario also extended Mothers' Allowances to women on reserves. The following year, a Child Welfare Agreement was signed with the federal government which extended Children's Aid Societies to reserves. As noted earlier, this move was a welcome step to the IHS.[47] In addition, First Nations peoples were added to new health and welfare legislation in the 1950s, at last birthed after a decades-long gestation period. First appearing on the federal Liberal's platform in 1919, the federal government passed the *Hospital Insurance and Diagnostic Services Act 1957* that permitted provinces to enter into a cost-sharing agreement with the federal government to provide universal hospital coverage for provincial residents. When Ontario enacted its program under the Act in 1958, it had secured guarantees from the federal government that if Ontario hospitals extended their services to on-reserve First Nations residents, they would receive federal reimbursements. Finally, in 1959, Ontario made amendments to its *General Welfare Assistance Act,* which paved the way for First Nations bands to be considered as municipalities for the purpose of administering the Act. While this move did not change a band's capacity to, for example, raise taxes to pay program costs, it nevertheless added to the structural toolkit settler governments were amassing to

[47] By 1957, nineteen Children's Aid Societies in Ontario had agreed to extend their services to reserve communities.

facilitate the end of the reserve system.[48] In the first fiscal year of the Act's operation seventeen bands had signed on. By the mid 1960s, half of Ontario's bands administered social assistance in this manner.[49] Ontario was indeed leading the way on provincial integration.

Despite this obvious growth in the extension of provincial services to First Nations peoples both on and off reserve, official attitudes around concepts of burden and dependence still hindered federal plans for complete integration. Ontario operated within a liberal capitalist economy in which each citizen was expected to make contributions to the system through the generation of individual wealth, the ownership of property, and the payment of tax.[50] Any deviation from this model or any degree of perceived dependency was looked on with disrespect. The Ontario Minister of Public Welfare, L.P. Cecile underscored this belief when he pointed out to the provincial legislature in 1960 that First Nations' "present dependence on the federal government leaves much to be desired."[51] Using the framework of Critical Race Theory, it becomes clear that the problem of this dependence was not so much the federal handling of it, but that First Nations themselves were viewed as a dependent people for whom the provincial government did not want responsibility. In an earlier comment to the provincial legislature, Cecile explained to his

[48] Reserves were to gradually lose their geographic and systemic isolation and become, not isolated jurisdictional enclaves of the federal government but regular tax-gathering municipalities of the provinces.
[49] Carisse, "Becoming Canadian," 72.
[50] In his "Prospectus for Canadian History," Ian McKay argues that Canada should be considered as an on-going project to enforce a liberal order in which equality before the law, the primacy of the individual and the sanctity of private property are embedded principles. Ian McKay, "The Liberal Order Framework: A Prospectus for a Reconnaissance of Canadian History," *The Canadian Historical Review* 8, no. 4 (2000) 616-645; See also, E.A. Heaman, *Tax, Order and Good Government: A New Political history of Canada, 1867-1917* (Montreal-Kingston: McGill-Queen's Press, 2017); Brian Gettler, "Take and Take: The Citizen-Taxpayer and the Rise of Democratic Colonialism in Canada," *Journal of the Canadian Historical Association,* Vol 31:1 (2021): 97-107; Hugh Shewell, *'Enough to Keep Them Alive': Indian Welfare in Canada, 1873-1965* (Toronto: University of Toronto Press, 2004), 236. For a focused examination of concepts of modernity, colonialism, and gender, see Mary Jane Logan McCallum, *Indigenous Women, Work, and History, 1940-1980* (Winnipeg: University of Manitoba Press, 2014), 143.
[51] Ontario, Legislative Assembly, Hansard, 25 March 1960 (Hon. L.P. Cecile, Minister of Public Welfare, PC): 1789. https://archive.org/details/v2indhansard1960ontauoft.

colleagues that "Ontario Indians are a gentle people, notably passive and, in some cases, even apathetic to conditions which surround them."[52] Later, he, along with his colleagues would regret the "lack of skills" First Nations displayed in "coping with modern-day living."[53] Without more signs of progress towards acceptance of and success in the settler economic system, which included the privatization of reserve land for the purpose of property tax collection, the Ontario government continued to hold fast to the belief that they held no legal financial responsibility for status First Nations individuals.[54] Services would be extended but the separation of status First Nations peoples remained a priority to ensure the federal government added to Ontario's provincial fund.[55]

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[52] Ontario, Legislative Assembly, Hansard, 25 March 1960 (Hon. L.P. Cecile, Minister of Public Welfare, PC): 1790. https://archive.org/details/v2indhansard1960ontauoft. Significantly, stereotypes of First Nations' passivity co-existed alongside stereotypes of First Nations' violence. Three days earlier, Harry Nixon made the following comment: "Now I have another little problem in my riding, and I know that I can appeal to the hon. Prime Minister in this. He said the other night that we were both big chiefs of the Mohawk tribe and that I was still able to lift scalps on occasions, but I can assure hon. Members that after the passing of these years, my zest for lifting scalps has somewhat waned." Ontario, Legislative Assembly, Hansard, 22 March 1960 (Harry Nixon, Brant, Lib): 1620-1621. https://archive.org/details/v2indhansard1960ontauoft. Not only do Nixon and Frost draw on violent racialized imagery to make their point, but they are also employing what Tuck and Yang have highlighted as a "settler move to innocence" known as "Settler adoption fantasies." This move seeks to "become without becoming" where "Indianness" is preformed and claimed by settlers. Eve Tuck and K. Wayne Yang, "Decolonization is not a Metaphor," *Decolonization, Indigeneity, Education and Society* 1, no. 1 (2012): 15-16.

[53] Ontario, Legislative Assembly, Hansard, 26 March 1963 (Hon. L.P. Cecile, Minister of Public Welfare, PC): 2230. https://archive.org/details/v2hansard196364ontauoft. See also, Ontario, Legislative Assembly, Hansard, 29 March, 1960. (Mr. Albert Wren, Kenora, Lib.-Labour): 1920. https://archive.org/details/v2indhansard1960ontauoft; Mr. Robert Gibson (Kenora, Lib.-Labour), while not explicitly criticizing First Nations peoples lack of skill, went on at length to champion Manitoba's work in community development under social worker Jean Lagassé. Quoting from the Legasse report, Gibson highlighted a belief that "this population was now scattered in the most unproductive areas of the province, existing at best, in a condition of independence created by physical and cultural isolation, and at worst, idleness, hunger and disease…the people of Indian background could still recapture the spirit of initiative and courage which they displayed before the coming of the white man." Ontario, Legislative Assembly, Hansard, 6 May 1963. (Mr. Robert Gibson, Kenora, Lib. Labour): 2868. https://archive.org/details/v2hansard196364ontauoft/.

[54] When Mr. Nixon asked Cecile if he favoured the "assumption of the responsibility of Indians by the province, Cecile began his response with "That is a very difficult question…there are so many things involved—property rights and things like that." He later added with pride that "there have been 1,000 children that have been up for adoption and have been adopted." Ontario, Legislative Assembly, Hansard, 24 March 1964 (Mr. Robert Nixon, Brant, Lib. and Hon. L.P. Cecile, Minister of Public Welfare, PC): 1943-1944. https://archive.org/details/v2hansard196364ontauoft

[55] In the Diefenbaker years alone, approximately 20 cost-sharing programs between the Federal and Provincial Governments came into effect. The late 1950s and through the 1960s were thus a period of acrimonious debate between Ottawa and the Provinces over the breakdown of tax distribution. and funding arrangements. Not happy with federal plans, all the provinces pushed back against Ottawa for a greater share. Robert Bothwell, Ian Drummond and John English, *Canada Since 1945: Power, Politics, and Provincialism* (Toronto: University of Toronto Press, 1981), 236.

Problematically, this racialized framing obscured structural challenges that colonialism had imposed on First Nations communities and limited their economic success. Especially in northern Ontario, as Anishinaabe scholar Harvey McCue has argued, the conditions of reserve life were hardly conducive to economic success, citing the lack of vocational training and inadequate schooling as contributors to chronic unemployment. Furthermore, the *Indian Act* played a substantial role. As McCue explained, the *Indian Act* gave control of First Nations title on reserves to the federal government and therefore reserve land could not be counted as assets for bank loan securities. Thus, banks would not loan money for business start-ups to First Nations on reserves.[56] Bureaucratic barriers such as these represent but one area of difficulty. Historians have also demonstrated how settler industrial activities also poisoned the waters in northern Ontario that both limited commercial fishing and wild rice harvesting as sources of income, to say nothing of their harmful impacts on human health.[57] Such conditions account far more for the challenges of First Nations communities than their presumed "inability" to cope with modernity. Nevertheless, as Mary Jane Logan McCallum succinctly summarized, "'Self-help' was about contemporary ways of dealing with inept colonial systems."[58] Therefore both federal and provincial governments clung to its diverting rhetoric. In integration debates, First Nations were to be the subject of scrutiny, not settler-colonial systems.

[56] Harvey McCue, "The Modern Age, 1945-1980," in *Aboriginal Ontario: Historical Perspectives on the First Nations* ed. Edward S. Rogers and Donald B. Smith (Toronto: Dundurn Press, 1994), 379.
[57] Brittany Luby, *Dammed: The Politics of Loss and Survival in Anishinaabe Territory* (Winnipeg: University of Manitoba Press, 2020); Lianne Leddy, *Serpent River Resurgence: Confronting Uranium Mining at Elliot Lake* (Toronto: University of Toronto Press, 2022); Adam Mosa and Jacalyn Duffin, "The Interwoven History of Mercury Poisoning in Ontario and Japan," *CMAJ* 189, no.5 (2017) E213-E215; Brittany Luby, "From Milk-Medicine to Public (Re)Education Programs: An Examination of Anishinabek Mothers' Responses to Hydroelectric Flooding in The Treaty #3 District, 1900-1975," *Canadian Bulletin of Medical History* 32, no. 2 (Fall 2015): 363-389.
[58] McCallum, *Indigenous Women, Work, and History,* 165.

Such a stance was still very much in favour by Ontario's leadership just prior to the start of the Federal-Provincial Conference on Indian Affairs. Here, a return to L.P. Cecile's comments is revealing. In his descriptions of First Nations individuals and communities, there is little question that Cecile clearly perceived an "Indian problem," specifically in northern Ontario. There he regretted the limited exposure of "our civilization" to First Nations communities. The exclusive maintenance of Indigenous languages, Cecile argued, had caused "acute problems," First Nations' use of alcohol had "caused much concern," and the addition of First Nations children to education programs had placed "a very decided strain on local resources."[59] Here, Cecile effectively employed a long-standing tradition in which powerful actors frame "the other" as a problem and burden to maintain the status quo. This deficit framework is then used to justify the enforcement of settler perspectives.

Beyond ideological motivation, one can still wonder why, despite resistance, Ontario took the lead in extending provincial programs to First Nations peoples. One factor was likely the context of both domestic and international attention on human rights and betterment. In this milieu, the continued neglect of a suffering population from any level of government would have caused a certain degree of political embarrassment. And no one in the provincial legislature could claim ignorance of the suffering of First Nations. Take for example the circumstances that NDP Leader D.C. MacDonald (York South) described in 1962,

> the conditions under which these Indians live are indescribably deplorable. Those in this House from southern Ontario will not believe and cannot conceive of the conditions of squalor, disease and hunger in which these people live. Whole families are living in tar

[59] Ontario, Legislative Assembly, Hansard, 18 March 1964 (Hon. L.P. Cecile, Minister of Public Welfare, PC): 1758-1759. https://archive.org/details/v2hansard196364ontauoft

> paper shacks, sleeping on the ground under a common blanket, and eating food, when they eat, that would be rejected by any hon. Member, no matter how hungry.[60]

Such terrible conditions hardly reflected Canada's commitment to human rights as a signatory of the UN Declaration. A second factor, as scholar Karl Carisse has previously argued, is that the Ontario government embraced integration for the access to land and natural resources that the policy could afford.[61] While this desire for land no doubt excited other provincial leaders—land as a capitalist resource was and remains a prime interest of settler-colonial societies—priorities of Ontario's premier and government as well as financial capacities of Ontario's businesses translated into a unique vigour. [62]

The post-war field of mining is but one example. The late 1950s had witnessed a tremendous growth in Ontario's mining industry. Between 1946 and 1960 there was a fivefold increase in revenue.[63] First Nations reserves, as Crown Land, remained off-limits to Ontario. Should the reserve system be dismantled, however, access, it was presumed, would follow. Certainly, there was industrial interest in reserve land. The Minister of Economics and Development Robert Macaulay happily informed the legislature in 1963 that oil companies Texaco and Home Oil had

[60] Ontario, Legislative Assembly, Hansard, 29 March 1962 (Mr. Donald Cameron MacDonald, York South, Leader of NDP): 1633. https://archive.org/details/v1hansard196263ontauoft
[61] Carisse, "Becoming Canadian," 58.
[62] Randall White has written about Premier John Robarts and his government's interest in economic development. Randall described how Robarts "became known for a characteristic injunction to his civil servants, 'show me a resource, and I'll sell it." Randall White, *Ontario, 1610-1985: A Political and Economic History* (Toronto: Dundurn Press, 1985), 282. See also, Lianne Leddy, *Serpent River*; Tyler A. Shipley, *Canada in the World: Settler Capitalism and the Colonial Imagination* (Halifax: Fernwood Publishing, 2020); Luby, *Dammed*; Sarah Rotz, "'They took our beads, it was a fair trade, get over it': Settler colonial logics, racial hierarchies and material dominance in Canadian agriculture," *GeoForum* 82 (June 2017):158-169; Sarah Carter, *Imperial Plots: Women, Land, and the Spadework of British Colonialism on the Canadian Prairies* (Winnipeg: University of Manitoba Press, 2016); John Lutz, *Makúk: A New History of Aboriginal-White Relations* (Vancouver: University of British Columbia Press, 2009); Carisse, "Becoming Canadian," 2000.
[63] Ontario, Legislative Assembly, Hansard, 25 February 1963 (Hon. George Wardrope, Minister of Mines, PC): 1025. https://archive.org/details/v1hansard196364ontauoft

made successful bids on territory released by the Walpole Island First Nation.[64] Months later, the Minister of Mines, George Wardrope, prepared a memorandum of his department's activities in preparation for the 1964 Federal-Provincial Conference. He explained that in conjunction with the Department of Lands and Forests, his department was attempting to negotiate the boundaries around Big Trout Lake Indian Reserve No. 84, which had been provided for in the 1931 adhesion to Treaty 9. The Minister's particular interest in this negotiation stemmed from the fact that the reserve was "located in good mining country and prospecting cannot be allowed by the province until the boundaries of the reserve are definite."[65] Thus, Ontario had very significant economic reasons to embrace integration, even though, like the federal government, it chose to forefront the rhetoric of First Nations "best interests" and "equality" as its rationale for increased claims over First Nations' land.[66] Although these motivations were alive and well, there were nevertheless clear limits to Ontario's enthusiasm.

Three months to the day since the opening of the Federal-Provincial Conference, Leader of the Opposition A.E. Thompson, highlighted an attitude that would remain the crux of First Nations' health and welfare policy for the rest of the decade. "It seems to me," Thompson stated, "there is an awful lot of buck-passing with respect to responsibility."[67] In some ways, this phrasing

[64] Ontario, Legislative Assembly, Hansard, 27 March 1963 (Hon. Mr. Robert Macaulay, PC): 2277. https://archive.org/details/v1hansard196364ontauoft

[65] Activities of Department of the Government of Ontario that are related to the Indian people of the Provinces—Department of Mines, RG 19 Vol 4763 File 5535-04/139, Other Federal Provincial Conferences & Meetings—Indian Affairs Conference, LAC.

[66] Mary Jane Logan McCallum's study of the IHS Community Health Worker revealed, the IHS "saw itself as a long serving Canadian charity rather than a shared and reciprocal institution embedded in the history of land and resource appropriation." Ontario's stance operated in much the same way. In a drive of economic expansion, however, charity held far less sway for Ontario than did unqualified access to First Nations' lands through the dismantlement of reserves. Mary Jane Logan McCallum, *Indigenous Women, Work, and History, 1940-1980* (Winnipeg: University of Manitoba Press, 2014), 143.

[67] Ontario Legislative Assembly, Hansard, 28 January 1965, (Mr. Andrew Thompson, Dovercourt, Lib): 105. https://archive.org/details/v1hansard1965ontauoft/

misrepresents the stance of Ontario's leadership. Rather than "buck passing," Premier John Robarts and his ministers entrenched their stance that the financial responsibility for the provision of health and welfare services lay entirely with the federal government. They refused to ever "accept the buck." Despite repeated assertions that the matter of service extension to First Nations peoples on reserve was a very complex matter, Robarts was able to succinctly sum up the impasse: "when they [the federal government] accept their financial responsibility, we will accept our responsibility, and we will develop programmes that will bring these people in."[68]

Nevertheless, Ontario continued to develop structural means and investments to facilitate closer ties between the provincial government and First Nations peoples. In 1955, the Department of Public Welfare, without question the department most deeply entrenched in First Nations service extension, had established an "Indian Advisory Committee." Then following the 1964 federal-provincial meeting, a federal-provincial co-ordinating committee on Indians was established with eight members, four from Ontario and four from Ottawa. Significantly, membership was reserved for senior civil servants, as was the case with Ontario's Cabinet Co-ordinating Committee and its

[68] Ontario, Legislative Assembly, Hansard, 16 March 1965 (Hon. Mr. John Robarts, Premier, PC): 1345. https://archive.org/details/v1hansard1965ontauoft/ In fact, political desires to protect Ontario's treasuries had not completely stalled any spending on development and well-being efforts for First Nations communities. In the Department of Health, for example, seven public health inspection officer positions had been established to serve 81 communities in northern Ontario with predominately First Nations residents. In addition, the Department of Public Welfare by mid 1965 had already expended $2.5 million. Cecile did not specify whether this was for on or off reserves First Nations' individuals. Ontario, Legislative Assembly, Hansard, 17 June 1965 (Hon. L.P. Cecile, Minister of Public Welfare, PC): 4348. https://archive.org/details/v3hansard1978ontauoft/ Nevertheless, Ontario orchestrated agreements so that their financial contribution was minimal. In the case of the General Welfare Agreement for example, "The Act specified that band councils coming under the Act would appoint their own welfare administrator, pay the costs of administration, as well as twenty per cent of the cost of all social assistance payments rendered. Ontario would fund eight per cent of the payments but in return was reimbursed by the federal government for fifty per cent of the total costs of allowances granted." In addition, under the Indian Welfare Services Agreement, Ontario would be reimbursed 100 per cent of the additional cost of serving above average expenditure. See, Carisse, "Becoming Canadian," 73, 106.

interdepartmental Committee.[69] The Cabinet Coordinating committee had been established in January of 1965 to develop a coordinated program for First Nations community development, education, employment, housing, and retraining.[70] Even though Minister of Health Matthew Dymond was a member of the committee, it is telling that in the press release that announced the Committee, no mention of health was made. Instead, its focus was on areas believed to most efficiently help First Nations to "adapt" to modern life in Ontario.

It is worthwhile to highlight that an obligation to assist the federal government honour treaty rights was never a key motivator of provincial efforts. Like the federal government, the overriding impression among provincial politicians was that treaties with First Nations were a matter to be settled and ended. Far from a framework of on-going relationship, many in the provincial legislature found them to be detrimental to First Nations' well-being because it was believed that they maintained an image and practice of separation. Less than a year after the federal-provincial conference, Minister Cecile hoped that the Ontario government would be able to assist in the social

[69]Ontario, Legislative Assembly, Hansard, 23 June 1966 (Hon. L.P. Cecile, Minister of Public Welfare, PC): 5163. https://archive.org/details/v4hansard1966ontauoft/ Members of the Federal-Provincial co-ordinating committee; Provincial: S.N. Asbury, chairman of the committee and director of community development, C.H. Westcott, executive assistant to the Minister of Education, H.W. Suters, vice-chairman and managing director of Ontario housing corporation, C.H.V. Bayly, Deputy Minister of The Department of Lands and Forests. Federal: "J.G. McGilp, regional director for Ontario, IAB, T.L. Bonnah, regional superintendent of development for Ontario IAB, H.B. Rodine, regional school superintendent for Ontario IAB, Dr. R.B. Splane, director general, welfare assistance and services DNHW. Indian Advisory Committee: Chairman Mr. Elliot Moses of Ohsweken, Mr. Lorenzo Big Canoe, Georgina Isle band at Lake Simcoe, Chief Floral Tabodadung, Parry Isle Band at Parry Sound; Mr. Thomas Archibald, New Post Band at Moosonee; Mr. Ralph Bruyere, Couchiching band at Fort Frances, Mr. Fred Greene, Shoal Lake band at Kenora, Mr. Melville Hill, Tyendinaga band, Deseronto, Chief William Meawasige, Serpent River Band at Culter and Chief Wilmer Nadjiwan, Cape Croker at Wiarton. The staff engaged in Indian programmes on May 31, 1966: Non-Indian—S.N. Ashbury, director; Mrs. E. Whyte, secretary, Miss M. Wolfer, stenographer, A.E. Johanson, development officer, C. Willis, development officer; S. Levy anthropologist; Indian—C.R. Cromarty, development officer, F. Kewaquedom development officer; R. Montague, welfare officer, and M. Ciaus, sociology undergraduate.
[70] Press Release for the Cabinet Coordinating Committee on Indian Affairs, (1965), RG 1-439 Box 5 File A, AO. Original Members of the Cabinet Coordinating Committee included: Stanley J. Randall (Minister of Economics and Development), William C. Davis (Minister of Education), J. Wilfrid Spooner (Minister of Municipal Affairs), Louis P. Cecile (Minister of Public Welfare), Arthur A. Wishart (Minister of Justice), Matthew B. Dymond (Minister of Health), and Archibald. K. Roberts (Minister of Lands and Forests).

and economic betterment of First Nations peoples but regretted that "the artificial status concept of the treaty Indians resulting from a background of federal legal responsibility and control, has unfortunately set them apart from other citizens."[71] One is left to question the sincerity of this regret due, as explained earlier, to its usefulness to "protect" provincial funds.[72] The following year, former lawyer and now MPP Mr. G. Ben of Bracondale presented treaties in an even darker frame. Ben began, "I firmly believe that we speak of treaty rights because we much prefer to preserve the inequalities rather than the benefits." Receiving no push back on his arguments, he continued, "If this country thought anything of the aborigines…they would have wiped out these reservations long ago. They would have said those treaties are just keeping them in subjugation and we are not going to perpetuate the inequities in these treaties, we are going to start on a forced programme of education of all the Indians in this country."[73] These perspectives reflect the hegemony with which settler viewpoints reigned in settler legislatures. In the face of significant First Nations' push back against the belief that treaties were problematic structures of separation, and that they, instead, formed a foundation of relationship and mutual resource sharing, settler political leadership continued to assert that First Nations communities were owed nothing beyond the paternalistic attention of settler governments and a summons to "modernity."

By the middle of the 1960s, this call persisted in painfully racialized terms. The first report commissioned by the Cabinet Committee in April of 1965 revealed the ongoing appeal for settler authors to reify First Nations cultural views to a pre-modern existence and to present cultural

[71] Ontario, Legislative Assembly, Hansard, 17 June 1965 (Hon. Louis Cecile, Minister of Public Welfare, Prescott, PC): 4346. https://archive.org/details/v3hansard1978ontauoft/page/4346/mode/2up
[72] Moreover, when Ontario convened a "Confederation of Tomorrow Conference," in 1967 to discuss with provincial leaders a series of possible changes to the Canadian constitution regarding the place of French Canada and Federal-Provincial Relations, the matter of First Nations jurisdiction was never raised.
[73] Ontario, Legislative Assembly, Hansard, 23 June 1966 (Mr. G. Ben, Bracondale, Lib.): 5157. https://archive.org/details/v4hansard1966ontauoft/

practices in a deficit framework. It claimed First Nations, for example, were unable to understand modern concepts such as germ theory. In addition, the report asserted that First Nations perceived "lack of desire for material possessions over and above his immediate need and some luxuries may well hinder any programme of employment and economic development."[74] Moreover, in analysis of local government, it falsely claimed that communities had no form of civic administration. Therefore, it was wrongly suggested, "the people constitute little more than a mass target, mute and inert, toward which these limited plans are directed." Such "knowledge" was presented to the Cabinet with the desire to underscore the necessity of a sociological, as well as material, approach to community development. "The Indian" in Ontario was a person apart from the rest. Ontario's efforts thus needed to be two-fold. First, be ready to target racialized particularities if integration into Ontario's social and economic agendas was to be realized. Second, fashion education and welfare programs that would then be able to "indoctrinate the Indian in our way of life."[75] Ontario political and business leaders did not look for partners in nation-to-nation land sharing agreements but for average citizens and negotiators who operated within settler defined systems of ownership, access, and wealth distribution. While they may have argued that "a rising tide" of economic success "floated all boats," envisioning that success as exclusively conditional on acceptance of settler sovereignty and its economic systems, ultimately facilitated a program of settler colonial land theft. Without sufficient adoption of settler values and relinquishing special privileges such as income-tax exemption, Ontario would continue to separate status-Indians rather than seeing them as average residents of the province. Ottawa's program of integration thus remained as

[74] 1965 Report of the Cabinet Committee for Indians submitted by G.H. Bayly, (April 1965), RG 1-439 Box 5 File A, AO.
[75] 1965 Report of the Cabinet Committee for Indians submitted by G.H. Bayly, (April 1965), RG 1-439 Box 5 File A, AO.

contested as ever. Undeniably, this persistence of Ontario's Citizen* would remain whilst health insurance debates intensified at mid-decade.

Medicare and the Maintenance of Difference

When the provincial and federal ministers of health gathered in Ottawa during the fall of 1965, a national program of Medicare was certainly top of mind. The previous year, a Royal Commission on Health Services had published its report expressing unequivocal support for a national program of universal health insurance. Convinced that Canadians were now ready to accept national health insurance, and with a relatively stable period of economic growth on which to rest, Prime Minister Lester Pearson had put forward proposals that were to form the basis of the Federal Government's plan to make medical care financially available to all Canadians. Simply put, the federal government was willing to accept fiscal responsibility for one half of the per capita costs of a national Medicare program.[76] Introducing the *Medical Care Act* in April of 1966, Minister of Health and Welfare Alan MacEachen, proclaimed that he was "proud…to be the pilot of this new measure, which will extend benefits now available beyond the doors of the hospital, ensuring the availability of physicians' services."[77] The federal government had long denied First Nations peoples their treaty and Indigenous rights to health care, but health care access was soon to become a right of Canadian citizenship.

[76] Opening Statement of Minister of National Health and Welfare Judy LaMarsh, Federal-Provincial Conference of Ministers of Health, (23-24 September 1965), RG 29 Vol 2670 File 801-2-F2 Pt. 1, Federal-Provincial Ministers of Health, LAC.
[77] Allan MacEachen, Edited Hansard. 17th Parliament, 1st Session (July 12, 1966). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/2431267/.

As a bastion of private health insurance companies and known for its fierce opposition to federal intrusion of provincial jurisdiction, Ontario had already begun to develop its own health care insurance programs.[78] In 1966, the Ontario government created the *Ontario Medical Services Insurance Plan* (OMSIP) to provide insurance through government subsidies for those whose taxable income rested below $1,000.[79] As Malcolm Taylor documents, Ontario's plan created an environment in which those who were considered able to afford medical care insurance were directed to the private sector, whereas those deemed "poor risks" were provided with government assistance.[80] By the end of 1966, 92.5% of Ontario residents were covered under some form of health care insurance, 6,154,000 privately and 585,000 under OMSIP.[81] Heather MacDougall argues, however, that many Ontarians felt private plans, while providing some support in times of medical difficulty, could still land patients with significant (unaffordable) debt.[82] Thus, many residents and politicians pushed for a national, universal program. And Ottawa had delivered. As MacEachen explained in his introduction, "the federal government has for some years been examining ways and means of ensuring that the opportunity for good health which is now viewed in western democracies as a right possessed by all should be available to every citizen of our country…the government recognize[s] the fundamental principle that health is not a privilege tied to the state of one's bank account, but rather a basic right which should be open to all."[83] Canada's

[78] Malcolm Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System and Their Outcomes* (Montreal-Kingston: McGill-Queens Press, 1987). Carey Doberstein, *Distributed Democracy: Health Care Governance in Ontario* (Toronto: University of Toronto Press, 2020).
[79] Taylor, *Health Insurance and Canadian Public Policy*, 340-341, 368.
[80] Taylor, *Health Insurance and Canadian Public Policy*, 340-341.
[81] Taylor, *Health Insurance and Canadian Public Policy*, 341.
[82] Heather MacDougall, "Making Medicare: The History of Health Care in Canada, 1914-2007," Canadian Museum of History, Created March 31, 2010. https://www.historymuseum.ca/cmc/exhibitions/hist/medicare/medic00e.html
[83] Allan MacEachen, Edited Hansard. 17th Parliament, 1st Session (July 12, 1966). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/2431267/. Universalism was one feature of a provincial program that Ottawa required before dispensing federal money. The other requirements were public administration, portability. Heather MacDougall, "Making Medicare: The History of Health Care in Canada, 1914-2007," Canadian Museum of History, Created March 31, 2010. https://www.historymuseum.ca/cmc/exhibitions/hist/medicare/medic00e.html

national Medicare program came into effect on July 1st, 1968, and slightly more than a year later, Ontario signed on. Canada now had the legal apparatus to ensure health care services were available to every citizen of the country. But how did the rhetoric of universalism impact policies and plans for First Nations people?

Across the early decades of the post-war period IHS officials and politicians had created policies that actively sought to dismantle any form of special status for First Nations individuals and communities. The willingness to maintain an Indian Health Service was explained principally in humanitarian language in which a "deserving poor"—or in IHS language the "indigent Indian"—should be supported only until they are ready to join society as "productive" and "contributing" members. When Medicare was introduced, it did little to shift this fundamental ethos. Medicare's requirement of universalism allowed Ottawa to once again entrench its stance that provinces must immediately include non-status individuals—and those status Indians who had lived off-reserve for a period of more than 12-months—in its provincial programs to receive federal funding. Universalism also called provinces to extend health insurance programs to on-reserve residents, but Ottawa agreed to remain, for the time being, responsible for the payment of premiums or utilization fees. This willingness, however, extended only to those individuals the IHS deemed "indigent" or, occasionally, for on-reserve individuals for whom the IHS was the "payment of last resort." The IHS thus focused its attention on the enactment of programs that would "prepare" on-reserve First Nations individuals to accept entrance into provincial plans and access to provincial assistance on terms equal to other Canadians. Put another way, a combination of historical precedent, on-going paternalism, and a deficit framework perspective of on-reserve individuals,

committed Ottawa to an on-going role in First Nations health care access.[84] When Ottawa deemed on-reserve residents economically and ideologically "ready" to accept citizenship, an unadulterated universalism—the absence of a special status arrangement—would apply. Ottawa's Medicare plan and its policy of integration thus worked in tandem.

As with many of the federal government's cost-sharing initiatives, the federal government knew the importance of preparing themselves for a contentious debate with the provinces over the inclusion of First Nations individuals. In September of 1965, Medical Services Director, H.A. Procter drafted an appraisal of the effect Medicare would have on the activities of the Medical Services Branch.[85] In it, Procter agreed that some level of IHS service would have to continue for many years to come due to the unlikely reality that provincial governments would take over the vast range of services currently provided. These areas included transportation, non-insured physician services, and visits by physicians to remote locations where there were no resident health personnel. Nevertheless, Procter underscored a cardinal principle far more in line with integration than the maintenance of a separate service: Unless First Nations peoples failed to meet resident

[84] Such a deficit framing lasted long-after the passage of the *Medical Care Act.* Liberal MP Jean-Robert Gauthier's (Ottawa-Vanier) comment in the House of Commons points to this fact. In his explanation of First Nations health problems Gauthier explained, "isolation and the environment are not the only causes of the problems. Many of these problems are the result of cultural and social difference or of ignorance and indifference. In the past, we tried to provide appropriate help and treatment facilities for the native who had been left to their own devices for many years. Today, these needs have changed. The fight will be won in the areas of prevention, of health education, and chronic diseases, but victory will remain uncertain as long as our native fellow citizens live in houses without running water fit to drink, a proper sewage system and other services that most of us take for granted." Rather than contextualizing these structural problems, Gauthier returned to a focus on the misguided belief in First Nations difficulties "transitioning to "modernity." He went on, "Since hygiene is an integral part of our daily life, Mr. Speaker, we have a tendency to forget that many native people do not have the same advantages as we do. It can take several years to educate people and to convince them to change lifelong habits, but cultural and language barriers make this even more difficult. The policy of this government is to encourage Indians and Inuits [sic] to be actively concerned with their own health." Robert Gauthier, Edited Hansard. 30th Parliament, 1st Session (June 13, 1975). Retrieved from LiPaD: The Linked Parliamentary Data Project.
https://www.lipad.ca/full/permalink/2976908/

[85] Percy Moore retired from federal service in 1965.

requirements or they were entitled to benefits under other legislation, the federal government expected First Nations individuals to be covered under provincial Medicare plans.[86] Given the requirement of universality for federal Medicare funding, the essential stance that Medical Services adopted was equal terms and conditions for *all* provincial residents. For Procter, the question of who would pay the coverage premium was a separate matter to initial access. With this first line of argument prepared, Ottawa was ready for Ontario's push back.

Ottawa correctly predicted Ontario would resist responsibility for the payment of on-reserve First Nations health care. If Ontario joined a national medical care insurance program, provincial bureaucrats and political leadership staunchly expected the federal government to pay the premiums of any First Nations individual on reserve. This unwillingness to provide full coverage for on-reserve individuals represented a definite policy pattern in Ontario. As the following table, created for a conference of Federal-Provincial Health Ministers in early November 1968, highlights, Ontario had removed several barriers to service extension but stayed adamant that financial responsibility for many services remained with the federal government. In the words of John Yaremko, who had replaced L.P. Cecile as Minister of Family and Social Services in 1966, "Constitutional responsibility, of necessity, requires financial responsibility."[87]

[86] Letter from H.A. Procter, Director Medical Services to Director General, Health Services, Department of National Health and Welfare, (15 September 1956), RG 29 Vol 3001 File 851-9-15, Medical Services Insurance Plan General, LAC.

[87] Ontario, Legislative Assembly, Hansard, 28 May 1968 (Hon. John Yaremko, Minister of Social and Family Services, PC): 3465.In March of 1967, the Department of Public Welfare became known as the Department of Social and Family Services.

Table 7: List of Programs with Health Content Universally Available to Ontario Residents with Identified First Nations Exclusions and Medical Services Involvement

Program or Benefit	Detail	Exclusions	Medical Services Involvement
Hospital Insurance	Pre-payment by premiums	Indian T.B. and Mental Hospitalization not covered	Payment of premiums for those Indians meeting MS criteria. Some bands cost share with M.S.
Public Health (1) (2)	Enrolment in Regional County Health Unit Enrolment in a municipal or district health unit	None, but subject to acceptance of a band by the M.O.H. None, but subject to acceptance by municipality or district	Assistance towards the 25% per capita cost payable, if bands have insufficient funds. As above, but 50% of the capita cost is payable
OMSIP	Pre-Payment by premiums	Reserves Indians can only enroll at the full premium rate; the province extends no premium assistance as it does for non-Indians.	(1) M.S. cost share PSI premiums for 12 bands in Ontario (2) M.S. continues to pay medical costs for Indians meeting M.S. criteria
Child Welfare Act	Functions of the Children's Aid Society	None; Indians may become full wards entitled to all benefits including health, until 18 years of age	NIL
Various Social and Family Welfare Acts	Allowances such as Old Age Assistance, Blind Persons Allowance, Disabled Persons Allowance and so on	Reserve Indians do not receive free OMSIP certificates as do all other recipients. N.B., they do however receive free hospital insurance certificates	M.S. continues to pay for physicians' services. M.S. is relieved of premium payment
General Welfare Assistance Act	Where a band may act as a municipality administering its welfare and allied health payments	All medical benefits under the G.W.A. are excluded under the agreement reached between I.A.B. and the province	M.S. continues to pay for various services
Administration Unorganized Areas	Province to administer welfare in unorganized territories	Verbal acknowledgement that Ontario would make no distinction between Indian and non-Indians and will pay all the health costs	M.S. will be relived of payments

Adapted from Ontario Region, Medical Services, DNHW, Oct. 7, 1968, RG 29 Vol 2670 File 801-2-F2 Pt 1 F-P Ministers of Health Conference

In some ways such a caveat was unsurprising. Ottawa's rhetoric had positioned health care access as a right of Canadian citizenship and the post-war citizen ideal increasingly became the citizen-

tax payer ideal.[88] Medicare stipulated that all Canadians should have access to a program of health insurance, but the potency of citizenship rights and responsibility discourse in Canada added the other side of the coin. Universal access yes, but universal contribution too. Policy makers in Ontario therefore resisted a plan to support provincial health care access to individuals from whom they could not collect the full range of taxes. Thus, by late 1968, the nature of Ontario's health service extension to First Nations peoples did as much to maintain the separation of on-reserve First Nations peoples as it did to break it down. The status Indian remained Citizen*. Significantly, no First Nation individual or collective was a signatory to the agreements.

It is worthwhile to remember Ontario's political and bureaucratic leadership's commitment to separation had to overcome criticism from opposition parties in Ontario's legislature. The leaders of both the NDP and the Liberal Party drew on the recently published Hawthorn Report—a study commissioned by the federal government to study "the Indian in Canada"—to raise questions about the Conservative government's actions. In May of 1968, Liberal leader Robert Nixon reminded his colleagues that Hawthorn had demonstrated "a strong ethical and moral ground for more provincial spending and training of personnel."[89] Nevertheless, Nixon stressed that the

[88] Heather MacDougall highlights how the Royal Commission of Health Services, the Hall Commission, made this linkage very clear. In recognizing "the responsibility of the individual to observe good health practices and use available health service prudently" and "the responsibility of the individual to allocate a reasonable share of his income (by way of taxes pr premiums or both) for health purposes," MacDougall explains, the Hall Commission "neatly respond[ed] to critics who objected to government funding on the grounds that it would sap personal initiative and lead to over-servicing." Heather MacDougall, "Making Medicare: The History of Health Care in Canada, 1914-2007," Canadian Museum of History, Created March 31, 2010. https://www.historymuseum.ca/cmc/exhibitions/hist/medicare/medic00e.html Alan MacEachen also made this connection clear when he introduced the *Medical Care Act to the House of Commons,* "Universality is achieved without compulsion of any sort except the compulsion to pay provincial taxes, which we *all* must pay." [emphasis added] Allan MacEachen, Edited Hansard. 17th Parliament, 1st Session (July 12, 1966). Retrieved from LiPaD: The Linked Parliamentary Data Project. https://www.lipad.ca/full/permalink/2431267/. See also Shirley Tillotson, *Give and Take: The Citizen-Taxpayer and the Rise of Canadian Democracy* (Vancouver: University of British Columbia Press, 2017), 12.

[89] Ontario, Legislative Assembly, Hansard, 27 May 1968, (Mr. Robert Nixon, Brant, Lib): 3431. https://archive.org/details/v3hansard1968ontauoft/

federal government should maintain financial responsibility for on-reserve peoples.[90] By contrast, NDP Leader Donald MacDonald criticized Nixon for perpetuating a myth of exclusive federal responsibility.[91] In addition, MacDonald's use of the Hawthorn report also demonstrated material consequences of provincial and federal disinterest in investing in First Nations' well-being. According to the report, per capita spending on First Nations peoples was less than half the national average, the latter receiving $740 per capita investment, the former a mere $300. MacDonald appealed to his colleagues in the legislature: "let us cut out this shameful procrastination."[92]

In some respects, the federal government was willing to proceed slowly with health care integration. On the one hand, Procter himself had acknowledged in 1965 that the arrival of Medicare would certainly cut back the need for the IHS in more settled parts of the country, but admitted it would have little immediate consequence for its treatment services in more sparsely settled areas such as Moose Factory or Sioux Lookout where alternate services were either non-existent or inadequate to replace IHS work.[93] In addition, officials in both the IHS and Indian Affairs were well aware of First Nations' concerns over the transfer of service provision to the provinces. At an inter-department committee on comprehensive agreements with the provinces for

[90] Ontario, Legislative Assembly, Hansard, 28 May 1968, (Mr. Robert Nixon, Brant, Lib): 3470. https://archive.org/details/v3hansard1968ontauoft/

[91] Ontario, Legislative Assembly, Hansard, 27 May 1968, (Mr. Donald MacDonald, York South, NDP): 3441. https://archive.org/details/v3hansard1968ontauoft/

[92] Ontario, Legislative Assembly, Hansard, 26 November 1968. (Mr. Donald MacDonald, York South, NDP): 164. https://archive.org/details/v1hansard1969ontauoft/ Other members of the NDP joined MacDonald in his criticism of provincial inaction. Using a different strategy, Mr. I. Deans (Wentworth), drew the Legislature's attention to the appalling lack of health care facilities to the Osnaburg First Nation. Among the problems described was the frequent closure of facilities due to lack of staff which then required round trip travel of approximately 31 hours. Deans challenged the belief that there was no provincial money available to remedy such terrible conditions, reminding MPPs that the Indian Development Branch had left approximately $400,000 unspent in the last fiscal year. Ontario, Legislative Assembly, Hansard, 6 February 1969. (Mr. Ian Deans, Wentworth, NDP): 1068-1070. https://archive.org/details/v1hansard1969ontauoft/

[93] Letter from H.A. Procter, Director Medical Services, to Director General, Health Services, (15 September 1965), An appraisal of the effect of Medicare on the activities of Medical Services, RG 29 Vol 3001 File 851-9-15, Medical Services Insurance Plan General, LAC.

the extension of provincial services to first nations peoples, R.F. Battle, Assistant Deputy Minister of Indian Affairs, articulated the necessity "to proceed cautiously so that the Indians can see the benefits of Provincial services as there is a good deal of suspicion in the minds of Indians as to the acceptance of provincial services."[94] Sudden integration was clearly unrealistic.

Both the DIA and the IHS, however, maintained the desire to actualize a significantly scaled back role in First Nations matters as efficiently as possible. One strategy developed early in 1968, was the articulation of the "duplicate payment thesis." During discussions of federal responsibility for the payment of premiums and utilization fees for First Nations in hospital and medical insurance plans, the IHS argued that the provinces were already amply compensated for this extension without federal top up. This funding included the proposed granting of the Federal Government of 50% of the cost of medical care per capita, premium payment and utilization fees, sales taxes paid by First Nations peoples, the economic product of First Nations peoples, General Hospital Grants, and special payment toward hospital construction in communities with a substantial First Nations tributary population. Officials in Ottawa argued that if the federal government accepted the cost of premiums and utilization fees for First Nations, Ottawa would be paying twice.[95] Certainly, Ottawa hoped that provinces would accept the federal governments' arguments in advance of any further federal action. But given the centrality of integration to the long-term goals of the IHS, Ottawa did not wait.

[94] Minutes of an Inter-Departmental Committee on Comprehensive Agreements with the Provinces for the Extension of Provincial Services to Indians, (N.D), RG 29 Vol 2670 File 801-2F2, Federal Provincial Ministers of Health Conference, LAC.
[95] Duplication Payment Thesis, Appendix II Memorandum to Cabinet submitted by Allan MacEachen, Minister of National Health and Welfare, (3 May 1968), RG 29 Vol 3001 File 851-9-15, Medical Services Insurance Plan General, LAC.

In April of 1968, IHS released its new "Health Plan for Indians." The new health policy articulated a desire to, once again, break away from the paternalism that had characterised past First Nations' policy and instead develop a means to encourage First Nations' self-determination. The plan sought to "create a vacuum in the provision of medical and paramedical care to Indians in Canada," with the intent that, over time, First Nations' communities would act independently of IHS to arrange health services. In contravention of treaty responsibilities, the aim of the plan was "to place squarely upon the shoulders of the Indian recipients of health services the responsibility for arranging and paying for them."[96] Significantly, the new policy adopted old tricks. As in the 1950s, when the IHS sought to encourage First Nations individuals and communities to arrange for private health and hospital insurance, this new Health Plan also enunciated an action plan for "high priority" bands—those deemed economically ready—who resisted the policy. Bands who contested the plan would first be sent a document entitled "Advice to Indian Bands on the Future of Health Services." If this educational approach failed to convince, then Medical Services would cease to provide health care services or payment for services to any individual in the community that could not prove their indigency.[97] Unsurprisingly, as Maureen Lux documented, the Health Plan raised considerable alarm in First Nations communities.[98] After more than a century of resistance to the dismissal of treaty rights, it is unsurprising that many communities did not want

[96] A Health Plan for Indians of Canada, Medical Services Branch, Department of National Health and Welfare, RG 10-18-1-24, AO. While it is true the Department was willing to continue financial support for health services, the Plan articulated an outright preference for Band payment of such costs.
[97] A Health Plan for Indians of Canada, Medical Services Branch, Department of National Health and Welfare, RG 10-18-1-24, AO. Resistance to this plan was also not to be tolerated among IHS staff. When K.F. Butler, Ontario Regional Director for the IHS, contacted his staff to announce the plan, he wrote "Your Regional Director and his officers unequivocally support the purpose of the Plan and not only agree, but have requested that copies of the Plan be placed in your hands for study to permit you to extend appropriate advice to Band Councils which manifest any interest." Letter from K.F. Butler, Acting Regional Director, Ontario Region, Medical Services to all Ontario Superintendents of Indian Agencies in Ontario, (25 April 1968), RG 29 Vol 2955 File 815-3-15 Pt.1, Health Administration by Natives, LAC.
[98] Maureen Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s* (Toronto: University of Toronto Press, 2016), 155.

to become health administrators on settler-defined terms of access. While Lux has also argued that the Plan proved ultimately unenforceable, it nevertheless demonstrated again to First Nations communities that settler priorities and values were at the forefront of First Nations health care policy in Canada.[99]

For IHS officials, a number of conditions made Ontario an ideal target for this Plan. Many bands had arrangements with Physician Services Incorporated for prepaid medical insurance. Moreover, OMSIP was available to First Nations in Ontario under particular conditions.[100] Upon concurrent release with the national plan, IHS sent out its new "Health Plan for Indians of Ontario" to all IHS staff, Superintendents of Indian Agencies, Chiefs and Band Councils in Ontario. In essence, the plan sought to create further policy space in which First Nations communities on reserve could become responsible for obtaining group medical care insurance for their band/nation. The Plan envisaged that interested communities would be assisted to form their own Board of Health who would take over major aspects of health care planning and eligibility decision-making from the IHS.[101] The Board would also then liaise with whatever insurance carrier it chose on a full-payment basis. Department officials admitted, however, that many of these established Boards of Health

[99] Lux, *Separate Beds*, 155.
[100] As of December 1967, OMSIP policy was as follows: "Any Indian may apply for OMSIP…[and] obtain this coverage on any one of three bases: 1. As a pay-direct contract holder, paying full premium. 2) As a recipient of social assistance through the Provincial Department of Social and Family Services, which will reimburse this Division for medical accounts paid on his behalf. 3. As a premium-assisted contract holder provided he submits income tax returns and pays income tax if required. Depending on his level of taxable income, such Indian contract holders can be given premium assistance according to this Division's present scale of benefits." Letter from Dr. J.S.W. Aldis, Executive Director of OMSIP, included in A Health Plan for Indians of Ontario, Medical Services Branch, Department of National Health and Welfare, RG 10-18-1-24, AO.
[101] Administrative responsibilities included making decisions on a variety of health care access matters. On one level, Boards of Health would be expected to decide which residents would be given a card to carry which authorized health practitioners to treat at person at the expense of the Band Council. On another, the board would decide which applicants for care would be required to meet the cost of transportation, dental care, and the first $1 of every prescription received. Of course, what was considered "allowable expenditure" remained largely the purview of IHS authorities who maintained substantial control over band funding. "A Health Plan for Indians of Ontario, Medical Services Branch, Department of National Health and Welfare. RG 10-18-1-24, AO.

would be unable to afford such insurance and that financial support would have to come from the federal government.[102] For Ottawa, however, the cost was worth the investment to bolster structural supports to integration.

Significantly, the Plan maintained several well-worn IHS principles. First, IHS maintained that no law or treaty obliged federal involvement in matters of First Nations Health. Second, it called for the pooling of resources from the individual, the community, the provincial, and lastly the federal government, to ensure First Nation's access to health care. In fact, the plan even attempted to provide communities the rationale and the language with which to entice provincial support. Should individuals or communities find that they are denied services which are normally available to other residents of the province, the Plan suggested that Councils "should approach the province to find out why this is so."[103] Remind them, the Plan further articulated, that community members are subject to Provincial laws, First Nations have the right to vote and they pay many taxes levied by the province on all its citizens. If individuals on reserve upheld these responsibilities, should they too not have all the privileges of citizens? Ontario's own Select Committee on Indian Affairs in 1954 had acknowledged First Nations individuals to be provincial citizens. Now, Ottawa was calling their bluff.

The mood in Ontario was immediately hostile to this federal initiative. Minister of Health Matthew Dymond pointed out that the contents of the plan were misleading in respect to Ontario's

[102] A Health Plan for Indians of Ontario, Medical Services Branch, Department of National Health and Welfare. RG 10-18-1-24, AO.
[103] A Health Plan for Indians of Ontario, Medical Services Branch, Department of National Health and Welfare. RG 10-18-1-24, AO.

responsibility for on-reserve First Nations peoples.[104] Ontario did not have any responsibility to provide health care services to First Nations on-reserve. In fact, authors of the Medical Services Insurance Act of 1965 had explicitly prevented this responsibility. The Act stated: "Where a person is covered by a standard contract and received or is to be compensated for medical or surgical care or services under any enactment of this Legislature or *of any other jurisdiction***,** he is not entitled to benefit under such standard contract to the extent that he received or is to be compensated for such care or services under such enactment.[105] [emphasis added] Moreover, Dr. J.S.W. Aldis, Executive Director, Medical Services Insurance Division explained to Deputy Minister of Health Dr. K.C. Charron, that he saw no way of giving OMSIP coverage with premium assistance to anyone who does not file an income tax return.[106] Later in August, Charron gathered various government officials together to discuss the Health Plan further and confirmed Aldis' contention that each First Nations individual on reserve remained a resident distinct from 'normal' residents of Ontario. Despite, or perhaps because of his previous experience as a civil servant within the DNHW, Charron did not generate sympathy for the federal perspective. Officials concluded that OMSIP coverage could indeed be provided to any First Nations individual "living an Indian way of life" (code for on-reserve), so long as the Government of Canada accepted the responsibility for guaranteeing full-payment of the premium.[107] In other words, Ontario had no intention of letting the federal government slip away from its financial role.

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[104] Minutes of Meeting Re. Health Plan for Indians, (23 July 1968), A Health Plan for Indians of Ontario, Medical Services Branch, Department of National Health and Welfare. RG 10-18-1-24, AO.
[105] Review prepared by J. Gregory, Registrar, Health Insurance Registration Board an Dr. Groom, Director Family Benefits Branch for the Honourable M.B. Dymond, Minister of Health and Honourable John Yaremko, Minister of Social and Family Services, Re. A Health Plan for Indians of Ontario, RG 10-18-1-24, AO.
[106] Letter from J.S.W. Aldis, Executive Director, Medical Services Insurance Division, Department of Health, Ontario to K.C. Charron, Deputy Minister of Health, (30 April 1968), RG 10-6-0-1376, OMSIP for Indians, AO.
[107] Meeting re. Health Plan for Ontario Reserve Indians, attended by Dr. K.C. Charron, Deputy Minister of Health; Mr. S.W. Martin, Dr. J.S.W. Aldis, Executive Director, Medical Services Insurance Division, Department of Health, Ontario; J.R. Gregory, Registrar of Health Insurance Registration Board (HIRB); J.M. Delaney, Mr. R. Harnett,

The Federal government should have, and in fact always did, anticipate this continued opposition. After more than one hundred years of separation from provincial jurisdiction and an even longer history of racialized rhetoric that framed First Nations peoples as "primitive," "untrained," and "lazy" or "dying," First Nations peoples remained resisted members of the provincial community.[108] The government of Ontario was far more interested in how residents "legitimately" within their jurisdiction would contribute to or take away from the provincial funds.[109] This priority was especially true following Ottawa's announcement in October 1968 that it would implement a 2 per cent income tax sur-charge for the federal government's exclusive use to support Medicare costs.[110] When new NDP Leader Stephen Lewis, challenged Dymond on his continued affronts to a principle of equality when he demonstrated his willingness to separate on-reserve First Nations residents from the rest of the Ontario population for "the purpose of getting a few more dollars," Dymond's response made his priorities plain: "I will take the hon. Member's views under consideration. They are his views, but it hurts me, you know, not to collect all the money I can."[111]

Manager Registration Services, HIRB; Dr. G.D. Cormack, Director, Mental Hospitals Branch; Dr. E.W. Best, (8 August 1968), RG 10-6-0-1376, OMSIP for Indians, AO.

[108] Travis Hay, *Inventing the Thrifty Gene: The Science of Settler Colonialism* (Winnipeg: University of Manitoba Press, 2021); Mary Jane Logan McCallum and Adele Perry, *Structures of Indifference: An Indigenous Life and Death in a Canadian City* (Winnipeg: University of Manitoba Press, 2018); Daniel Francis, *The Imaginary Indian: The Image of the Indian in Canadian Culture,* 2nd Ed. (Vancouver: Arsenal Pulp Press, 2011); John Lutz, *Makúk: A New History of Aboriginal-White Relations* (Vancouver: University of British Columbia Press, 2009); Adele Perry, *On The Edge of Empire: Gender, Race and the Making of British Columbia, 1849-1871* (Toronto: University of Toronto Press, 2001); Mary-Ellen Kelm, "Diagnosing the Discursive Indian: Medicine, Gender, and the 'Dying Race," *Ethnohistory* 52, no. 2 (Spring 2005): 371-406; Maureen Lux, "Perfect Subjects: Race, Tuberculosis, and the Qu'Appelle BCG Vaccine Trial," *Canadian Bulletin of Medical History* 15, no. 2 (Fall 1998): 277-295; James Walker, "The Indian in Canadian Historical Writing," *Historical Papers*—Canadian *Historical Association* 6, no. 1 (1971): 21-51.

[109] By the 1969-70 fiscal year, Ontario would spend $350 million on its health programs. This level of expenditure made it the third largest budget item for the province. Within four years, it would become the most expensive. White, *Ontario,* 298.

[110] Richard Simeon, *Federal-Provincial Diplomacy: The Making of Recent Policy in Canada, 3rd Ed.* (Toronto: University of Toronto Press, 2006), 86.

[111] Ontario, Legislative Assembly, Hansard, 24 June 1969 (Hon. Matthew Dymond, Minister of Health, Ontario, PC): 6076. https://archive.org/details/v5hansard1969ontauoft/

Thus, while Ottawa had made universalism a necessary condition of federal financial contributions to any Medicare plan, it had not specified gratis coverage of First Nations peoples as a condition. Nor was it a condition of funding under the Hospital Services and Diagnostic Services Act ten years prior. The post-war period was one of intense federal-provincial negotiations and at times antagonisms over jurisdiction; Quebec's opting-out of the Canadian Pension Plan in 1964, had demonstrated Ottawa's vulnerabilities. It is possible that Ottawa feared the breakdown of health and welfare programs if it pushed the provinces too far on First Nations service extension and economic responsibility.

The federal government acquiesced. In May, officials from Health and Welfare, Legal, Treasury Board, Finance, and Indian Affairs agreed to go to Cabinet to seek approval for federal payment of on-reserve resident premium costs, with the proviso that such payment would only be for "indigent Indians." Committed as ever to integration, however, these officials also proposed that the dates 1970 and 1973 be set for a review of Hospital Insurance and Medical Care insurance acts, respectively, "as mileposts in the full retreat from full payment by the federal government on account of Indians."[112] Settler-colonialism and capitalism have and continue to frame indigeneity and indigency as temporary phenomena. In time, the federal government believed it could envision Integration's ultimate success. In November, Treasury Board granted its approval.

Following Ottawa's acknowledgement of the present impracticability of full First Nations integration into provincial health services, the federal government prepared for its next engagement. In November of 1968, Ministers of Health from across the country gathered in

[112] Discussion on draft of cabinet submission submitted by Allan J. MacEachern, Minister of National Health and Welfare, (May 1968), RG 29 Vol 3001 File 851-9-15, Medical Services Insurance Plan General, LAC.

Ottawa. Newly appointed Federal Minister of Health John Munro became a fierce defender of long-standing federal policy. In his opening remarks, he asserted that "the Indian cannot be allowed to become a bone of contention and pawn between these two levels…neither is legally obligated to provide for Indian health [but] both are morally obligated to do so." Munro stressed that the unrelenting separation of First Nations peoples from the rest of the population was inappropriate, and that denial of First Nations individuals' access to health care would be in contravention of provincial jurisdiction to provide health care to its residents. Evidently not willing to dance around the issue, he went on, "there is a misconception of provincial capitals in regard to the basis for federal assistance to Indians. They persistently refuse to accept the fact that federal assistance is intended to supplement rather than supplant provincial services."[113] Federal payment should only, in Ottawa's view, be the payment of last resort, for failure to do so would continue to erode an individual's right to access on equal terms. Nevertheless, reluctance from both the provinces and First Nations' leadership to accept Ottawa's arguments remained. The jurisdictional battles were far from over.

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While the aim of this study has been to scrutinize the rhetoric, rationale, and motivations of settler colonial actions, it has also endeavoured to stress that alternative narratives to systemic racism and settler colonialism always existed. First Nations resistance to these forces was a consistent reality in the period under study and the government of Ontario could no more escape it than could the

[113] Opening Statement of Minister of National Health and Welfare John Munro, Ministers of Health Conference, (4 November 1968), RG 29 Vol 2670 File 801-2-F2 Pt. 1, Federal-Provincial Conference Ministers of Health, LAC.

federal government. Thus, the close of this chapter is left mainly to First Nations assertions to reflect their marginalization in settler discourse and to highlight their persistent presence. While settler governments continually dismissed activism to achieve their own objectives, resistance remained.

Certainly, dismissals of meaningful partnerships with First Nations peoples are not difficult to find.[114] In 1966, for example, when a member of Ontario's interdepartmental co-ordinating committee on Indian Affairs raised the question of having First Nations peoples present when the committee discussed matters that affected them, there was little enthusiasm for the position. The minutes highlight that "there was general agreement that this would be a beautiful thing but that the Committee could not do this until it was clear on the nature of its role."[115] Despite calls for First Nations consultation, settler organizations continued to deny them roles as architects of any health care plan. This exclusion even extended to the field of data collection. When the Union of Ontario Indians approached Ontario with a request for $54,000 in funding to support a First Nations-led investigation into the concerns and living conditions of First Nations people in Ontario, the provincial government refused for months. Even with substantial sums unspent in the budget of the Indian Development Branch, repeated calls to do so from opposition MPPs in the

[114] Maureen Lux, in her history of Indian hospitals in Canada highlights repeated instances of First Nations resistance against federal efforts. For example, she described the anxiety among some First Nations communities that the arrival of national health grants and later hospital insurance would result in a removal of funding that Indian hospitals badly needed. Instead, as Lux writes, new definitions of national health enforced an equality of treatment that denied First Nations peoples as requiring or deserving a separate health care system. In addition, Lux is attentive to the fierce opposition that arose from the implementation of the Health Plan for Indians. The Indian Association of Alberta, for example, encouraged First Nations patients to show their treaty cards rather than Medicare cards to receive aid. Lux, *Separate Beds*, 130-131; 156-157.

[115] Minutes of the Interdepartmental Co-Ordinating Committee on Indian Affairs, (November 1966), Container B334469 [2], AO.

legislature, and the mass resignation of the Indian Development Branch, the province remained unmoved.[116] That is until later events in 1969 shifted the integration landscape.

Despite Federal and Provincial resistance to alternative perspectives on the nature of First Nations -Settler relationships and their attendant obligations, communities and organizations across Ontario never gave up. In March of 1969, the Union of Ontario Indians drafted a submission for the federal government during its consultation meetings on changes to the *Indian Act*. The Union once again expressed their frustrations with the federal government that insufficient time and financial resources had been allotted to them to adequately prepare their comments. Notwithstanding these hurdles, the Union had plenty to say, and their focus was clear. The brief argued, "it is not as important to talk about the *Indian Act* as it is to talk about treaties and aboriginal rights. Basically, the *Indian Act* grows out of the treaties and therefore the treaties are of greater priority."[117] Treaty discussions with the federal government, to date, however, had been directed by settler interests. The brief went on, "the treaties, as they presently stand, are little more than land swindles or legal frauds dressed up in the form of Indian Treaties." Again, the brief repeated, more discussion on treaty and Aboriginal rights was needed. To underscore that these beliefs were not the position of the Union alone, the brief quoted at length from a statement made and accepted by delegates of one of the main consultation meetings [unidentified] in Ontario. The position is worth quoting at length here as well:

> The meeting unanimously wishes to go on record that it will not agree to any revisions to the *Indian Act* until the Canadian government acknowledged the existence of and

[116] Just prior to the mass resignation of the Indian Development Branch, Chief Wilmer Nadjiwon from Cape Croker, President of the Union of Ontario Indians, and member of the Department of Social and Family Services Indian Advisory Committee, also resigned. He believed that the government's attitudes and policy were "inadequate, ineffective, and insincere." Ontario, Legislative Assembly, Hansard, 8 May 1969 (Mr. Donald Cameron, York South, NDP): 4155. https://archive.org/details/v3hansard1969ontauoft/

[117] Submission of the Union of Ontario Indians, Brief on Changes in the Indian Act, (March 1969), RG 19-6-1 No. 4. AO.

> inviolability of Indian treaties and treaty rights. It is therefore recommended that before any final decision is made or legislation passed by the Canadian Parliament respecting revisions to the *Indian Act*, that consultation be held in which treaties and treaties only be discussed.[118]

Here First Nations communities made the call once again to honour treaty rights as the foundation of responsibility debates in the Settler-First Nations relationships. It was neither a call to equal settler citizenship nor to settler imaginings of modernity. By the following June, it would become inescapably clear that, once again, the federal government would fail to heed this call to recognize foundation treaty rights.

On June 24, 1969, Prime Minister Pierre Elliot Trudeau and his Minister of Indian Affairs and Northern Development, Jean Chrétien released their now infamous White Paper on Indian Policy. Presented as a significant break from past treatment of First Nations peoples, the contents of the White Paper would have been unsurprising to anyone who had followed the settler political discourses of the last fifteen years. "To be an Indian," the statement's foreword began, "is to...be different…is to be someone apart…is to lack power…is to be without."[119] Drawing again on racialized stereotypes that sought to justify settler-colonial dominance and incursion, the policy statement went on to call for the elimination of the legal status of Indian, the resolution and termination of treaties, abolishment of the *Indian Act*, the dissolution of the Department of Indian Affairs within five years, and the transfer of responsibility for Indian Affairs from the federal government to the provinces. Here was to be the climax of settler-colonialism's integration policy. As Trudeau himself argued, "it is inconceivable that one section of a society should have a treaty

[118] Submission of the Union of Ontario Indians, Brief on Changes in the Indian Act, (March 1969), RG 19-6-1 No. 4. AO.
[119] Canada, "Statement of the Government of Canada on Indian Policy," Department of Indian Affairs and Northern Development, (1969), https://publications.gc.ca/site/eng/9.700112/publication.html

with another section of a society. The Indians should become Canadians as have all other Canadians."[120] Here, was the supreme invitation to White settler-colonial citizenship, framed as First Nations' only hope for future well-being.

The failure of government policy to speak to the interests and assertions of First Nations communities was made plain. Well-known policy responses like Harold Cardinal and the Indian Association of Alberta's "Red Paper," described the White Paper as a "thinly disguised programme of extermination through assimilation" and a "form of cultural genocide" captured the depth of rejection many Indigenous leaders felt.[121] Such a reaction called for a new environment of policy development in which First Nations would at last be again conceived of as collaborators. A little over a week later, the Board of Directors of the Union of Ontario Indians released the following statement to the Minister:

> The past policies were in no way conducive to our development and as a result the Indian people have suffered poverty and deprivation. This cannot be allowed to persist, and your Policy Statement holds no more hope for the future. Your government cannot legislate the Indian out of existence no more than you can legislate bigotry and racism out of the non-Indian population….MOVED by Mr. Art Solomon and seconded by Mr. Aylmer Plain that: WHEREAS the Union of Ontario Indians called an emergency meeting of July 3, 1969, unanimously rejecting the White Paper policy statement as submitted in the House of Commons, June 25, 1969, and WHEREAS the Board Members feel that the top priority, which is Treaties and Aboriginal Rights and the Study thereof, has not been implemented as yet, that the government make haste in seeing that this study be implemented immediately.[122]

Yet again, a call for the recognition of Indigenous and treaty rights had been rung.

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[120] Mark Cronlund Anderson and Carmen L. Robertson, *Seeing Red; A History of Natives in Canadian Newspapers* (Winnipeg: University of Manitoba Press, 2011), 157.
[121] Harold Cardinal cited in Thomas Courchene*, Indigenous Nations Canadian Citizens: From First Contact to Canada 150 and Beyond* (Kingston and Montreal: McGill-Queen's University Press, 2018), 67.
[122] Resolution of the Union of Ontario Indians in Response to the Federal Government's White Paper on Indian Policy, (3 July 1969) RG 16-1 Container B359783, Correspondence of the Minister of Agriculture and Food—Cabinet Committee on Indians, AO.

The breadth and depth of First Nations' resistance to the White Paper led the federal government to officially retract it in 1971. Ultimately, however, settler priorities and policies remained much the same as they had from the start of the post-war period. For example, in 1972 two members of Ontario's Minister of Social and Family Service's Advisory Committee wrote scathing letters that criticized what they viewed as the fundamentally problematic operations of the Committee. Andrew Rickard (Executive Director of the Union of Ontario Indians) and Mr. William Sault (Vice President of the Union of Ontario Indians) both expressed profound frustration with what they saw as the unilateral appointment of committee members, answerable only to the government and not to the people they were meant to represent. Moreover, using Rickards's words, both individuals refused to "participate in any committee that the Government is using to rubber-stamp decisions made in total isolation. Nor [be] involved in a committee which the Government is attempting to use to approve of its own political election gimmicks."[123] Six years later, the National Indian Brotherhood released its brief *Indian Control for Indian Health*. Clearly dissatisfaction with settler policy and health care provision remained.

In September of 1978, Ottawa attempted once again to retract federal funding and responsibility for a separate First Nations health care service. Specifically, Ottawa sought to end the Non-Insured Health Benefits Programs for individuals who were either employed or who lived off the reserve.[124] When fierce First Nations opposition again arose to this time-tested settler move,

[123] August 17, 1971 (ON Archives, RG 1-439 Box 5, file A. Meeting of the Minister's Indian Advisory Committee) Letters from Andrew Rickard and William Sault discussed to Minister of Family and Social Services, Government of Ontario, August 17,1971. RG 1-439 Box 5 File A (Meeting of the Minister's Indian Advisory Committee). *Archives of Ontario,* Toronto, Ontario.

[124] Mary Jane Logan McCallum and Maureen Lux explain the NIHB program in greater detail. In sum, the program was implemented in order to cover costs historically paid from IHS accounts that were not covered under provincial medicare programs. These included "list of prescription drugs, medical supplies and equipment, vision care and

Ottawa promised change. The resulting 1979 new Indian Health Policy reversed the previous funding decision and extended coverage to all status Indians. In addition, in the opening paragraphs of the three-page policy, Ottawa acknowledged that "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."[125] Once again, however, the details of the plan reflected settler-colonial priorities. The policy states that treaties inform First Nations health policy, but it falls short of acknowledging health care extension as a right or to provide mechanisms for accountability.[126] Moreover, the policy articulated its desire to "promote the ability of Indian communities to pursue their aspirations" but "*within the framework of Canadian institutions*."[127] Was the rhetoric of change being used yet again to mask the maintenance of settler-colonialism's status quo?

dental services, medical transportation, and mental health services." Mary Jane Logan McCallum and Maureen Lux, "Medicare versus Medicine Chest: Court Challenges and Treaty Rights to Health Care," in *Medicare's Histories: Origins, Omissions, and Opportunities in Canada,* ed. Esyllt W. Jones, James Hanley, and Delia Gavrus (Winnipeg: University of Manitoba Press, 2022): 118.

[125] Canada. Department of National Health and Welfare. *Indian Health Policy.* [Ottawa, Ontario]: 1979. https://publications.gc.ca/collections/collection_2018/sc-hc/H14-296-1979.pdf

[126] For example, the NIHB are presented as "indications of good faith." The limitations of the NIHB program and the 1979 Indian Health policy has been the focus of much recent scholarship. See, McCallum and Lux, "Medicare versus Medicine Chest." Angela Mashford-Pringle and Denise Webb, "Appraising Canada's 1979 Indian Health Policy: Informing Co-Development of Distinction's-Based Indigenous Health Legislation," *Canadian Public Administration* 66, no. 1 (March 2023): 62-77; Josée G. Lavoie, "Policy Silence: Why Canada Needs a National First Nations, Inuit and Metis Health Policy," *International Journal of Circumpolar Health* 72 (2013), 10.3402/ijch.v72i0.22690.

[127] [emphasis added] Canada. Department of National Health and Welfare. *Indian Health Policy.* [Ottawa, Ontario]: 1979. https://publications.gc.ca/collections/collection_2018/sc-hc/H14-296-1979.pdf

Conclusion

> It is the avowed intention of every agency of government to foster a sense of self-sufficiency and independence in these people—to advance them to the stage where they can if they wish assume the full privileges and full responsibilities of citizenship.[1]
>
> DNHW Annual Report, 1957

> The barriers—constitutional, legal, social, and economic—are to come tumbling down. The days of tutelage are to end. The Indians are to join the contemporary Canadian scene as equals and partners.[2]
>
> *Ottawa Citizen, 1969*

> You have to be careful with the stories you tell. And you have to watch out for the stories that you are told.[3]
>
> Thomas King

This study has offered an in-depth critical analysis of the values, assumptions, and objectives that informed Ottawa's integration policy and documented their impact on First Nations' health care access in the post-war period. Broadly speaking, several important conclusions can be gleaned from this analysis. First, integration policy successfully shifted political discourse and policy in Ottawa. Rather than a program of segregation, integration policy called for the dismantlement of any special privileges and protections afforded to First Nations individuals and communities. These included reserve lands, tax exemptions, the denial of public alcohol consumption, and a dedicated health care service. Second, the post-war rhetoric regarding new solutions to the "Indian problem" in Canada did not fundamentally alter the long-standing settler intent to erode First Nations' sovereignty and to impede First Nations self -determination. Rather, it involved a critique

[1] Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1957,* Ottawa: Queen's Printer, 1948. Accessed, *Internet Archive*, September 2021.
[2] "Rights for Indians," *The Ottawa Citizen,* June 26, 1969, 6.
[3] Thomas King, *The Truth About Stories: A Native Narrative* (Toronto: House of Anansi Press, 2003), 10.

of previous attempts to achieve it. Moreover, integration policy continued to employ racialization to justify such efforts.

The title of my study "By their own efforts" reflects this dual experience of change and continuity. In the first half of the 20th century, First Nations' bodies were portrayed as inherently weak and their cultures pathologized as unhealthy so that it was broadly believed within settler society that First Nations remained ill, in large part, "by their own efforts." Thought also as dangerous vectors of disease to surrounding communities, settlers called for First Nations to be isolated on reserves for the protection of all. By the middle of the century however, the pathologization of First Nations' bodies had changed. Still deemed incapable of ensuring the well-being of themselves and others, First Nations' individuals and communities were now offered a new solution: improve well-being "by their own efforts" through a rejection of pre-existing claims of sovereignty and with full acceptance of the contract of White-settler citizenship. First Nations were being offered access to a program that sought to improve their access to health care as individuals but on the condition that they deny treaty or Indigenous rights to health care. Thus, while medicare's universalism was touted as an arguably laudable requirement to ensure poverty was not a barrier to Canadians' health care access, its usage in a context of a settler-colonialism state also served more nefarious priorities. Despite the change in rhetoric, in both contexts structural discrimination continued to be framed as First Nation cultural deficit and Indigenous erasure presented to be in individuals' best interests. As chapter one demonstrated, such beliefs constituted the "organizing principles" of First Nations' entitlement to settler systems of post-war health care.

Third, this study has revealed who truly benefited most from the ways in which integration policies were conceived and implemented. Despite the rhetoric that framed integration policy as both in First Nations' "best interests" and as a repudiation of past practices, the priorities and assumptions at integration's core were profoundly reflective of settler actors in the period of segregated assimilation. Like their predecessors, political and bureaucratic leaders continued to claim sovereignty over the land and employed racialized stereotypes to justify their actions. The move from second-class to full citizens left little space in settler discourse for a rejection of settler citizenship. Despite First Nations' repeated assertion that access to health care services as First Nations rests on a foundation of Indigenous sovereignty, both federal and provincial governments relied instead on a framework of racialization and Indigenous erasure. Racialized wards were to be paid for by Ottawa until they could be trained to accept the behaviours, values, rights, and responsibilities of White settler citizenship at which time they would become full citizens and thus fall under provincial purview, without special rights. Thus, as was explored in chapter four, the discourses and policies of integration remained an outgrowth of an old settler-colonial logic that failed to inaugurate a period of renewed partnership and collaboration between settlers and First Nations peoples. Instead, integration was a reimagined method to maintain the settler status quo.

As a result, both Indigenous and treaty rights to health care were repeatedly denied while settler leadership maintained that First Nations individuals "deserved" only equal treatment with their fellow Canadian citizens. The IHS unflinchingly argued that the Canadian government had no legal obligation to provide health services to First Nations peoples who were status Indians. Moreover, settler leadership also continued to embrace the racialized discourse that framed First Nations peoples to need "development" in order to focus the centre of change on their mindsets

and behaviours and away from the values and structures of Canadian settler society. Instead, IHS discourse presented the success or failure of First Nations peoples as a product of individual and community effort.

Employing these tools of settler-colonialism—the denial of Indigenous rights and the racialization of an entire peoples as dependent—Percy Moore and his team negotiated the major priorities and anxieties of the IHS: to control disease and to limit spending. Consequently, as discussed in chapters two and four, department leadership pursued a program of limited funding and gradual withdrawal of services that resulted in a health care service that was coercive, underfunded, and culturally unsafe. Such a perspective was perhaps best articulated through long-standing Deputy Minister of Health, G.D.W. Cameron, who had been with the DNHW since 1939. In 1963, Cameron wrote to MP Larry T. Pennell to clarify First Nations health economic policy:

> It has always been assumed that as the degree of isolation diminished and as the economic circumstances of the Indian people improved, they would take more interest and responsibility in providing their own necessary medical and hospital care. In the province of Ontario, Indians are expected to pay their own hospital insurance premiums if able to do so and to participate in any form of prepaid medical care plan available to other employees at their place of work. Those who have left their reserves and settled in non-Indian communities are expected to look to their new home municipality for any assistance necessary exactly as would any other member of the community.[4]

In sum, the federal Department of National Health and Welfare and its Indian Health Service was increasingly to be the source of last resort.

And yet, as this dissertation has documented, integration's call to equality encountered significant roadblocks. While Ottawa claimed that equality of treatment was a prime objective of its post-war

[4] Letter from G.D.W. Cameron DM to Larry T. Pennell, MP, (5 February 1963), RG 29 Vol 2905 File 851-1-A479 Pt. 3, Indian and Northern Health Services Brantford District, LAC.

political priorities, status First Nations individuals were denied the federal vote until 1960. Such a delay was likely born from the hope that the "carrot" of the vote would have persuaded more First Nations individuals to select voluntary enfranchisement to access it, while simultaneously being asked to renounce treaty or Indigenous rights. When so few individuals elected to do so, Ottawa changed course. After centuries of resistance to colonial subordination, it should have hardly been surprising to policy makers that so many First Nations peoples continued to oppose Ottawa's efforts. It did, however, facilitate an approach to First Nations policy that strove to make "special status" increasingly untenable. While new social welfare programs were developed, including hospital and medical insurance plans, First Nations peoples were offered access alongside other Canadians as citizens but in exchange their access to health care as status Indians was retracted. Tragically, such a stance facilitated barriers to First Nations access to quality health care and led to significant harm.

At the same time, conflict arose with the repeated assertions of many First Nations peoples that they remained both sovereign peoples, despite the efforts of settler-colonialism, and bearers of rights to protection, including health care. Integration policy may have been powerful, but it certainly had limitations. This project has documented a history of First Nations marginalization in circles of settler power, but it would be a misconception to believe that such a positioning was passively accepted. Rather, as is argued throughout this research, settlers chose to remain deaf to the ringing calls for reconciliation to renew a partnership of equals. This focus on settler choice allows my research to highlight that First Nations' marginalization was constructed and never inevitable.[5]

[5] Nursing scholars Annette J. Browne et al. remind scholars of the importance of this endeavour. They argue "we must guard against undermining human agency by portraying people as necessarily marginalized or disadvantaged

Finally, and perhaps unexpectedly for federal politicians, their reliance on and perpetuation of racialized and colonial narratives resulted in challenges from the provinces who saw First Nations peoples as burdens rather than fellow equal citizens, as explored in both chapters three and five. Despite Ontario's early post-war claims that First Nations residents of the province were to be considered as citizens, during the implementation of this vision, they were offered only a qualified citizenship status. Throughout the period under study, Ontario stressed that status First Nations individuals were the exclusive financial responsibility of the federal government to limit any drain on provincial budgets. Thus, Ontario continued to draw on discourses and structures of difference in a political climate that suggested the formal legislative equality of Canadian peoples was within reach. The history of First Nations health care access complicates this interpretation and reminds scholars of the need to document and assess how systemic racism continues in periods when a post-racial ideal was being advocated.[6] In particular, my study's use of Critical Race Theory helps to reveal the specific ways racialization continued to be perpetuated within settler structures in the post-war period and argues that jurisdictional debates were as much about racialized stereotypes of First Nations as burdens than about any other concern.

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or as victims by virtue of their category for we risk reinforcing the very power relations we seek to dismantle." Annette J. Browne et al., "The Relevance of Postcolonial Theoretical Perspectives to Research in Aboriginal Health," *Canadian Journal of Nursing Research* 37, no. 4 (2005): 24-25.

[6] In this endeavour, I join with other scholars who challenge a laudatory history of post-war universalism. Travis Hay, *Inventing the Thirty Gene: The Science of Settler Colonialism,* (Winnipeg: University of Manitoba Press, 2021); Catherine Carstairs and Ian Mosby, "Colonial Extractions: Oral Health Care and Indigenous Peoples in Canada, 1945-79," *The Canadian Historical Review* 10, no. 2 (June 2020): 192-216; Mary Jane Logan McCallum, and Adele Perry, *Structures of Indifference: An Indigenous Life and Death in a Canadian City* (Winnipeg: University of Manitoba Press, 2018); Mary Jane Logan McCallum, "Starvation, Experimentation, Segregation, and Trauma: Words for Reading Indigenous Health History," *The Canadian Historical Review* 98, no. 1 (March 2017): 96-113; Maureen Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s* (Toronto: University of Toronto Press, 2016); Karen Stote, *An Act of Genocide: Colonialism and the Sterilization of Aboriginal Women* (Halifax: Fernwood Publishing, 2015); Ian Mosby, "Administering Colonial Science: Nutrition Research and Human Biomedical Experimentation in Aboriginal Communities and Residential Schools, 1942-1953," *Histoire sociale* 46, no. 91 (May 2013): 145-172.

As described at the close of chapter five, the evidence of fundamentally static priorities of settler-colonial governments in Canada is perhaps best encapsulated in the Federal Government 1969 White Paper on Indian Affairs. Now widely understood as a watershed moment in Indigenous-Settler relations, the content of Ottawa's policy repeatedly refused to adopt a rights-based lens to First Nations matters. Thus, while the initial aim of this study was to examine how the frameworks of Post-Colonial Theory and Critical Race Theory inform the histories of First Nations health care access in post-war Canada broadly and Ontario in particular, I have encountered the need for additional frames of analysis to approach a full history of this field. Specifically, the dominance of epistemic racism that my research documented—the belief that White-settler-colonial readings of treaties as land surrenders and their associated rights as of inherently less value than the rights of White-settler-citizenship—encouraged me to see the value of a rights-based lens of analysis in the history of First Nations health care to destabilize such assumptions. As Mr. Archie Redsky of Shoal Lake pointed out to an *Indian Act* consultation meeting in 1968, "I could understand how the treaty rights would have been broken if the rivers were diverted or the growth of the grass had stopped," but neither of these events have occurred.[7] Additional scholarship taken from this standpoint, I believe, along with Mary Jane Logan McCallum and Maureen Lux, would greatly enrich the field of health care history in Canada and supports their argument that "there appears to be much more room for a discussion of the Indigenous history of medicare than has been previously afforded by the guiding questions and methods of medical and health care history."[8]

[7] Archie RedSky, Report of the Indian Act Consultation Meeting, Fort William, Ontario, (16-19 August 1968), RG 10 Vol 11580, Indian Affairs Branch, Dept of Citizenship and Immigration, LAC.
[8] Mary Jane Logan McCallum and Maureen Lux, "Medicare versus Medicine Chest: Court Challenges and Treaty Rights to Health Care," in *Medicare's Histories: Origins, Omissions, and Opportunities in Canada,* ed. Esyllt W. Jones, James Hanley, and Delia Gavrus (Winnipeg: University of Manitoba Press, 2022).

With the historical context that my research provides there are number of fields upon which future research could expand. Because I am a White settler-scholar, I acknowledge that this positioning has inescapably shaped my research methodology and the (re)sources available to this study. Thus, this dissertation has offered only a historiographical model suited to calling out settler accountability for past actions and blind spots rather than for a detailed history of First Nations' resistance—its myriad dynamics and own internal adaptions, developments, and tensions. Such an in-depth history of resistance to systemic racism and settler-colonialism and of First Nations' perspectives on appropriate health care provision and partnership remains a vital sphere for attention not sufficiently covered here.

Furthermore, racialization is unquestionably a powerful process that needs focused and critical examination, but it is an inescapable fact that identities are multifaceted and intersectional.[9] Thus, while alternative components of identity such as gender were beyond the scope of this dissertation for matters of feasibility, future research that posed critical questions about the ways the history described herein can be nuanced through such analysis would be very welcome. So too, would studies with a focus on the local context of health care provision. Through such additions, the mechanics of how the top-down policies outlined and examined in this study operated "on the ground" could be further understood.

[9] Scholarship that has already taken such an approach include Sarah Nickel's "Reconsidering 1969: The *White Paper* and the Making of the Modern Indigenous Rights Movement," *The Canadian Historical Review* 100, no. 2 (June 2019): 223-238; Mary Jane Logan McCallum, *Indigenous Women, Work, and History, 1940-1980* (Winnipeg, University of Manitoba Press, 2014); Myra Rutherdale, *Women and the White Man's God: Gender and Race in Canadian Mission Field* (Vancouver: University of British Columbia Press, 2002).

Celebratory histories of Canada's universal health care system often leave Canadians with a sense of pride. As this dissertation argues such honouring of political will to improve the common good and successful federal- provincial diplomacy are only parts of Canada's health care history. Health care historiography must engage with Canada's history of systematic racism and settler-colonial harm. Historical consciousness of the ways in which racialized stereotypes of First Nations peoples were developed, sustained, and persist to this day can also meaningfully inform current health care policy practice. In *Locating Medical History,* Allan Brandt suggested that "a deeply historical sensibility may alert those with policy-level responsibilities to unintended consequences, legitimate complexities, and the precise timing and context of both potentials and obstacles to reform."[10] I argue that the continuity of settler-colonial constructions of Indigenous people into the post-war period helps to explain the limitations of post-war health policy. Moreover, I believe that without the marriage of such historical consciousness with contemporary policy planning and action, stereotypes will persist, and disparities of ill-health will incorrectly appear inevitable. Effective policy today needs to be accountable to the history and realities of on-going settler-colonialism and its racialized rhetoric.[11]

As outlined in the introduction, my dissertation joins with a rising number of health care historians who recognize that the history of settler-colonialism and systemic racism are necessary additions

[10] Allan M Brandt, "From Analysis to Advocacy: Crossing Boundaries as a Historian of Health Policy," in *Locating Medical History: Their Stories and Their Meanings,* ed. Frank Huisman and John Harley Warner (Baltimore: John Hopkins Press, 2006), 467.

[11] The expansion of the scope of medical and health care history to include the social determinants of health has made significant contributions to our understanding of how health inequalities develop and persist. As scholars Sarah de Leeuw, Nichole Marie Lindsay, and Margo Greenwood have argued, however, a focus on the "social" determinants of health, marginalizes attention to alternative causes of ill-health. For Indigenous peoples, they argue, colonialism remains the "broadest and most fundamental determinate of Indigenous health and well-being in countries where settler-colonial power continues to dominate." Sarah de Leeuw et al., "Introduction: Rethinking Determinants of Indigenous Peoples' Health in Canada" in *Determinants of Indigenous Peoples' Health in Canada: Beyond the Social,* ed. Sarah de Leeuw et al. (Toronto: Canadian Scholars Press, 2015), xii.

to the history of health care in Canada and responds to calls from outside the academy. It bears repeating that *The Truth and Reconciliation Commission* (TRC) has created a call to action that specifically addresses this point. Call to Action 18 states: "We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties."[12] Clearly, there is a need to review and reassess with a new lens policy and policy making in Canada with respect to Indigenous health. My research is one contribution to addressing this need. The historical and recent tragedies outlined at the start of this study demand a serious engagement with this past.

Finally, my research also serves as a stark reminder that a repeated dismissal of First Nations voices in health care specifically, and Canadian society more broadly, never resulted in the widespread improvement of First Nations well-being that policy makers of my research period hoped that it would. If substantial and widespread improvement to First Nations' health care access and well-being are to occur, it can only be achieved through truly collaborative endeavours. As the TRC final report stated, "by establishing a new and respectful relationship, we restore what must be restored, repair what must be repaired, and return what must be returned."[13]

[12] *Final Report of the Truth and Reconciliation Commission of Canada, Vol 1: Summary, Honouring the Truth, and Reconciling for the Future* (Toronto: James Lorimer & Company Ltd, 2015), 322.
[13] *Final Report of the Truth and Reconciliation Commission of Canada,* 6.

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Appendix A

Department of National Health and Welfare, Allotment State of Expenditures, as of March 31, 1946 and 1947 (Selected)[1]

Statement of Allotment Balances as of March 31, 1946,		as of March 31, 1947
Minister Salary and Motor car allowance	$12,000	$12,000
Miscellaneous Gratuities	$1,423.32	$250.00
Family Allowances Payments	$172, 632,146.98	$245,140,531.59
Old Age Pensions	$33,715,092.01	$35,927,514.20
Department Administration	$250, 749.19	$434,091.25
Health Branch Administration	$71,392.49	$89,421.74
Food and Drugs	$181, 119.93	$314,780.73
Opium and Narcotic Drugs	$87, 370.99	$$82,929.92
Proprietary or Patent Medicines	$16,297.38	$15,905.67
Quarantine and Leprosy	$167, 353.93	$226,847.62
Laboratory of Hygiene	$190, 991.24	$170, 078.16
Immigration Medical Inspection	$71,454.15	$87,688.78
Child and Maternal Hygiene	$46, 630.13	$86,437.74
Public Health Engineering	$42,766.02	$121,387.19
Treatment of Sick Mariners	$321, 375.34	$358,281.09
Industrial Hygiene	$20,024.04	$77, 569.26
Nutrition Service	$76,687.27	$132,343.49
Combatting Venereal Disease Administration	$31, 603.83	$20,007.03
Combatting Venereal Disease Assistance to Provinces	$179,859.19	$171,850.29
Combatting Venereal Disease Distribution of Drugs	$49,914.43	$49,900.95
Grants to Institutions Assisting Sailors	$2,400.00	$2,400.00
Health Insurance Studies	$1865.00	$4763.44
Dental Health Division	$2,109.55	$12,623.52
Civil Services Health Division	$3,994.85	
Hospital Design Division	$1,162.51	$14,302.41
Mental Health Division	$2,889.40	$19,180.38
Blindness Control Division	$4,018.95	$10,393.62
Tuberculosis Control Division	$350.00	$2,880.57
Advertising and Labels Division	$100.11	$5,932.65
Welfare Branch Administration	$19,245.04	$25,060.31
Family Allowances Division Administration	$1, 721, 096.90	$1,695,855.74
National Council on Physical Fitness	$29, 571	

[1] Data collected from Department of National Health and Welfare, *Annual Report for the Fiscal Year Ended March 1946 and 1947,* Ottawa: Queen's Printer, 1946;1948. Accessed, *Internet Archive*, September 2021.

Administration		
National Council on Physical Fitness Financial Assistance to the Provinces	$23,434.18	
Old Age Pensions Including Pensions To the Blind—Administration	$43,555.30	$50,563.94
Indian Medical—Indian Hospitals and General Care of Indians	$2,299,763.65	$3,853,424.34
Indian Medical—Grants to Hospitals	$4,320.00	$4,320.00
Indian Medical—Grant to provide Additional services to Indians of British Columbia	$39,998.80	
Total Ordinary: $212, 494,970.52		$289,684,737.64

Appendix B

Treasury Office, DNHW, Allotment State of Expenditures as of March 31, 1951 (Selected)[2]

Total Ordinary:	$448, 852, 907.05
National Physical Fitness Assistance to provinces	$150, 288.00
National Physical Fitness	$74, 868.00
Old Age Pensions and Pensions To the Blind Administration	$ 77,937.23
Family Allowance Administration	$1, 811, 854. 01
Welfare Branch Administration	$30, 116.51
General Health Grants	$18, 874, 786.18
Civil Aviation Medicine	$40, 302.00
Medical Services—Indians and Eskimos	$10, 285, 667.75
Grants to Institutions Assisting Sailors	$2,600.00
Epidemiology	$26, 084.98
Blindness Control	$26, 504.78
Mental Health	$73, 449.41
Hospital Designs	$18, 757.61
Dental Health	$39, 068.12
Health Insurance Studies	$55, 274.98
Venereal Disease Control	$34, 360.28
Nutrition	$109, 438.39
Civil Service Health	$213, 555.22
Industrial Health	$158, 738. 76
Treatment of Sick Mariners	$557, 403.76
Public Health Engineering	$126, 091. 93
Child and Maternal Health	$66, 420.55
Immigration Medical Inspection,	$686, 112.27
Laboratory of Hygiene	$388, 854. 69
Quarantine and Leprosy	$262, 297.74
Opium and Narcotic Drugs	$165, 736.75
Proprietary or Patent Medicines	$26, 330.02
Food and Drugs	$716, 634.96
Health Branch Administration	$108, 911.84
Departmental Administration	$778, 259. 37
Welfare:	
Assistance to Schools of Social Work	$52, 500.00
Family Allowance Payments	$309, 465,460.52
Old Age Pensions, Including the Blind	$103, 169, 114.54
Miscellaneous Gratuities	$2,076.00

[2] RG 29 Vol 1846, File R120/1000-1/90-4. LAC.

Appendix C: List of the Members of the Select Committee on Indian Affairs

Mr. William A. Goodfellow (chair)	Northumberland (Minister of Public Welfare)	Progressive Conservative
John A. Fullerton	Algoma-Manitoulin	Progressive Conservative
John A. Pringle	Addington	Progressive Conservative
John P. Johnstone	Bruce	Progressive Conservative
George G. Johnston	Simcoe-Centre	Progressive Conservative
Roscoe Robson	Hastings East	Progressive Conservative
Bryan L. Cathcart	Lambton West	Progressive Conservative
William. G. Noden	Rainy River	Progressive Conservative
Harry C. Nixon	Brant	Liberal
Albert Wren	Kenora	Liberal-Labour
William. J. Grummett	Cochrane South	Co-operative Commonwealth Federation