

Early Administrative Developments in Fighting Tuberculosis among Canadian Inuit: Bringing State Institutions Back In

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Concern has recently been expressed about the manner in which the federal government administered its anti-tuberculosis campaign in the Canadian North during the 1940s and 50s. As well as scholarly literature generated on this subject in the last few years, popular interest has been aroused by a *Globe and Mail* front page article in September and a CBC Radio documentary in October of 1986 which highlighted the practice whereby Inuit men, women, and children were rounded up (generally by Arctic naval patrols) tested for TB and, if afflicted, immediately removed from their community. In some instances, Inuit cured of TB were never returned to their homes and, frequently, families were not informed as to their whereabouts during the treatment period and/or thereafter.

At the height of the anti-TB case-finding and treatment program between 1953 and 1964, records indicate that 4836 Inuit from the Northwest Territories (roughly half of the estimated average population of the NWT Inuit during this period) were institutionalized, 75-80 percent of whom were sent to southern sanatoria. The average stay in such institutions was 28 months. For an interdependent communal society this was a staggering loss. The strategy was to "sweep" a community, testing everyone possible and immediately confining those diagnosed as having the disease. For logistical reasons certain communities, at least during the early 1950s, were easier to test than others, and therefore the loss of members to southern institutions was much higher for some settlements than others. For example, one study of the Clyde River Inuit notes that approximately "70% of the Clyde Inuit over the age of 25 (were hospitalized in the south)." The author then added, "Indeed, I was able to find only two adult males in this group (of 225) who had not been in hospital away from Clyde." While estimates vary

as to how many patients were "lost" at some point in this evacuation process, there is no doubt some and probably many were.¹

Beyond the obvious emotional appeal of this issue and the undoubted grief and chaos these events caused Inuit families and communities, the anti-TB campaign demonstrates a number of the difficulties encountered by a fledgling northern administration belatedly attempting to deal with the social and economic situation Canadian Inuit faced by the middle of this century. However, the central role that such nascent administrative bodies played in policy developments has been minimized or ignored by recent scholarly treatment of this subject. Instead emphasis has been placed on the impact of wider social, cultural, and economic factors as the key determinants of government policy. State structures and their capacities, personnel, interactions, and organizational developments at particular points in time are viewed, implicitly or explicitly, as mere instruments of such determinants.

John O'Neil, for example, in a 1981 essay argues that both historic and contemporary deficiencies in the health care delivery system in Inuit communities are understandable as "symptoms typically associated with industrialized, capitalist political economies." For O'Neil, emphasis in the policy was on "specialized hospital-based medicine as opposed to community-based ambulatory care; a focus on curative rather than preventative medicine treatment; a concern with personal rather than public and environmental health; and a system structured to protect the vested interests of the professionally dominant segment of health workers — physicians."² In an article published last year, O'Neil favourably cites Malcom Segal³ in order to advance the analytical usefulness of the political economy perspective by eschewing concentration on the "theoretical linkages between structural and ideological factors, and health care practices." He focuses on the specific way in which "macro social, economic and political factors affect: 1. the causes of disease, 2. the capacity of people to undertake health-related activities, and 3. the professional control of health care services and their distribution."⁴ In neither of the above cases, however, do state institutions or the actions of state personnel warrant specific attention as determinants of policy content. Other examples drawn from recent literature on this subject provide the same omission.

George Wenzel's account of the Inuit health care system relies on the analytic categories provided by Siegler and Osmond,⁵ and

thus understands changes affecting Inuit health in terms of a value conflict between two models of health care. The first is the "Western medical praxis in which emphasis is placed on diagnosing and treating physical symptoms as a problem separate from the patient's social and environmental relationships." The second is "the Inuit model in which physical illness is seen as extending beyond the patient with societal and environmental effects and, therefore, is interpreted here as continuous, rather than disassociative."⁶ Similarly Corinne Hodgson's "cultural interpretation of health care,"⁷ which focuses specifically on native tuberculosis programs, argues that the federal government's response to Inuit tuberculosis can best be understood by recognizing that "perceptions and prejudices about disease . . . vary among cultures."⁸ For Hodgson, policy shortcomings, which compromised effectiveness and had a deleterious impact on native societies, are attributable to the insensitivities of decision-makers caused by culturally produced blindspots. Such blindspots allowed the federal government to believe its "treatment of tuberculosis among natives was a humanitarian movement conducted in a manner typical of the time," thus failing to recognize and adjust policy accordingly to the native view that this treatment was "tardy, motivated by white society's own interests, and carried out in a manner threatening to the continuity of native families and communities."⁹

While provocative and enlightening, missing in the Wenzel and Hodgson accounts is the fact that a significant debate occurred within the federal public service during the late forties and early fifties over the appropriateness of applying a "western" model of medicine on northern natives. This debate, which left the extent of the imposition of such a model in doubt, focuses our attention on the state processes which influenced the outcome. As noted above, all policy-makers did not initially share such a perspective or blindspots nor, as I will argue later, did they in the unfolding of the anti-TB campaign.

The purpose of this paper then is to round out these explanations of Inuit health care policy by exploring the inner dynamics of state institutions, and examining the role they play in mediating, interpreting, representing, and prioritizing the demands of the economic system. While broad cultural and ideological explanations may provide insight into the parameters from which the values, perceptions, and ideas of policy actors are drawn, my concern is in detailing the actual orientations of those formally involved in

policy making in order to make the linkages between the general and particular clear. This is important because in the transfer of broad cultural assumptions to individuals charged with policy-making responsibilities subtle, but often important differences, can occur. Finally, it is necessary to consider the effect of distinct administrative norms and problems which may produce divergent and potentially conflicting interests and values. Conflicts may occur between state actors and the popular or dominant culture and even within various sections of public bureaucracies themselves.

With respect to the federal government's Inuit anti-TB campaign this paper will examine the early administrative history, arguing that the often nightmarish developments in this area are understandable not only in terms of a colonial political economy or the problems of cultural ethnocentrism and arrogance, but also because of: the logistics of program delivery in the particular area being served; the division of responsibility for Eskimo policy-making principally between a new and small Arctic Services Division within a continually reorganizing northern administration and a more established and powerful Department of Health and Welfare; the legacy of the private sector as central actors in northern policy making; and public utterances aside a tight fisted set of political masters whose commitment to the Canadian North and its people was fragmented and more symbolic than substantive.

Such an analysis might allow us to say, for example, that physician-dominated health care is as much a factor of physicians' relative strength in health care policy-making at this particular point in northern administrative development as the preeminence of physicians in general in an industrialized, capitalist form of medicine. Or that sanatoria treatment was chosen over domiciliary care because of the particular characteristics of this disease and for pragmatic administrative considerations, rather than because such treatment was the "culturally accepted form." And that people were whisked away without adequate notice to their families because of the naval method of transportation chosen for program delivery and the resulting requirements (because of ice and other weather-related factors) to enter and exit isolated communities often in a matter of hours, rather than evidence of disregard for the needs of a differentiated other. Ultimately my argument is that all of these factors are, in this case, likely complementary explanatory tools and all should be considered in a full analysis.

The Development of an Administrative Response to Inuit TB

Prior to the introduction in 1947 of federally funded medical facilities, placed aboard the Hudson's Bay Company ship conducting the Eastern Arctic Patrol, the governmental role in providing for the tubercular care needs of Canadian Inuit had been limited to occasionally augmenting the health resources of the voluntary sector. Earlier, despite evidence from the Canadian Tuberculosis Association presented to the Canadian government in 1935 concerning the "uncontrolled menace" of tuberculosis in native populations generally, in 1938 a government published weekly pronounced the Inuit population "in good health," incorrectly reporting that instances of tubercular disease among them "are less frequent than among whites."¹⁰ As Richard Diubaldo documents in a 1985 report commissioned by the Department of Indian and Northern Affairs corporate policy section,

The basis of this official report was a general medical survey of Eastern Arctic Inuit conducted by Dr. Keith F. Rogers during the summer of 1938. Yet, if one examines Rogers' reports, one discerns a gap between what he actually reported and what the government wished to convey.¹¹

As this was Rogers' first trip to the Arctic he clearly noted that his findings were more a matter of opinion than based on empirically grounded analysis and called for the scientific work necessary for a definitive picture to be undertaken. This would not be done until 1945.

Several factors explain inaction on the part of government during this period, including general government parsimony during the depression,¹² the lack of distinction in both the public's and politicians' minds between Inuit and Indians,¹³ the absence of effective treatment procedures even if something was desired to be done, the lack of unified administrative structure dealing with all Inuit, and the apparent belief in health circles that "Eskimos must have a good deal of natural resistance."¹⁴ Diamond Jenness succinctly describes pre-World War Two government policy:

The police could continue as before to uphold Canada's sovereignty and maintain peace. . . . The missions, supported by small subsidies, could provide all the hospitalization or rudimentary education required, while the traders, gently regulated, could take care of their (the Inuit's) economic welfare.¹⁵

As in many other areas of Inuit social policy World War Two and its aftermath would produce change.

Elsewhere I have explored in some detail the reasons for increased government activity in the North after World War Two,¹⁶ and, as Peter Clancy has noted, while northern matters in general drew greater attention in Ottawa after 1945, several factors highlighted conditions among the Inuit. Among these,

The fur market slid into decline in the late 1940s, bringing severe pressure to bear on native hunter-trappers. At the same time, the new post-war social transfer programs for family allowances and old age pensions were extended to the north, injecting new cash streams into the native economy but also raising fears about the deleterious affects of the welfare state on a "simple" society. Beyond this reports circulated of distress and starvation among certain Eskimo groups.¹⁷

As well, the war and, in particular, the massive American presence during the war in territories Canada claimed as her own, produced concern over Canadian sovereignty and Inuit living conditions among a new generation of activist state personnel. On the sovereignty issue many public servants ultimately involved with northern administration, recalled that there was a feeling among them after the war that "we (previous administrations and politicians) had pretty much given everything away up there . . . Free! And it was time we (post-war public servants) did something about it."¹⁸

With respect to the latter point, R.A.J. Phillips, who immediately after the war was an official with External Affairs and in the early fifties became a senior officer within northern administration, has written of the legacy left in Inuit settlements neighbouring the Fort Chimo military development and the inadequacy of the then governmental response:

In those days the Canadian government had little time, inclination or knowledge to consider the effects of the impact of defense construction on the native population. The base became a magnet for those who were finding living off the land already thin. Jobs requiring no skill were easy to find . . . Fort Chimo (consequently) became a community of great but transitory affluence. When the boom suddenly ended, the Eskimo could neither continue in the new life or go back to the old . . . The results were painful.¹⁹

Equally, the Deputy Minister of Transport called the Northwest Territories Council's attention to the "deplorable health of the natives of Chimo"²⁰ and the Undersecretary of State for External

Affairs wrote to the Vice-Chairman of the same Council requesting information with respect to Council programs concerning Inuit education and health. As Jenness has noted,

Airmen and construction workers returned (to the United States and Britain as well as southern Canada) with first hand descriptions of the Eskimo settlements they had visited, and foreign newspapers and magazines published accounts of Canada's north that reflected little credit on its administrators.²¹

Specifically, complaints by American physicians attached to their military outposts in the Canadian north over "the shocking and outrageous condition of Inuit health and the medical care extended to them by the government of Canada"²² led to a review of what had been a longstanding policy of the government of refusing to reimburse the treatment of incurable tubercular patients by the church-run hospitals. In response to a query from the Deputy Commissioner of the NWT, the official responsible for overseeing government transfers for Inuit health care, D.L. McKeand, pointed out that, "incurable tubercular Eskimo patients have never been admitted, except under exceptional circumstances. Moreover, when death was imminent from any cause, patients were removed from the hospital to die in tents or snow houses." Concluding, McKeand pugnaciously added "I doubt if... the U.S. doctors temporarily stationed in the Arctic are familiar with these well known departmental regulations and practices."²³ Precipitated by the above pressures, departmental regulations and practices were about to change and a number of seminal events in Inuit health care were to occur.

In 1943, the Canadian Social Sciences and Research Council was given a \$10,000 grant by the Rockefeller Foundation to conduct a survey of conditions in the Canadian Arctic, under the direction of Harold Innis. G.J. Wherrett of the Canadian Tuberculosis Association was commissioned to survey health conditions and medical hospital services in the Northwest Territories. His findings were published the following year. In 1945 P.E. Moore, who had been acting Director of Medical Services for the Department of Indian Affairs during the war, was appointed Director. In January of 1945 the Advisory Committee for the Control and Prevention of Tuberculosis Among Indians was established. On 1 November 1945 the responsibility for the delivery of health care to Canadian Inuit was transferred from the Department of Mines and

Resources to the newly created Department of Health and Welfare. While the substance of these events and reports didn't necessarily lead health care policy and the anti-TB program in an identical direction cumulatively they provided not only the energy behind new policy in this field but also its context.

Wherrett's report²⁴ was confined to the Mackenzie River District where only 7% of the estimated Inuit population of the NWT resided. Based on RCMP and mission reports it provided the first serious estimate of the extent of the disease among the Inuit noting that the death-rate from tuberculosis was 314.6 per 100,000 of population as opposed to the Canadian average of 52 per 100,000. In Wherrett's view there was good reason to believe that these rates would be higher if figures included those listed in his study as "ill-defined and unspecified." This was the group where there was no doctor in attendance at death, which he later estimated as 84% of Inuit deaths. Taken together this evidence indicated that the problem was staggering and "clearly . . . the greatest health problem in the Territories."

Noting that the high rates for tuberculosis and other respiratory diseases were influenced by climatic conditions and the close confinement, poor ventilation, and intimate contact characteristic of the Inuit lifestyle, particularly during winter months, Wherrett was nevertheless fiercely critical of government policy and, more gently, the private sector. Concerning government, Wherrett cited a host of problems: the paucity of medical personnel available (6 for the entire western Arctic) and their role as administrative officers and Indian agents which kept them from their medical duties; the lack of uniformity across the Territories regarding public health ordinances and policy; the shortage of specialized equipment (caused by the refusal of the government to contribute towards the purchase of x-ray or other medical equipment); the lack of a sanatorium for the treatment of tubercular patients in the north; and the general "ad hoc" approach to health care where funds were spent in dramatic, emergency "save a life" flights rather than long term preventative and curative strategies. For Wherrett it was "high time the Department formulated a health policy founded on the needs of the people, rather than the meagre sum that 'Treasury Board' will allow it to put in the estimates." Focusing on the private sector, in particular the churches, as they ran all but two of the functioning hospitals at the time (those two were run by mining companies), he noted the tremendous under-

utilization of hospital beds (approximately 150 of the 233 available beds in the area being empty) and duplication of services as a result of the Roman Catholics and Anglicans maintaining separate facilities in Aklavik. The clear concern was that proselytising, inter-church competition, or other activities within denominational hospitals, had discouraged usage. Also, the churches desired to maintain general rather than specialized sanatoria care facilities, even though the latter was obviously the most needed. The challenge for the denominational hospitals was "to give a service and create an atmosphere which will induce patients to accept treatment and to remain as long as necessary."

The Advisory Committee for the Control and Prevention of Tuberculosis Among Indians emerged from a consultative process, begun in 1937, between the government and The Canadian Tuberculosis Association. At that time G.J. Wherrett, in his capacity as executive secretary of the CTA, petitioned Ottawa "for the sake of the Indians, but to protect the interests of the White population as well" (a common theme) to undertake a study of the tuberculosis problem, offering the CTA's assistance as a representative advisory committee. A conference on this subject was agreed to and held in June of 1937 with, as would become the norm, "representatives" were drawn exclusively from the medical profession, including those from within the relevant federal and provincial ministries, the CTA, sanatoria, and private physicians with experience in the tuberculosis field. The presented view which developed from this conference was that tuberculosis was essentially a medical, as opposed to a broader social-economic, phenomena and therefore was to be solved, if at all, by medical practitioners. Wherrett himself, as indicted in his later study of the Mackenzie Valley, would come to challenge this position. But it is fair to say that when these informal gatherings were reconstituted by order-in-council on 30 January 1945 as a formal advisory body with "the authority... to inquire into the present methods of tuberculosis prevention, detection, treatment and aftercare... of Indians"²⁵ and the responsibility to report to government with a view to "correlating (all governmental) anti-tuberculosis work... and (recommending) the best possible use of monies... for the purpose of eradicating and preventing the spread of the disease among Indians," it was designed to be the voice of the medical profession. Membership was confined to twelve members, "ten of who, including the chairman, shall be nominated by the Department of Health

and Welfare (Dr. Brock Chisholm, the Deputy Minister was their first annual nominee), and one to be a senior medical officer of the Indian Affairs Branch of the Department of Mines and Resources, who shall act as secretary of the committee."²⁶

On 1 November 1945 the medical responsibilities of the Indian Affairs Branch of Mines and Resources were transferred to the new Department of Health and Welfare. Dr. P.E. Moore, the director of Indian health services in Mines and Resources and their representative on the Advisory Committee, went to Health and Welfare as well.

The cumulative result of all of this organizational activity was that the committee mandated a central role in formulating the federal government's response to Indian and Inuit tuberculosis was exclusively staffed by one sector of health care workers. Thus the department charged with the responsibility for policy implementation in this field was functionally divorced from those with administrative responsibility for more general aspects of native life. This schism between health officials and other policy actors involved with Inuit affairs would play itself out on a variety of fronts affecting the nature of tuberculosis treatment and methods of service delivery in the crucial years ahead. Among these would be the tension between those in northern administration favouring local or domiciliary care versus those in health demanding southern evacuation. In addition, there was the administrative nightmare of one department attempting to mandate a strong-willed other as to the procedures it should follow in the identification of clientele (patients), rehabilitation, and familial correspondence. The relative institutional strengths of each of these departments at this point in time and the clarity in which they held their respective purposes greatly affected the policy outcomes of these debates.

For its part, after 1945, P.E. Moore and the Department of Health and Welfare, with the backing of the authoritative and powerful Canadian Tuberculosis Association as voiced through the Advisory Committee on the Control and Prevention of Disease Among Indians, were preparing to wrestle control of health care from the missions, and institute their own aggressive case finding, immunization, and southern Canada based treatment program. To this end the Eastern Arctic Medical Patrol was established to locate cases of TB, redundant military hospitals were purchased for the treatment of Inuit evacuees²⁷, and the controversial BCG vaccine, although selectively employed in southern Canada, was

aggressively applied to all Inuit who tested negative on one of the variety of skin tests employed. Complementing these actions, Moore was challenging the role of the churches in the operation of hospitals and rapidly implanting a system of primary health care facilities, including nursing stations and lay dispensaries in the north.²⁸ Coupled with the policy of evacuating any "serious"²⁹ or long term patients to southern hospitals, the mission facilities were effectively and consciously undermined. Buoying the political efficacy of this activist strategy was the ability to claim and show in hard numbers the progressive decline in the incidences of Inuit death from TB.³⁰ and other diseases. Dramatic budgetary increases³¹ awarded Health and Welfare for their programs during this period are testimony to their institutional success.

In stark contrast, those responsible for all other aspects of Inuit administration were constantly being re-organized at this time.³² With each new organizational form came new, often inexperienced, personnel and administrative mandates,³³ generally without a complementary increase in budget.³⁴ Further, such departments were still "desperately short of accurate information on field conditions in the Arctic"³⁵ and thus believed that the church mission stations and Hudson's Bay Company outposts were required not only as the first level of medical aid (increasingly a misperception, though a telling one regarding interdepartmental co-ordination and communication) but as the field staff of all social policy endeavours. As reflected in the calling of a Conference on Eskimo Affairs for May 1952 the Department of Mines and Resources and its successor, Resources and Development, perceived a need to avoid institutional resistance in the field and political fallout back home by maintaining a consensus between the traditional northern triumvirate of the churches, the trading companies and the police over their fledgling northern programs.

Complicating matters further, policy deliberations were occurring in the context of an ideologically charged debate of the late forties and early fifties. Ads were run by American oil companies in major newsmagazines, and articles in Canadian news dailies,³⁶ about the dangers of "Kenauyaksait" (family allowance payments) and other social welfare programming for the freedom and vigor of the "once proud Eskimos." As the churches and the Hudson's Bay Company had previously joined forces to support such concerns, northern administrators were put in the position of having to delicately tread on the pronounced sensibilities of its key policy

delivery constituency, and its own desires for future programs. Thus, a full five years after Health and Welfare had begun "boldly and aggressively"³⁷ advancing their department and personal professional concerns, the Deputy Minister of Resources and Development and Commissioner of the Northwest Territories, Major-General H.A. Young, could only cautiously open the 1952 Conference on Eskimo Affairs:

The purpose of this meeting is to consider the changes that have been taking place in the Canadian Arctic and the problems they are raising, particularly with regard to the Eskimo population. These problems are familiar to most of us and it is generally agreed, I think, that something should be done to cope with them. *Opinions seem to differ greatly on what can or should be done.* However, it is hoped that from an informal discussion of this kind it may be possible to obtain a clearer understanding of the main problems involved and perhaps be able to decide in a general way what our future policies should be.³⁸ (my emphasis)

Reflecting the institutional and political dilemma they were in and the department's own doubts about their ability to "meet the requirements of the Eskimos" Young concluded his remarks to the conference in otherwise startling fashion by stating, two years *before* a new department and minister would declare the previous *absence* of attention to Inuit problems, that "It would seem that we have to come to a point now where there may be a real danger of trying to do too much for these people."

The position that Young and the pre-Lesage/Robertson northern administration in general were expounding was one of minimal intervention into Inuit lives, "encouraging them to continue in their aboriginal ways of hunting in widely scattered small groups." With respect to health care policy they maintained several positions at odds with the then current orthodoxy of Health and Welfare.³⁹ They believed that increased subsidies to the mission hospitals were a better and less costly strategy for improved health care than government ownership,⁴⁰ and that local rather than southern care was preferable, not only because of the individual suffering caused by family separation but because of the disruption of the traditional economy and the problem posed by re-adaptation of Inuit to the North and their traditional lifestyle after lengthy stays in southern hospitals.

On this point archival evidence indicates that both the Department of Mines and Resources and its successor Resources and Development were sensitive to the problems caused by southern treatment and sympathetic to building northern facilities. An

internal memo to the Deputy Minister, H.L. Keenleyside, attached to a 1949 newspaper article which depicted the plight of an Eskimo child returning north after three years in a sanatorium and feeling "neither English or Eskimo," notes approvingly, "this is such a perfect little summary of problems faced by the Northwest Territories Administration . . . Seldom have so few words said so much."⁴¹ On the advisability of southern care the Department's position was spelled out in a 1950 memo from R.A. Gibson, Deputy Commissioner, Northwest Territories Administration, to the acting Deputy Minister of the new Department of Resources and Development, C.W. Jackson: "where possible, treatment (should) be undertaken in the country. (Only) where impossible, should patients be taken to hospitals farther south."⁴² If evacuation to the south was absolutely necessary their position was that emphasis should then be placed on northern rehabilitation facilities so that patients could be released from hospitals earlier.

The minutes of the sixth meeting of the Eskimo Affairs Committee record both northern administration's position and the resistance of Health and Welfare to such a plan:

The need for centres to which Eskimo patients could be discharged after undergoing prolonged treatment in hospitals was generally recognized . . . Dr. Proctor (the deputy to P.E. Moore and representing him at this meeting) strongly opposed sending back to the north any Eskimos who had undergone major surgery or who had been under prolonged treatment in an outside hospital. The opinion of the other members of the committee, however, was that most Eskimos would prefer to return home after discharge and would find it difficult to adapt themselves to another environment in southern Canada.⁴³

Similarly, these documents record concerns raised by the northern administration regarding the addition of social workers to the health care team to expedite recovery by reducing the "mental turmoil of patients," and for the maintenance of connections with home during hospitalization by encouraging correspondence and providing Inuit translators for this purpose. As these matters were largely within the jurisdiction of northern administration a departmental official, Leo Manning, "who speaks the language fluently," began hospital visits in 1952. These were sporadic until 1955 when two Inuit were hired to accompany him and make their own visits. Under severe pressure from Bishop Marsh, northern administrators also clearly pushed Health and Welfare to tighten identification and family notification procedures when individuals were "sent out."

Conclusions

By 1954 many of the suggestions emanating from northern administration concerning implementative procedures had been accepted as policy. As a result, the administration of the anti-TB program incrementally changed for the better. On the big issues of southern hospitalization and northern rehabilitation centres, the influence of this alternative agenda, while present, was less impressive. For example, by 1955 only 150 of the 600 institutionalized Inuit TB patients were hospitalized in the north. These were either the mildest cases or the most hopeless. While the need for northern rehabilitation facilities had been established at the Conference on Eskimo Affairs called by the Department of Resources and Development in May 1952, the issue was still at the discussion stage three years later at the sixth meeting of the permanent Committee on Eskimo Affairs.

In these instances the "medical" view did prevail. This was not a foregone conclusion, however, and was determined at least in part by internal state processes including the restrictive advisory and support role northern administration played regarding Inuit health policy, and their lack of more general institutional strength and political support *at this point in time* relative to the physicians of Health and Welfare. By comparison in the early 1960s the strength of Health and Welfare on these matters had waned. Criticism within the medical profession regarding tuberculosis treatment⁴⁴ contributed to this decline. Also, northern administration, profiting from the "northern vision," increased its status as the prime mover of Inuit social policy.⁴⁵ Following these changes in institutional strength, community based health care strategies, featuring local health committees and the training of Community Health Representatives, became more the norm.⁴⁶

In conclusion, this case indicates the importance of taking institutional factors seriously when doing policy analysis. It also suggests that even though state agencies and personnel work within particular economic, cultural, and ideological structures, policies produced by different state bodies at particular points in time can vary substantively as a result of factors like those which I have discussed. Thus there is a need to study individual instances of public policy and the institutional processes which surround their development and implementation in order to evaluate the degree of state autonomy or, conversely, social determination in each case.

The result of such work should provide a fuller account of policy determinants and a more accurate general theory of the state.

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NOTES

- ¹ See G.J. Wherrett, *Miracle of the Empty Beds*, University of Toronto, 1977, pp. 116-118 and G. Wenzel, "Inuit Health and the Health Care System: Change and Status Quo," *Inuit Studies*, vol. 5 no. 1, 1981, p. 9.
- ² John D. O'Neil, "Health Care in a Central Canadian Arctic Community: Continuities and Change," in *Health and Canadian Society*, D. Cobourn et al., eds., Fitzhenry and Whiteside, Toronto, 1981, p. 123.
- ³ M. Segall, "On the Question of a Socialist Health System: A Question of Marxist Epidemiology," in *International Journal of Health Services*, vol. 13, no. 2, 1983, pp. 221-225.
- ⁴ John D. O'Neil, "The Politics of Health in the Fourth World: A Northern Canadian Example," *Human Organization*, vol. 45, no. 2, 1986, p. 119.
- ⁵ M. Siegler and H. Osmond, *Models of Madness, Models of Medicine*, MacMillan, New York, 1974.
- ⁶ George W. Wenzel, "Inuit Health and the Health Care System: Change and Status Quo," in *Inuit Studies*, vol. 5, no.1, 1981, p. 7.
- ⁷ Corinne Hodgson, "The social and Political Implications of Tuberculosis Among Native Canadians," in *Review of Canadian Sociology and Anthropology*, vol. 19, no. 4, 1982, pp. 502-512.
- ⁸ *Ibid.*, p. 502.
- ⁹ *Ibid.*, p. 509.
- ¹⁰ Cited in R. Diubaldo, "The Government of Canada and the Inuit 1900-1967," prepared for Research Branch, Corporate Policy, Indian and Northern Affairs Canada, 1985, p. 93.
- ¹¹ *Ibid.*
- ¹² As particularly brutal evidence of this in 1937 Indian agents were instructed that the medical services they provided were to be restricted to "those required for the safety of limb, life or essential function" and "there (were to be) no funds for tuberculosis surveys, treatment in sanatoria, or hospitals of chronic tuberculosis, or other conditions." Memo, Department of Indian Affairs, Public Archives of Canada, RG 22, vol. 253, file 40-801, part 1.
- ¹³ For evidence of Parliamentary problems in this regard see, *House of Commons Debates*, Dec. 14, 1945, vol. 248, p. 3519, and June 17, 1946, vol. 251, pp. 2577-82.
- ¹⁴ See G.J. Wherret, *The Miracle of the Empty Beds*, University of Toronto Press, Toronto, 1977, p. 117.
- ¹⁵ D. Jenness, *Eskimo Administration: II Canada*, Arctic Institute of North America, Technical Paper, No.14, 1964, p. 50.

- ¹⁶ P.G. Nixon, "Eskimo Housing Programs 1954-65: A Case Study in Representative Bureaucracy," unpublished Ph.D. dissertation, University of Western Ontario, London, 1984. In particular chapter 3.
- ¹⁷ Peter Clancy, "The Life and Times of the Eskimo Affairs Committee," paper presented to the annual Meeting of the Canadian Political Science Association, June, 1986, p. 4.
- ¹⁸ Interviews R.G. Robertson, Don Snowdon, R.A.J. Phillips, all formerly of the Department of Northern Affairs and National Resources.
- ¹⁹ R.A.J. Phillips, *Canada's North*, MacMillan, Toronto, 1967, p. 152.
- ²⁰ Jenness, p. 76.
- ²¹ Ibid.
- ²² Diubaldo, p. 100.
- ²³ Ibid., p. 101.
- ²⁴ G.J. Wherrett, "Survey of health Conditions and Medical and Hospital Services in the Northwest Territories," in *Canadian Journal of Economics and Political Science*, vol. 11, Feb. 1945, pp. 49-60.
- ²⁵ Cited in, P.E. Moore, "No Longer Captain: A History of Tuberculosis and Its Control Amongst Canadian Indians," in *Canadian Medical Association Journal*, vol. 84, May 1961, p. 1015.
- ²⁶ Ibid.
- ²⁷ For example, the Charles Camsell Hospital in Edmonton, the Miller Bay Hospital near Prince Rupert, and the hospital in Nanaimo.
- ²⁸ For the rapid expansion see, "Indian and Eskimo Health," in *Canada's Health and Welfare*, vol.5, no.6, March 1950, special supplement. The antagonism between the churches and Health officials, particularly Moore, leaps from the pages of archival files of the period. However, the correspondence between church officials and various government agencies operating in the north also provides insiders testimony (as the churches sat on the Eskimo Affairs Committee) to the institutional battles being fought at this time. An example is a letter to the Minister responsible for northern administration in 1955, Jean Lesage, from the Anglican Bishop of the Arctic, Donald Marsh, who, after complaining about the belligerence of Dr. Moore in opposing a northern based sanatoria and a litany of other Health Department sins including losing Inuit children during the hospitalization process, adds: "I have come to the conclusion that the Department of Health and Welfare are not concerned with the true meaning of the two words (as far as the Eskimos are concerned) which make up the title of the Department, but are concerned purely on medical grounds with treatment of T.B. This is quite evident from their letters, and since the Prime Minister is satisfied with this situation, it seems that the responsibility for the Eskimo people will fall in greater measure and almost completely on your shoulders, although it would appear that in many ways your hands are tied." (Source: Public Archives of Canada. RG 22, vol.270, file 40-8-1, part 6.)
- ²⁹ The Policy was that serious but treatable patients were to be evacuated. Thus terminal patients remained in the north in the mission hospitals or occasionally nursing stations. However sound this was from an efficiency point of view it also negatively skewed the "success" rate of northern facilities which then became an argument against the expanded use of northern hospitals.
- ³⁰ As compared to Wherrett's 1945 figures, by 1969 not a single Inuit death from tuberculosis was recorded and morbidity rates had reached the level of the post World War Two Canadian average — though certain areas persisted in morbidity rates as high as 1%. As well, Health and Welfare could report on the numbers of Inuit being x-rayed, tested, and the declining numbers of T.B. patients as a result of institutional care. For

example, in 1955 at the height of the case finding program 698 Inuit were registered in tuberculosis institutions. By 1964 this number had dropped to 221 even though case finding procedures had become more exact.

- ⁵¹ Indian Medical Services' budget (which covered Inuit health) rose from roughly 1.3 million in 1943 to 11 million by 1949. Source: *Indian and Eskimo Health*, special supplement.
- ⁵² See Nixon, 1984, chapters 3 and 4.
- ⁵³ *Ibid.*
- ⁵⁴ For example, in 1953-54 Northern Administration Branch Funds represented one-third of total departmental expenditures (3.5 million) and by 1956-57 this percentage had actually decreased. In fact, the year the new department of Northern Affairs and National Resources was proclaimed with such fanfare its budget dropped from that of its predecessor in Resources and Development by nearly fifteen million dollars. Sources: R.T. Flanagan, "A History of the Department of Northern Affairs and National Resources," unpublished manuscript for Department of Indian Affairs and Northern Development, 1966, p. 86; and Jenness, 1964, p. 90.
- ⁵⁵ Clancy, 1986, p. 8.
- ⁵⁶ See *Newsweek*, Feb. 16, 1963, p. 81, *The Globe and Mail*, Dec. 6, 1952, *Ottawa Journal*, Jan. 8, 1953. Responding to this debate at one point, and indicating the tensions Moore's actions were producing even within his own department, a letter from George Davidson, Deputy Minister of Welfare, to H.A. Young, Deputy Minister of Resources and Development, dated 21 Jan. 1953, reads as follows: "I can well understand how anyone (in the press) after listening to Dr. Moore's very forthright expression of his views on conditions in the Arctic and his need for extra staff, money and facilities, would come to the conclusion that tuberculosis was on the rampage and rapidly increasing among our Eskimos. The unfortunate fact, which is not always realized by people like Dr. Moore, is that strong statements made by him as to our shortcomings and inadequacies in meeting the problems of Canada's Northland are oftentimes twisted around by people who are antagonistic to what we are doing and converted into a condemnation of even the inadequate efforts that are now being made." (Source: Public Archives of Canada, RG 22, vol.254, file 40-80-1, part 3.)
- ⁵⁷ Wherrett, 1977, pp. 114-116.
- ⁵⁸ Public Archives of Canada, RG 22, vol.254, file 40-8-1, part 2.
- ⁵⁹ This position was by no means uniformly held by officials in Resources and Development and its predecessor Mines and Resources, but it was the preponderant sensibility. A notable dissident in this regard was Bent Sivertz who was to become Chief of the Arctic Division and then Director of the Northern Administration Branch under the Gordon Robertson-led Department of Northern Affairs and National Resources.
- ⁶⁰ Following the advice of G.J. Wherrett's 1944 report.
- ⁶¹ P.A.C. RG 22, vol 254, file 40-8-1, part 2. Health and Welfare's position on these matters was starkly put by the Minister, Paul Martin, in a letter to the Prime Minister on 1 April 1955, after his department had been attacked by Bishop Marsh for, among other things, refusing to build northern sanatoria. It reads: "Patients in hospitals, if a hundred miles or so away from their point of origin are actually as much removed from their families as they are in Quebec City, Hamilton or Edmonton. The change from an igloo or skin tent to a hospital bed is just as marked whether that be in Holman Island or the city of Edmonton, and the patient discharged requires the same readjustment to go back to his rigorous Arctic life. It is the contention of my officials that once you move an Eskimo from his native environment to a hospital bed, the change is absolute and the location of the

bed makes very little difference. If the hospital bed is to be located at a distance greater than can be travelled by dog team, a few extra hours in an aircraft cannot make much difference to the patient, or to his family as regards visits. (Sources: P.A.C. RG 22, vol.270, file 40-8-1, part 6.)

⁴² copy?

⁴³ P.A.C. RG 22, vol. 270, file 40-8-1, part 6.)

⁴⁴ See in particular, O. Shaefer, "Medical Observations and Problems in the Canadian Arctic, Parts 1 and 2," *Canadian Medical Association Journal*, August 15, 1969, vol. 1, pp. 248-253 and September 1, 1959, vol. 1, pp. 386-393, respectively.

⁴⁵ I have documented the effect of the largely bureaucratically inspired "northern vision" on the resources and influence of the Department of Northern Affairs and National Resources in "Bureaucracy and Innovation," *Canadian Public Administration*, vol.30, no.2, Summer 1987.

⁴⁶ John O'Neil has in fact noted these changes in "The Politics of Health in the Fourth World: A Northern Canadian Example," *Human Organization*, vol.45, no.2, Summer 1986, pp. 119-128.